

SERFF Tracking Number: MNNL-128074946 State: Arkansas
Filing Company: Minnesota Life Insurance Company State Tracking Number:
Company Tracking Number: 12-400
TOI: L04I Individual Life - Term Sub-TOI: L04I.103 Renewable - Single Life -
Fixed/Indeterminate Premium
Product Name: Individual Term Life Policy
Project Name/Number: 2012 Term Refresh/12-400

Filing at a Glance

Company: Minnesota Life Insurance Company

Product Name: Individual Term Life Policy

TOI: L04I Individual Life - Term

Sub-TOI: L04I.103 Renewable - Single Life -
Fixed/Indeterminate Premium

Filing Type: Form

SERFF Tr Num: MNNL-128074946 State: Arkansas

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

Co Tr Num: 12-400

State Status: Approved-Closed

Authors: Carol Ouhl, Susan
Johnson, Matthew Harrington,
Joyce Townsend

Date Submitted: 02/09/2012

Reviewer(s): Linda Bird

Disposition Date: 02/21/2012

Disposition Status: Approved-
Closed

Implementation Date:

Implementation Date Requested: 03/07/2012

State Filing Description:

General Information

Project Name: 2012 Term Refresh

Project Number: 12-400

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Deemer Date:

Submitted By: Susan Johnson

Filing Description:

This filing is an individual, term life policy with a guaranteed level premium period chosen by the applicant. Thereafter, the policy is an annually increasing, renewable term policy. This policy is new and replaces the Advantage Elite Term Policy, form # 07-400, approved on March 28, 2007 under SERFF Tracking # MNNL-125124999.

The term policy provides level term insurance protection with premiums guaranteed level for a specific period of time. The minimum issue age is 16 and it is renewable to age 95. The maximum issue age varies according to the length of

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Individual

Individual Market Type:

Filing Status Changed: 02/21/2012

State Status Changed: 02/21/2012

Created By: Susan Johnson

Corresponding Filing Tracking Number: 12-400

SERFF Tracking Number: MNNL-128074946 State: Arkansas
Filing Company: Minnesota Life Insurance Company State Tracking Number:
Company Tracking Number: 12-400
TOI: L041 Individual Life - Term Sub-TOI: L041.103 Renewable - Single Life -
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the guaranteed period for the level premium as follows: 5 year level premium = maximum issue age of 80; 10 year = 80; 15 year = 70; 20 year = 65 and 30 year = 50. Following the guaranteed premium period, the policy may be renewed annually at an increasing premium.

This policy will be marketed without an illustration to those of the general public who want lower cost coverage. Included is an exhibit of the required policy summary Statement of Policy Cost and Benefit Information.

The submitted applications will replace the corresponding versions in our 2010 applications submitted under SERFF Tracking # MNNL-126770349 and approved on August 18, 2010. These applications will be used in both paper and electronic formats. Security on and verification of electronic data is handled through an outside vendor, iPipeline. Electronic signature is applied via the use of "Accept" and "Decline" buttons which become active upon the completion of reading the Terms and Conditions Disclosure. Attached to the Supporting Document tab is a brief description of the iPipeline process.

The submitted applications will be used to apply for any one, or a multiple of, the products available in the entire portfolio we offer which consist of the individual life products listed below:

Term Life - Advantage Elite Select Term (5, 10, 20, 25, or 30 years of guaranteed level premium)
Term Life - Advantage Annual Renewal Term
Term Life Second Death - Advantage Annual Renewal Term Second Death
Whole Life - Secure Whole Life
Universal Life - Adjustable Life Legend, Adjustable Life Summit
Universal Life Second Death - Legacy Protector Survivorship
Indexed Universal Life - Eclipse Indexed Life
Indexed UL Second Death - Eclipse Protector Survivorship
Variable Life - Variable Adjustable Life Horizon
Variable Universal Life - Variable Adjustable Life Summit, Minnesota Life Accumulator VUL, and Waddell & Reed Accumulator VUL

An Extended Conversion Agreement is available for the Term Policy for review. This optional agreement extends the conversion privilege of the policy. The charge for this Agreement can be found in the Policy Data Pages.

A Waiver of Premium Agreement is also included for approval. This agreement provides for the waiver of premiums on the policy if the insured becomes totally and permanently disabled.

We also intend to offer this policy with the following previously approved forms:

SERFF Tracking Number: MNNL-128074946 State: Arkansas
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Form 11-904, Children's Term Agreement, approved on July 15, 2011 under SERFF Tracking # MNNL-127316395.

Form 09-931, Accelerated Death Benefit Agreement approved on May 15, 2009 under SERFF Tracking # MNNL-126122998.

The Actuarial Memorandums for the policy and agreements are attached as well as rates charged for the different age bands and risk classes.

A Statement of Variability is included. Minnesota Life Insurance Company certifies that any change or modification to a variable item outside stated ranges shall be administered in accordance with the requirements in the Variability of Information section, including any requirements for prior approval of a change or modification.

Thank you for your consideration.

Company and Contact

Filing Contact Information

Susan Johnson, Companies/Product susan.johnsonlaw@securian.com
 Compliance Analyst
 400 ROBERT STREET NORTH 651-665-4277 [Phone]
 ST. PAUL, MN 55101-2098 651-665-5424 [FAX]

Filing Company Information

Minnesota Life Insurance Company	CoCode: 66168	State of Domicile: Minnesota
400 Robert Street North	Group Code: 869	Company Type: Life Insurance
Law Department	Group Name:	State ID Number:
St. Paul, MN 55101-2098	FEIN Number: 41-0417830	
(651) 665-3500 ext. [Phone]		

Filing Fees

Fee Required?	Yes
Fee Amount:	\$750.00
Retaliatory?	No
Fee Explanation:	\$50 x 15 forms = \$750.
Per Company:	No

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COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Minnesota Life Insurance Company	\$750.00	02/09/2012	56205882

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	02/21/2012	02/21/2012

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	02/16/2012	02/16/2012	Susan Johnson	02/16/2012	02/16/2012

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Disposition

Disposition Date: 02/21/2012

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		Yes
Supporting Document	Application		Yes
Supporting Document	Life & Annuity - Actuarial Memo		No
Supporting Document	Statement of Variability		Yes
Supporting Document	Exhibit - Tele-Interview Script		Yes
Supporting Document	Exhibit - Brief Description - Electronic Signature Application Process		Yes
Supporting Document	Exhibit - Statement of Policy Cost and Benefit Information		Yes
Form (revised)	Advantage Elite Select Term Policy		Yes
Form	Advantage Elite Select Term Policy	Replaced	Yes
Form	Waiver of Premium Agreement		Yes
Form	Extended Conversion Agreement		Yes
Form	Application Part 1		Yes
Form	Application Part 3		Yes
Form	Application Part 3		Yes
Form	Application Part 1		Yes
Form	Application Part 1		Yes
Form	Application Part 2		Yes
Form	Application Part 2		Yes
Form	Application Part 2		Yes
Form	Application Part 1		Yes
Form	Application Part 1A		Yes
Form	Application Part 1B		Yes
Form	Supplemental Information to the Application		Yes

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Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 02/16/2012
Submitted Date 02/16/2012
Respond By Date 03/16/2012

Dear Susan Johnson,

This will acknowledge receipt of the captioned filing.

Objection 1

Comment:

We did not find a provision in the contract that provides for the payment of 8% interest on delayed claim payments as described in Ark. Code Ann. 23-81-118.

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

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Response Letter

Response Letter Status Submitted to State
Response Letter Date 02/16/2012
Submitted Date 02/16/2012

Dear Linda Bird,

Comments:

Please see the following in response to your recent objection.

Response 1

Comments: Attached please find the policy which has been corrected as follows:

1. The "What guaranteed interest rate will we pay on the policy proceeds?" provision on page 3 was corrected to add a new sentence: "If we do not pay the death benefit within 30 days of receipt of proof satisfactory to us, we will pay interest on the death benefit at the rate required in Arkansas Code 23-81-118(c)."
2. The suicide exclusion on page 5 has been corrected to remove reference to reinstatement pursuant to 23-81-115(a)(2)(E).

Related Objection 1

Comment:

We did not find a provision in the contract that provides for the payment of 8% interest on delayed claim payments as described in Ark. Code Ann. 23-81-118.

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:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form	Edition	Form Type	Action	Action	Readability Attach
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	Number	Date		Specific Data	Score	Document
Advantage Elite Select Term Policy	12-400.03		Policy/Contract/Fraternal Certificate	corrected	52.200	12-400.03 Advantage Elite Select Term Policy.pdf

Previous Version

Advantage Elite Select Term Policy	12-400		Policy/Contract/Fraternal Certificate	Initial	52.200	12-400 Advantage Elite Select Term Policy.pdf
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No Rate/Rule Schedule items changed.

Sincerely,
 Carol Ouhl, Joyce Townsend, Matthew Harrington, Susan Johnson

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Form Schedule

Lead Form Number: 12-400

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	12-400.03	Policy/Cont Advantage Elite ract/Fratern Select Term Policy al Certificate	Other	Other Explanation: corrected	52.200	12-400.03 Advantage Elite Select Term Policy.pdf
	12-900	Policy/Cont Waiver of Premium ract/Fratern Agreement al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		53.900	12-900 Waiver of Premium Agreement.pdf
	12-920	Policy/Cont Extended Conversion ract/Fratern Agreement al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		57.000	12-920 Extended Conversion Agreement.pdf
	F59410 Rev 1-2012	Application/ Application Part 1 Enrollment Form	Initial		54.100	F59410 Rev 1-2012 no sec.pdf
	F59534 Rev 1-2012	Application/ Application Part 3 Enrollment Form	Initial		53.600	F59534 Rev 1-2012 no sec.pdf
	F59536	Application/ Application Part 3	Initial		50.200	F59536 Rev

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Rev 1-2012 Enrollment Form				1-2012 no sec.pdf
F59537 Application/ Application Part 1	Initial	52.200	F59537 Rev	
Rev 1-2012 Enrollment Form			1-2012 no sec.pdf	
F59538 Application/ Application Part 1	Initial	50.100	F59538 Rev	
Rev 1-2012 Enrollment Form			1-2012 no sec.pdf	
F59572 Application/ Application Part 2	Initial	51.200	F59572 Rev	
Rev 1-2012 Enrollment Form			1-2012 no sec.pdf	
F59573 Application/ Application Part 2	Initial	50.000	F59573 Rev	
Rev 1-2012 Enrollment Form			1-2012 no sec.pdf	
F59573-T Application/ Application Part 2	Initial	50.100	F59573-T	
Rev 1-2012 Enrollment Form			Rev 1-2012 no sec.pdf	
F65324 Application/ Application Part 1	Initial	52.700	F65324 Rev	
Rev 1-2012 Enrollment Form			1-2012 no sec.pdf	
F72540 Application/ Application Part 1A	Initial	50.500	F72540 Rev	
Rev 1-2012 Enrollment Form			1-2012 no sec.pdf	
F72541 Application/ Application Part 1B	Initial	61.800	F72541 Rev	
Rev 1-2012 Enrollment Form			1-2012 no sec.pdf	
F72587 Application/ Supplemental	Initial	53.800	F72587 Rev	
Rev 1-2012 Enrollment Information to the Form Application			1-2012 no sec.pdf	

ADVANTAGE ELITE SELECT TERM POLICY

Face Amount payable at death during the term period

Premiums as stated on the Policy Information Page

Conversion Privilege

Renewal Privilege

Nonparticipating

**READ YOUR POLICY CAREFULLY
THIS IS A LEGAL CONTRACT**

Subject to the provisions of this policy, we promise to pay to the beneficiary the face amount when we receive proof satisfactory to us that the insured died during the term period shown on the Policy Information Page.

We make this promise and issue this policy in consideration of the application for this policy and the payment of the premiums.

The owner and the beneficiary are as named in the initial application unless they are changed as provided in this policy.

Signed for Minnesota Life Insurance Company, a stock company, at St. Paul, Minnesota, on the policy date.

Notice of Your Right to Examine This Policy

It is important to us that you are satisfied with this policy after it is issued. If you are not satisfied with it, you may return the policy to us or to your agent within 30 days after you receive it. If you return the policy, you will receive a full refund of any premiums you have paid within 10 days of the date we receive your notice of cancellation.



President



Secretary

MINNESOTA LIFE

Minnesota Life Insurance Company
400 Robert Street North
St. Paul, MN 55101-2098
651.665.3500

INDEX

If you have questions or complaints about this policy, you may contact your advisor, us, or the insurance department of your state at the following location.

Insurance Department of: []
[Address]
[Address]

Telephone Number []
Toll Free Telephone Number []

Assignment	5
Beneficiary	2
Benefits	3
Conversion Privilege	4
Definitions	2
Grace Period	4
Incontestability	5
Lapse (Premiums)	4
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Premiums	4
Reinstatement (Premiums)	4
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Settlement Options	3
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Advantage Elite Select Term Policy

An annually renewable, convertible term policy with a guaranteed level premium period

Insured: [JOHN JAMES DOE]
 Issue Age: [35]
 Gender: [Male]
 Policy Number: [1-000-000W]
 Policy Date: [January 1, 2012]
 Risk Class: [Standard Non-Tobacco]
 Face Amount: [\$1,000,000]

Payment Options	Premium	Annual Payment
Annual:	[\$1,375.00]	[\$1,375.00]
Semi-Annual:	[\$715.00]	[\$1,430.00]
Quarterly:	[\$371.25]	[\$1,485.00]
Monthly:	[\$121.00]	[\$1,452.00]

Basic Policy	Annual Premium
Level Term Policy	[\$1,195.00]
Level premium period [20] years	
Effective: [January 1, 2012]	
Premiums payable through [December 31, 2031]	

Renewal Privilege
 See following pages for renewal
 premiums payable through [December 31, 2070]

Conversion Privilege
 Conversion period begins [January 1, 2013] and ends [12/31/2021]

Additional Agreements

Annual Premium

Extended Conversion Agreement

Extended conversion period begins [January 1, 2022] and ends [December 31, 2031]

Premiums payable through [December 31, 2031]

[\$40.00]

Waiver of Premium Agreement

[\$140.00]

Effective: [January 1, 2012]

Premiums payable through [December 31 2031]

Total Annual Premium on Policy Date -----

[\$1,375.00]

Insured: [JOHN JAMES DOE]

Policy Number: [1-000-000W]

Renewal Premiums Based on Current Experience [with Waiver of Premium Agreement included through [December 31, 2031]].

Renewal Date	Annual	Semi-Annual	Quarterly	Monthly
[January 1]				
[2032	\$10,720.00	\$5,340.40	\$2,772.90	\$903.76
2033	\$11,320.00	\$5,886.40	\$3,056.40	\$996.16
2034	\$12,430.00	\$6,463.60	\$3,356.10	\$1,093.84
2035	\$13,650.00	\$7,098.00	\$3,685.50	\$1,201.20
2036	\$15,010.00	\$7,805.20	\$4,052.70	\$1,320.88
2037	\$11,380.00	\$5,917.60	\$3,072.60	\$1,001.44
2038	\$12,550.00	\$6,526.00	\$3,388.50	\$1,104.40
2039	\$13,880.00	\$7,217.60	\$3,747.60	\$1,221.44
2040	\$15,390.00	\$8,002.80	\$4,155.30	\$1,354.32
2041	\$17,100.00	\$8,892.00	\$4,617.00	\$1,504.80
2042	\$18,990.00	\$9,874.80	\$5,127.30	\$1,671.12
2043	\$21,040.00	\$10,940.80	\$5,680.80	\$1,851.52
2044	\$23,240.00	\$12,084.80	\$6,274.80	\$2,045.12
2045	\$25,610.00	\$13,317.20	\$6,914.70	\$2,253.68
2046	\$28,180.00	\$14,653.60	\$7,608.60	\$2,479.84
2047	\$31,100.00	\$16,172.00	\$8,397.00	\$2,736.80
2048	\$34,930.00	\$18,163.60	\$9,431.10	\$3,073.84
2049	\$38,200.00	\$19,864.00	\$10,314.00	\$3,361.60
2050	\$42,570.00	\$22,136.40	\$11,493.90	\$3,746.16
2051	\$47,480.00	\$24,689.60	\$12,819.60	\$4,178.24
2052	\$52,760.00	\$27,435.20	\$14,245.20	\$4,642.88]

Insured: [JOHN JAMES DOE]

Policy Number: [1-000-000W]

Renewal Premiums Based on Current Experience [with Waiver of Premium Agreement included through [December 31, 2031]].

Renewal Date	Annual	Semi-Annual	Quarterly	Monthly
[January 1]				
[2053]	\$58,310.00	\$30,321.20	\$15,743.70	\$5,131.28
2054	\$64,260.00	\$33,415.20	\$17,350.20	\$5,654.88
2055	\$70,390.00	\$36,602.80	\$19,005.30	\$6,194.32
2056	\$76,890.00	\$39,982.80	\$20,760.30	\$6,766.32
2057	\$85,780.00	\$44,605.60	\$23,160.60	\$7,548.64
2058	\$95,810.00	\$49,821.20	\$25,868.70	\$8,431.28
2059	\$107,270.00	\$55,780.40	\$28,962.90	\$9,439.76
2060	\$120,340.00	\$62,576.80	\$32,491.80	\$10,589.92
2061	\$134,890.00	\$70,142.80	\$36,420.30	\$11,870.32
2062	\$150,660.00	\$78,343.20	\$40,678.20	\$13,258.08
2063	\$167,460.00	\$87,079.20	\$45,214.20	\$14,736.48
2064	\$185,190.00	\$96,298.80	\$50,001.30	\$16,296.72
2065	\$203,550.00	\$105,846.00	\$54,958.50	\$17,912.40
2066	\$222,780.00	\$173,752.80	\$90,217.80	\$29,404.32
2067	\$243,100.00	\$189,602.40	\$98,447.40	\$32,086.56
2068	\$264,820.00	\$206,544.00	\$107,244.00	\$34,953.60
2069	\$288,570.00	\$225,069.00	\$116,862.75	\$38,088.60
2070	\$315,250.00	\$245,879.40	\$127,668.15	\$41,610.36]

Insured: [JOHN JAMES DOE]

Policy Number: [1-000-000W]

Guaranteed Renewal Premiums [with Waiver of Premium Agreement included through [December 31, 2031]].

Renewal Date	Annual	Semi-Annual	Quarterly	Monthly
[January 1]				
2032	\$19,760.00	\$10,275.20	\$5,335.20	\$1,738.88
2033	\$22,010.00	\$11,445.20	\$5,942.70	\$1,936.88
2034	\$24,420.00	\$12,698.40	\$6,593.40	\$2,148.96
2035	\$26,570.00	\$13,816.40	\$7,173.90	\$2,338.16
2036	\$29,030.00	\$15,095.60	\$7,838.10	\$2,554.64
2037	\$26,820.00	\$13,946.40	\$7,241.40	\$2,360.16
2038	\$29,820.00	\$15,506.40	\$8,051.40	\$2,624.16
2039	\$33,480.00	\$17,409.60	\$9,039.60	\$2,946.24
2040	\$37,590.00	\$19,546.80	\$10,149.30	\$3,307.92
2041	\$41,910.00	\$21,793.20	\$11,315.70	\$3,688.08
2042	\$46,470.00	\$24,164.40	\$12,546.90	\$4,089.36
2043	\$51,090.00	\$26,566.80	\$13,794.30	\$4,495.92
2044	\$55,770.00	\$29,000.40	\$15,057.90	\$4,907.76
2045	\$60,810.00	\$31,621.20	\$16,418.70	\$5,351.28
2046	\$66,030.00	\$34,335.60	\$17,828.10	\$5,810.64
2047	\$72,360.00	\$37,627.20	\$19,537.20	\$6,367.68
2048	\$79,440.00	\$41,308.80	\$21,448.80	\$6,990.72
2049	\$88,740.00	\$46,144.80	\$23,959.80	\$7,809.12
2050	\$98,550.00	\$51,246.00	\$26,608.50	\$8,672.40
2051	\$108,870.00	\$56,612.40	\$29,394.90	\$9,580.56
2052	\$120,150.00	\$62,478.00	\$32,440.50	\$10,573.20
2053	\$132,450.00	\$68,874.00	\$35,761.50	\$11,655.60
2054	\$146,730.00	\$76,299.60	\$39,617.10	\$12,912.24
2055	\$163,410.00	\$84,973.20	\$44,120.70	\$14,380.08

Insured: [JOHN JAMES DOE]

Policy Number: [1-000-000W]

Guaranteed Renewal Premiums [with Waiver of Premium Agreement included through [December 31, 2035]].

Renewal Date	Annual	Semi-Annual	Quarterly	Monthly
[January 1]				
2056	\$182,670.00	\$94,988.40	\$49,320.90	\$16,074.96
2057	\$203,670.00	\$105,908.40	\$54,990.90	\$17,922.96
2058	\$227,580.00	\$118,341.60	\$61,446.60	\$20,027.04
2059	\$252,480.00	\$131,289.60	\$68,169.60	\$22,218.24
2060	\$279,330.00	\$145,251.60	\$75,419.10	\$24,581.04
2061	\$309,060.00	\$160,711.20	\$83,446.20	\$27,197.28
2062	\$342,270.00	\$177,980.40	\$92,412.90	\$30,119.76
2063	\$379,080.00	\$197,121.60	\$102,351.60	\$33,359.04
2064	\$419,280.00	\$218,025.60	\$113,205.60	\$36,896.64
2065	\$462,360.00	\$240,427.20	\$124,837.20	\$40,687.68
2066	\$507,810.00	\$264,061.20	\$137,108.70	\$44,687.28
2067	\$555,240.00	\$288,724.80	\$149,914.80	\$48,861.12
2068	\$599,850.00	\$311,922.00	\$161,959.50	\$52,786.80
2069	\$646,350.00	\$336,102.00	\$174,514.50	\$56,878.80
2070	\$695,400.00	\$361,608.00	\$187,758.00	\$61,195.20

Death Benefit Alternative Settlement Options

Option 1: Interest Payments

Please refer to the Payment of Death Benefit section of your policy.

Option 2: Payments for a Specified Period

Monthly payments per \$1,000 of death benefit applied under this option are shown below.

Number of Years	Monthly Payments
5	\$17.08
10	8.75
15	5.98
20	4.59
25	3.76

[Option 3: Life Income

Monthly payments per \$1,000 of death benefit based on the Annuity 2000 Table and applied under this option are shown below.

Life Income with Payments Guaranteed for Male				
Age	Life	5 Years	10 Years	20 Years
50	\$2.98	\$2.98	\$2.97	\$2.89
55	3.37	3.37	3.34	3.20
60	3.89	3.87	3.82	3.55
65	4.58	4.55	4.43	3.90
70	5.54	5.46	5.20	4.21
75	6.87	6.67	6.08	4.43

Life Income with Payments Guaranteed for Female				
Age	Life	5 Years	10 Years	20 Years
50	\$2.75	\$2.74	\$2.74	\$2.70
55	3.08	3.08	3.06	2.99
60	3.52	3.51	3.49	3.34
65	4.11	4.09	4.03	3.72
70	4.93	4.89	4.75	4.09
75	6.12	6.01	5.66	4.37]

[Option 3: Life Income

Monthly payments for each \$1,000 of death benefit based on the Annuity 2000 Table and applied under this option are shown below.

Life Income with Payments Guaranteed for Unisex				
Age	Life	5 Years	10 Years	20 Years
50	\$2.79	\$2.79	\$2.78	\$2.74
55	3.14	3.14	3.12	3.04
60	3.59	3.58	3.55	3.38
65	4.20	4.18	4.44	3.76
70	5.05	5.00	4.84	4.12
75	6.26	6.14	5.75	4.38]

Option 4: Payments of a Specified Amount

Please refer to the Payment of Death Benefit section of your policy.

Settlement Option Guaranteed Annual Interest Rate: 1%

Summary of Policy Features

This policy is an annually renewable term life policy with guaranteed level premiums payable for the period shown on the policy data pages. Following the guaranteed premium period, the policy premium will increase on each renewal date as shown on the policy data pages.

Death Benefit

The amount payable to the beneficiary on the death of the insured is the total of the following amounts:

- PLUS** - The face amount (see policy data pages),
- PLUS** - Any additional amounts on the insured's life provided by any additional agreements (see policy data pages),
- PLUS** - Any premium paid beyond the policy month in which death occurs (see page 5),
- MINUS** - Any premium due (see page 5),

Additional Agreements

The additional agreements, if any, listed on the policy data pages are described more fully in those additional agreements.

Definitions

When we use the following words, this is what we mean:

age

The insured's age at nearest birthday.

death benefit

The amount we will pay under the terms of this policy when the insured dies.

face amount

The basic policy amount of insurance initially purchased.

grace period

The period of time measured from the due date of the last premium, during which coverage will remain in force despite non-payment of premium. The grace period is sixty-one days.

guaranteed level period

The length of time your premium for this policy will remain level.

inforce

The insured's life remains insured under the terms of this policy.

insured

The person whose life is insured under this policy as shown on the policy data pages.

issue age

The insured's age at nearest birthday as of the policy date.

lapse

A premium is in default, and the insured's life is no longer insured.

policy anniversary

The same day and month as your policy date for each succeeding year your policy remains in force.

policy date

The date shown on the policy data pages, which is the date from which policy anniversaries, policy years, policy months and premium due dates are determined.

we, our, us

Minnesota Life Insurance Company.

written request

A request in writing signed by you. We also may require that your policy be sent in with your written request.

you, your

The owner of this policy, as shown in the application, unless changed as provided in this policy. The owner may be someone other than the insured.

General Information

What is your agreement with us?

Your policy and any application attached to it contain the entire contract between you and us. This includes the initial application and all subsequent applications to change your policy. Any statements made in the application either by you or by the insured in the initial application or in any application for change will, in the absence of fraud, be considered representations and not warranties. Also, any statement made either by you or by the insured will not be used to void your policy nor defend against a claim under your policy unless the statement is contained in the initial application or any application for change to this policy.

No change or waiver of any of the provisions of this policy will be valid unless made in writing by us, attached to the policy and signed by our president, a vice president, our secretary or an assistant secretary. No agent or other person has the authority to change or waive any provisions of your policy.

Any additional agreement attached to this policy will become a part of this policy and will be subject to all the terms and conditions of this policy unless we state otherwise in the agreement.

When does your policy become effective?

Your policy will become effective on the earlier of the policy date or the date the policy is delivered to you, provided you have paid the first full premium, while the health of the proposed insured remains as stated in the application for this policy.

How do you exercise your rights under the policy?

You can exercise all the rights under this policy during the insured's lifetime by making a written request to us. This includes the right to change the ownership. If your policy is assigned, we will also require the written consent of the assignee. If you have designated an irrevocable beneficiary, the written consent of that beneficiary will also be required.

Beneficiary

To whom will we pay the death benefit?

When we receive proof satisfactory to us of the insured's death, we will pay the death benefit of this policy to the beneficiary or beneficiaries who are named in the application for this policy unless you have changed the beneficiary. In that event, we will pay the death benefit to the beneficiary named in your last change of beneficiary request as provided below.

What happens if one or all of the beneficiaries die before the insured?

If a beneficiary dies before the insured, that beneficiary's interest in the policy ends with that beneficiary's death. Only those beneficiaries who survive the insured will be eligible to share in the death benefit. If no beneficiary survives the insured, we will pay the death benefit of this policy to you, if living, otherwise, to your estate, or your successor if you are a corporation no longer in existence.

Can you change the beneficiary?

If you have reserved the right to change the beneficiary, you can request in writing to change the beneficiary. If you have not reserved the right to change the beneficiary, the written consent of the irrevocable beneficiary will be required.

Your written request will not be effective until we record it in our home office. After we record it, the change will take effect as of the date you signed the request. However, if the insured dies before the request has been so recorded, the request will not be effective as to the death benefit we have paid before we recorded your request.

Payment of Death Benefit

When will the policy death benefit be paid?

The death benefit of this policy will be payable if we receive proof satisfactory to us that the insured died while the policy was in force. Proof of any claim under this policy must be submitted in writing to our home office. The death benefit will be paid at our home office and in a single sum unless a settlement option has been selected.

We will pay interest on single sum death benefit from the date of the insured's death until the date of payment. Interest will be at an annual rate determined by us which will never be less than the settlement option guaranteed interest rate shown on the policy data pages. Settlement will be made within two months after receipt of satisfactory proof of death.

Can the death benefit be paid in other than a single sum?

You may, during the insured's lifetime, request that we pay the death benefit under one of the following settlement options. We may also use any other method of payment that is agreeable to you and us. A settlement option may be selected only if the payments are to be made to a natural person in that person's own right.

The following settlement options are all payable in fixed amounts as described below.

Option 1 -- Interest Payments

Payment of interest on the death benefit at such times and for a period that is agreeable to you and us. Withdrawal of death benefit may be made in amounts of at least \$500. At the end of the period, any remaining death benefit will be paid in either a single sum or under any other method we approve.

Option 2 -- Payments for a Specified Period

Monthly payments for a specified number of years. The amount of each monthly payment for each \$1,000 of death benefit applied under this option is shown on the policy data pages. The monthly payments for any period not shown will be furnished upon request.

Option 3 -- Life Income

Monthly payments for the life of the person who is to receive the income. We will require satisfactory proof of the person's age and gender. Payments can be guaranteed for 5, 10, or 20 years. The amount of each monthly payment for each \$1,000 of death benefit applied under this option is shown on the policy data pages. The mortality table used for these rates is shown on the policy data pages. The monthly payments for any ages not shown will be furnished upon request.

Option 4 -- Payments of a Specified Amount

Monthly payments of a specified amount until the death benefit and interest are fully paid.

If you request a settlement option, we will prepare an agreement for you to sign, which will state the terms and conditions under which the payments will be made.

Can a beneficiary request payment under a settlement option?

A beneficiary may select a settlement option only after the insured's death. However, you may provide that the beneficiary will not be permitted to change the settlement option you have selected.

Is the death benefit exempt from claims of creditors?

To the extent permitted by law, no payment of death benefit or interest we make will be subject to the claims of any creditors.

Also, if you provide that the option selected cannot be changed after the insured's death, the payments will not be subject to the debts or contracts of the person receiving the payments. If garnishment or any other attachment of the payments is attempted, we will make those payments to a trustee we name. The trustee will apply those payments for the maintenance and support of the person you named to receive the payments.

What guaranteed interest rate will we pay on the policy death benefit?

We will pay interest on single sum death benefit from the date of the insured's death until the date of payment. Interest will be at an annual rate determined by us which will never be less than the settlement option guaranteed interest rate shown on the policy data pages. Additional interest earnings, if any, on deposits under a settlement option will be payable as determined by us. If we do not pay the death benefit within 30 days of receipt of proof satisfactory to us, we will pay interest on the death benefit at the rate required in Arkansas Code 23-81-118(c).

Premiums

When and where do you pay your premiums?

Your first premium is due as of the policy date and must be paid when your policy is delivered. All premiums after the first premium are payable on or before the date they are due and must be mailed to us at our home office. A premium may not be paid earlier than 20 days before its due date.

How often do you pay premiums?

You may pay your premiums once a year, twice a year, or four times a year. These premiums are shown on the policy data pages as the annual, semi-annual and quarterly premiums.

If you decide to pay premiums once a year, your annual premium will be due on the policy anniversary date of your policy. Should you decide to pay premiums more than once a year, your semi-annual premiums will be due every six months and your quarterly premiums will be due every three months. In each year, one of the premium due dates must fall on the policy anniversary.

Are there other methods of paying premiums?

With the consent of your financial institution, you may request that your premiums be automatically withdrawn on a monthly basis from your account at that institution and paid directly to us. If for any reason your financial institution fails to pay a premium when it is due or if this premium payment arrangement is ended, you must pay an annual, semi-annual or quarterly premium directly to us before the end of the grace period to keep your policy in force.

What are the premiums for your policy?

The premiums due for your policy are level for the period of years shown on the data pages; thereafter they change every year. There are two tables in the policy data pages. The first table shows renewal premiums after the guaranteed level premium period, based on our experience at the time your policy was issued. As long as our experience on policies of this type remains the same, these are the premiums we will bill you. If our experience changes, the premiums we will bill you may be higher or lower. However, we will never bill you for a premium higher than those shown in the second table. These premiums are called "guaranteed" premiums.

Can you pay a premium after the date it is due?

Your policy has a 61-day grace period. This means that if a premium is not paid on or before the date it is due, you may pay that premium during the 61-day period immediately following the due date. Your premium payment, however, must be received in our home office within the 61-day grace period. The insured's life will continue to be insured during this grace period.

If the insured dies during this period, we will deduct a premium for this 61-day grace period from the death benefit of this policy. This 61-day grace period does not

apply to the first premium payment. The first premium must be paid when your policy is delivered.

What happens if a premium is not paid before the end of the grace period?

If a premium is not paid before the end of the 61-day grace period, your policy will lapse and no further premium payments may be made. At any time within three years from the date of lapse, you may ask us to restore your policy to a premium paying basis. We will require:

- (1) your written request to reinstate this policy;
- (2) that you submit to us at our home office during the insured's lifetime evidence satisfactory to us of the insured's insurability so that we may have time to act on the evidence during the insured's lifetime; and
- (3) payment of the premium currently due on your policy.

Is there a premium refund at the insured's death?

We will refund and pay to the beneficiary any part of a paid premium that covers the period from the end of the policy month in which the insured died to the date to which premiums are paid. However, if your policy contains a Waiver of Premium Agreement and the last premium was waived by us under that agreement, we will not refund that premium.

Renewal Privilege

Can this insurance be renewed?

This policy may be renewed, after the initial level guarantee period term period for additional one-year term periods provided:

- (1) the insured's age on the birthday nearest the date of renewal is less than age 95; and
- (2) we receive payment in our home office of the amount shown in the table of Renewal Premiums in the data pages for the date of renewal. The renewal premium must be received in our home office within 61 days from the date the insurance provided by this policy terminates.

Conversion Privilege

Can this insurance be converted to a new policy?

Yes. You may convert this policy during the period shown on the policy data pages upon our receipt of your written request provided:

- (1) all premiums due on this policy have been paid; and
- (2) we are not waiving premiums on this policy under a waiver of premium agreement.

What type of policy will I have after I convert?

The new policy must be single life permanent coverage on the policy forms we are then issuing. Also the new policy must satisfy the current minimum requirements of the product to which you are converting.

What will be the face amount of the new policy after conversion?

The face amount of the new policy may not be:

- (1) greater than the face amount for this policy on the date of conversion; or
- (2) less than the minimum amount we then issue on the new policy you request.

Can you convert less than the face amount?

If you convert less than the face amount and want to retain some of this policy, you may do so as long as the remaining coverage under this policy satisfies the minimum face amount requirements. The premium on the remaining coverage will be based on the face amount and risk classification then in effect.

What will be the risk class for the new policy?

The new policy will be on the same risk class, if available, as shown on the data pages for the original policy. If that original risk class is not available, the new policy will be in the same or equivalent rating class as this policy. The premium rate will be based on the insured's age on the policy date of the new policy.

Will evidence of insurability be required?

Evidence of insurability satisfactory to us will not be required of the insured unless the new policy is to contain an additional agreement. However if this policy contains a waiver of premium agreement, a waiver of premium agreement may be included in the new policy without evidence of insurability. The new policy will not, of course, cover any disability commencing before the date of conversion.

What if we are waiving premiums on this policy?

You cannot convert this policy to a new policy so long as we are waiving premiums on this policy under the waiver of premium agreement.

Who will be the beneficiary of the new policy?

The beneficiary of the new policy will be the same as the beneficiary designated for this policy on the date of conversion, unless you specify otherwise in a written request.

Additional Information

Can you assign your policy?

Your policy may be assigned. The assignment must be in writing and filed with us at our home office. We assume no responsibility for the validity or effect of any assignment of this policy or of any interest in it. Any portion of the death benefit which becomes payable to an assignee will be payable in a single sum. Any claim made by an assignee will be subject to proof of the assignee's interest and the extent of that interest.

What if the insured's age or gender is misstated?

If the insured's age or gender has been misstated, we will adjust the amount of death benefit payable under this policy, or any agreement attached to this policy, to that amount which the premiums paid would have purchased at the insured's correct age and gender.

When does your policy become incontestable?

After this policy has been in force during the insured's lifetime for two years from the policy date, we cannot contest this policy, except for fraud or the nonpayment of premiums. However, if there has been a reinstatement or policy change for which we required evidence of insurability, that reinstatement or policy change will be contestable for two years during the lifetime of the insured, from the effective date of the reinstatement or policy change.

Is there a suicide exclusion?

If the insured, whether sane or insane, dies by suicide, within two years from the policy date, our liability will be limited to an amount equal to the premiums paid for this policy. If there has been a policy change for which we required evidence of insurability, and if the insured dies by suicide within two years from the effective date of the policy change, our liability with respect to the policy change will be limited to an amount equal to the premiums paid for the policy change.

ADVANTAGE ELITE SELECT TERM POLICY

Face Amount payable at death during the term period

Premiums as stated on the Policy Information Page

Conversion and Renewal Privileges

Nonparticipating

Minnesota Life Insurance Company, a stock company, is a subsidiary of Minnesota Mutual Companies, Inc., a mutual holding company. You are a member of the Minnesota Mutual Companies, Inc., which holds its annual meetings on the first Tuesday in March of each year at 3 p.m. local time. The meetings are held at 400 Robert Street North, St. Paul, Minnesota 55101-2098.

MINNESOTA LIFE

Waiver of Premium Agreement

This agreement is a part of the policy to which it is attached and is subject to all its terms and conditions. This agreement is effective as of the policy date of this policy unless a different effective date is shown on the policy data pages.

What does this agreement provide?

This agreement provides for the waiver of premiums on this policy if the insured becomes totally and permanently disabled. This means that you will not be required to pay any premium that falls due while the insured is totally and permanently disabled. To qualify for this benefit you must give us timely notice of the insured's disability. You must also furnish evidence satisfactory to us that the insured's total disability:

- (1) commenced while this policy and agreement were in force and;
- (2) commenced before the policy anniversary nearest the insured's age 65; and
- (3) was continuous for 6 months or more; and
- (4) did not result directly from any act of war, declared or undeclared.

What is "total" disability?

Total disability is a disability resulting from an accidental injury or a disease that requires the care of a licensed physician and continuously prevents the insured from engaging in an occupation. During the first 24 months of total disability "occupation" means the insured's regular occupation. After 24 months it means any occupation for which the insured is reasonably fitted by education, training or experience.

Also, the insured's total and irrecoverable loss of:

- (1) the sight of both eyes, or
- (2) the use of both hands, or
- (3) the use of both feet, or
- (4) the use of one hand and one foot, or
- (5) hearing, or
- (6) speech,

will be considered total disability even if the insured engages in an occupation.

What is "permanent" disability?

Total disability will be considered permanent only after it has existed continuously for at least 6 months.

What premiums will be waived?

If the insured is disabled as defined in this agreement, we will waive the premiums shown on the policy data pages, until the policy anniversary nearest the insured's 65th birthday. We will then automatically convert this policy to a new policy of single life permanent coverage on the policy forms we are then issuing. We will waive the premiums for the converted policy.

On what basis will premiums be waived or refunded?

We will waive or refund premiums according to the frequency of premium payment that was in effect on this policy on the date the insured's total disability commenced.

We will refund premiums paid from the date total disability commenced to the date the insured's claim is approved; however, we will not refund any premium paid more than six months before we were notified of the claim.

Are there any limitations?

No premium will be waived or refunded if the insured's total disability results directly from an act of war while the insured is serving in the military, naval or air forces of any country at war, declared or undeclared.

When must we be notified?

We must receive written notice of the insured's total disability at our home office:

- (1) while the insured is living and totally disabled; and
- (2) not later than one year after the termination of this agreement; and
- (3) within one year after the due date of the premium that you request us to waive or refund.

However, the failure to give this notice within the time provided will not invalidate the claim if it is shown that notice was given as soon as reasonably possible.

What is the premium for this agreement?

The annual premium for this agreement is shown on the policy data pages of this policy. If this agreement terminates, the total annual premium for this policy will be reduced by the amount shown.

What proof will be required?

You must furnish proof satisfactory to us that the insured is totally and permanently disabled as defined in this agreement before any premiums will be waived or refunded. We will from time to time also require additional proof satisfactory to us that the insured continues to be totally and permanently disabled. We may also require the insured to submit to one or more physical examinations at our expense. However, we will not require a physical examination of the insured more frequently than once a year if the total disability has continued for two years.

Is there an automatic conversion if the insured is totally disabled?

Yes. If we are waiving premiums under this policy we will automatically convert this policy on the policy anniversary nearest the insured's 65th birthday. The new policy will be single life permanent coverage.

The policy date of the new policy will be the date of conversion. Also, we will continue to waive premiums on the new policy so long as the insured remains continuously and totally disabled from the date this policy is automatically converted.

You may request in writing that we do not automatically convert this policy to a new policy. If you do this, the insurance under this policy will continue as provided for in this policy.

What if this policy lapses?

If this policy is lapsed for nonpayment of premium before notice of the insured's total disability is received at our home office, premiums will be waived or refunded only if the notice is received within one year after the due date of the first unpaid premium. Also, the total disability must have commenced prior to the due date of the unpaid premium or during the grace period allowed for the payment of that premium.

When is this agreement incontestable?

This agreement is subject to the incontestability provision in this policy. However, the contestable period for this agreement will be measured from the effective date of this agreement.

When will this agreement terminate?

This agreement will terminate on the earliest of:

- (1) the date any premium due for this policy remains unpaid at the end of the grace period; or
- (2) the date this policy terminates; or
- (3) the date we receive your written request to cancel this agreement; or
- (4) the policy anniversary nearest the insured's 65th birthday.



Secretary



President

Extended Conversion Agreement

This agreement is a part of the policy to which it is attached and is subject to all its terms and conditions. This agreement is effective as of the date shown on the policy data pages.

What does this agreement provide?

This agreement extends the conversion privilege of your policy.

What is the premium for this agreement?

The premium payable for this agreement is shown on the policy data pages.

What is the period of the extended conversion privilege?

The period of the extended conversion privilege is shown on the policy data pages.

Do the terms of this agreement change any of the other terms of the policy other than the conversion privilege?

No. The terms of this agreement do not change any other terms of the policy other than the conversion privilege provision.

When will this agreement terminate?

This agreement will terminate on the earliest of the following:

- (1) The extended conversion privilege end date shown on the policy data pages; or
- (2) the date we receive your written request to cancel this agreement; or
- (3) the date the policy terminates; or
- (4) the date of the insured's death.

Can this agreement be reinstated?

Yes. This agreement can be reinstated under the following conditions:

- (1) all of the reinstatement conditions stated in your policy have been satisfied; and
- (2) we receive written request from you; and
- (3) your written request for reinstatement is received prior to the extended conversion privilege end date shown on the policy data pages; and
- (4) your term insurance policy has not already been converted.



Secretary



President

Application Part 1
Individual Life Insurance

MINNESOTA LIFE

Minnesota Life Insurance Company - A Securian Company
 Life New Business • 400 Robert Street North • St. Paul, Minnesota 55101-2098

A. Proposed Insured Information	Proposed insured name (last, first, middle)			
	Social Security number		Date of birth (month, day, year)	
			Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
	Driver's license number		Issue state	Expiration date
	Primary telephone number		Secondary telephone number	
	Birthplace (state or, if outside the US, country)		E-mail address	
	Street address (no P.O. Box)			
	City		State	Zip code
Occupation		Years in occupation	Income	Net worth
B. Product	Product applied for		Base face amount \$	
	Total annual planned premium (excluding NRP)		Plan of insurance (if applicable)	
	Death benefit qualification test (if applicable, defaults to GPT if none selected) <input type="checkbox"/> Guideline Premium Test (GPT) <input type="checkbox"/> Cash Value Accumulation Test (CVAT)			
	Death benefit option (if applicable, defaults to cash/level if none selected) <input type="checkbox"/> Cash/Level <input type="checkbox"/> Protection/Increasing <input type="checkbox"/> Sum of Premiums			
	Dividend option (if applicable, defaults to policy improvement for AL Legend and paid-up additions for Secure Whole Life)			
C. Additional Benefits and Agreements <i>Select only those agreements available on the product(s) applied for.</i>	<input type="checkbox"/> Accelerated Benefit Agreement (Submit ABA Outline of Coverage form) <input type="checkbox"/> Accidental Death Benefit Agreement \$ _____ (Coverage Amount) <input type="checkbox"/> Additional Insurance Agreement \$ _____ (Coverage Amount) <input type="checkbox"/> Business Continuation Agreement <input type="checkbox"/> Business Value Enhancement Agreement Select one: <input type="checkbox"/> Maximum Single Premium <input type="checkbox"/> Level Premium with PDA (Submit Premium Deposit Account Information form) <input type="checkbox"/> Children's Term or Family Term - Child Agreement (Submit Family/Children's Term Application) \$ _____ (Coverage Amount) <input type="checkbox"/> Death Benefit Guarantee Agreement <input type="checkbox"/> Early Values Agreement <input type="checkbox"/> Enhanced Guaranteed Agreement <input type="checkbox"/> Enhanced Guaranteed Choice Agreement <input type="checkbox"/> Estate Preservation Agreement \$ _____ (Coverage Amount) Face Amount (Not to exceed 122% of base amount) <input type="checkbox"/> Estate Preservation Choice Agreement \$ _____ (Coverage Amount) Face Amount (Not to exceed 122% of base amount) <input type="checkbox"/> Exchange of Insureds Agreement			
	<input type="checkbox"/> Extended Conversion Agreement <input type="checkbox"/> Extended Maturity Agreement <input type="checkbox"/> Face Amount Increase Agreement <input type="checkbox"/> First to Die Agreement \$ _____ (Coverage Amount) <input type="checkbox"/> Guaranteed Insurability Option Agreement \$ _____ (Coverage Amount) <input type="checkbox"/> Guaranteed Insurability Option Agreement with Waiver \$ _____ (Coverage Amount) <input type="checkbox"/> Inflation Agreement <input type="checkbox"/> Interest Accumulation Agreement <input type="checkbox"/> Long-Term Care Agreement (Submit LTC Supplemental Application) <input type="checkbox"/> Overloan Protection Agreement <input type="checkbox"/> Premium Deposit Account Agreement (Submit Premium Deposit Account Information form) <input type="checkbox"/> Single Life Term Agreement \$ _____ (Coverage Amount) <input type="checkbox"/> Single Premium Paid-Up Additional Insurance Agreement \$ _____ (Premium Amount) <input type="checkbox"/> Surrender Value Enhancement Agreement <input type="checkbox"/> Term Insurance Agreement \$ _____ (Coverage Amount) <input type="checkbox"/> Waiver of Charges Agreement <input type="checkbox"/> Waiver of Premium Agreement <input type="checkbox"/> Other _____ <input type="checkbox"/> Other _____			

THE FOLLOWING BENEFITS AND AGREEMENTS WILL BE ADDED IF AVAILABLE FOR YOUR POLICY, UNLESS YOU CHOOSE TO OMIT THEM:

- Omit Automatic Premium Loan Provision Omit Cost of Living Agreement
 Omit Inflation Agreement Omit Policy Split Agreement
 (AL Summit, VAL Summit and VAL Horizon only)

D. Special Dating

- Date to save age
 Specific date (month/day/year): _____ (cannot select 29th, 30th, or 31st of the month)
 Are there any other Minnesota Life applications associated with this application? Yes No
 If yes, please provide Proposed Insured(s) full name(s) and whether the policies should have the same issue date.

E. Life Insurance In Force and Replacement

Submit appropriate replacement forms (not needed if replacing group coverage).

Excluding this policy, does the Proposed Insured have any life insurance, annuity or mutual fund in force or pending, including life insurance sold or assigned, or is in the process of being sold or assigned, to a life settlement, viatical or secondary market provider? If yes, provide details in the chart below. Yes No

Excluding this policy, has there been, or will there be, replacement of any existing life insurance, annuity or mutual fund, as a result of this application? (Replacement includes, but is not limited to, a lapse, surrender, 1035 Exchange, loan, withdrawal, or other change to any existing life insurance or annuity.) If yes, provide details in the chart below. Yes No

Life Insurance In Force

Full Company Name	Amount	Year Issued	Type	Will it be Replaced?
			<input type="checkbox"/> Individual or <input type="checkbox"/> Group <input type="checkbox"/> Personal or <input type="checkbox"/> Business	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Individual or <input type="checkbox"/> Group <input type="checkbox"/> Personal or <input type="checkbox"/> Business	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Individual or <input type="checkbox"/> Group <input type="checkbox"/> Personal or <input type="checkbox"/> Business	<input type="checkbox"/> Yes <input type="checkbox"/> No

F. Beneficiary Information

If the beneficiary is a trust, give complete trust name and date trust established.

	Beneficiary First and Last Name	Relationship to Proposed Insured	SSN/TIN (If known)	Percentage
Primary				
Contingent				

G. Owner Information

Submit the appropriate trust, corporate, or non-corporate form(s).

Only complete this section if the Owner is different than the Insured.

Owner name (last, first, middle)

- Individual
- Trust (submit Certification of Trustee Authority form)
- Corporate (submit Corporate/Non-Profit Resolution and Employer Notification Regarding the Potential Taxation of Death Benefit forms)
- Partnership (submit Partnership/LLC Resolution and Employer Notification Regarding the Potential Taxation of Death Benefit forms)
- Other _____

Social Security or tax ID number

Date of birth or trust date

Street address (no P.O. box)

City

State

Zip code

Relationship to proposed insured

Telephone number

E-mail address

H. Premium and Billing Information

Premium Notice Should Be Sent To:

- Proposed Insured Address in Section A
- Owner's Business/Employer Address (Indicate below)
- Owner Address in Section G
- Other (Indicate below)

Name

Address

City

State

Zip code

Payment Method:

- Annual
- Semi-Annual
- Quarterly
- Monthly Electronic Funds Transfer (EFT) Plan Number _____
(If new plan, submit EFT Authorization)
- Payroll Deduction Plan (PRD) Plan Number _____
- List Bill Plan Number _____ (if new plan, submit List Bill Setup form)

Source of Funds:

- Earnings
- Existing Insurance
- Gift/Inheritance
- Retirement Funds
- Sale of Investments
- Savings
- Other _____

Third Party Notification (optional):

If you wish, you may give us the name and address of a person whom you designate to also receive notice of an overdue premium or pending lapse. (Indicate below)

Name

Address

City

State

Zip code

I. Additional Premium	<p>1035 Exchange <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, submit 1035 Exchange Agreement form)</p> <hr/> <p>Non-Repeating Premium (NRP) Regular NRP \$ _____</p> <p>Billable Non-Repeating Premium (Billable NRP) (If base premium is paid through a list bill, the NRP must also be billed through the same list bill.) Total Annual Billable NRP \$ _____ (Minimum annual \$600 NRP required. Minimum annual \$2,400 base premium required.)</p> <p>Include Billable NRP at issue, with first premium payment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Payment Method</p> <p><input type="checkbox"/> Annual <input type="checkbox"/> Monthly Electronic Funds Transfer (EFT) Plan Number _____ (If new plan, submit EFT/APP Authorization)</p> <p><input type="checkbox"/> Semi-Annual <input type="checkbox"/> Payroll Deduction Plan (PRD) Plan Number _____</p> <p><input type="checkbox"/> Quarterly</p> <hr/> <p>Universal Life and Whole Life Additional Premium (excluding 1035) \$ _____</p>			
J. Money Submitted with Application <i>Make all checks payable to Minnesota Life.</i>	<p>Has the Owner paid money with this application to the representative? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, amount: \$ _____</p> <p>Was a Life Receipt and Temporary Insurance Agreement given? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>			
K. Special Mailing Address	<p>If mail (other than the premium notice) should be sent somewhere other than the Owner's Home Address, please indicate here.</p> <p><input type="checkbox"/> Owner's Business Address <input type="checkbox"/> Other - Indicate Name and Address</p> <hr/> <p>Name (last, first, middle) _____</p> <hr/> <p>Address _____</p> <hr/> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;">City _____</td> <td style="width: 20%; border: none;">State _____</td> <td style="width: 30%; border: none;">Zip code _____</td> </tr> </table>	City _____	State _____	Zip code _____
City _____	State _____	Zip code _____		
L. Request for Illustration <i>Complete for non-variable products, excluding term.</i>	<p>Choose one of the following: (For Policy Exchanges, only the first option is available.)</p> <p><input type="checkbox"/> An illustration matching the policy applied for was presented to the Owner/Applicant and a signed copy is included with this application. The Owner/Applicant has received a copy.</p> <p><input type="checkbox"/> An illustration was presented or provided to the Owner/Applicant, but is different from the policy applied for. An illustration conforming to the policy as issued will be provided to the Owner/Applicant no later than at the time of policy delivery.</p> <p><input type="checkbox"/> No illustration conforming to the policy as applied for was shown or provided to the Owner/Applicant prior to or at the time of taking this application. An illustration conforming to the policy as issued will be provided to the Owner/Applicant no later than at the time of policy delivery.</p>			
M. Proposed Insured Underwriting Information	<p>1. Is the proposed insured a US citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, citizen of _____ Indicate visa type _____</p> <p>2. Does the proposed insured plan to travel or reside outside the US in the next two years? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide the city(s) and country(s), dates, length of stay, and purpose of travel: _____ _____</p> <p>3. Has the proposed insured within the last five years, or does the proposed insured plan, within the next two years, to engage in piloting a plane? If yes, complete the Military and Aviation Statement. <input type="checkbox"/> Yes <input type="checkbox"/> No</p>			

4. Has the proposed insured within the last five years, or does the proposed insured plan, within the next two years, to engage in skin diving (snorkel, scuba, or other), sky diving, mountain/rock climbing, horse racing, rodeo, polo, bull fighting, bungee jumping, BASE jumping, canyoneering, boxing, professional wrestling, extreme skiing, or racing (motor vehicle or boat)? If yes, complete Sports and Avocation Statement. Yes No
5. Is the proposed insured in the Armed Forces, National Guard, or Reserves? If yes, complete Military and Aviation Statement. Yes No
6. Has the proposed insured applied for insurance within the last six months? If yes, provide details below. Yes No
- _____
7. Has the proposed insured applied for life insurance in the past five years that was declined or rated? If yes, provide details below. Yes No
- _____
8. Has the proposed insured, within the past five years, been convicted of a driving while intoxicated violation, had a driver's license restricted or revoked, or been convicted of a moving violation? If yes, provide dates and details below. Yes No
- _____
9. Except for traffic violations, has the proposed insured ever been convicted of a misdemeanor or felony? If yes, provide dates and details below. Yes No
- _____
10. Will the Proposed Owner and/or beneficiary, and/or any entity on the Proposed Owner's behalf, receive any compensation, whether via the form of cash, property, an agreement to pay money in the future, a percentage of the death benefit, or otherwise if this policy is issued? Yes No
11. Has the Proposed Owner been involved in any discussion about the possible sale or assignment of this policy or a beneficial interest in a trust, LLC, or other entity created on the owner's behalf? If yes, provide details and a copy of the applicable entity's controlling documents. Yes No
- _____
12. Is this policy being funded via a premium financing loan or with funds borrowed, advanced or paid from another person or entity? If yes, submit the Premium Financing Advisor Attestation and Premium Financing Client Disclosure forms. Yes No
13. Have you had a life expectancy report or evaluation done by an outside entity or company? If yes, please explain why the expectancy report was obtained. Yes No
- _____
14. Is this policy in accordance with your insurance objectives and your anticipated financial needs? Yes No
15. Has the representative discussed whether this policy is suitable for you? Yes No
16. Reason for purchasing policy:
- a. Accumulation Yes No
- b. Business Planning/Key Person Yes No
- c. Charitable Giving Yes No
- d. Death Benefit Protection Yes No
- e. Estate Planning Yes No
- f. Retirement/Deferred Compensation Yes No
- g. Other _____ Yes No

**N. Additional
Remarks**

**O. Home Office
Endorsements**

Home Office Corrections or Additions

Acceptance of the policy shall ratify changes entered here by Minnesota Life. Not to be used for change in age, gender, amount, classification, plan or benefits unless agreed to in writing.

**Policy Change Application Part 3 (Underwriting)
Agreements and Authorizations**

Individual Life Insurance

MINNESOTA LIFE

Minnesota Life Insurance Company - A Securian Company
Individual Life Policy Administration • 400 Robert Street North • St. Paul, Minnesota 55101-2098

Insured name (last, first, middle)

AGREEMENTS: I have read, or had read to me the statements and answers recorded on my application. They are given to obtain this insurance and are, to the best of my knowledge and belief, true and complete and correctly recorded. I agree that they will become part of this application and any coverage issued on it. I understand that the policy will be contestable, as to representations in this application, from the date of reinstatement or reissue, for the time period stated in the incontestable provision of the policy. The insurance applied for will not take effect unless and until the policy is reissued and delivered and the full first premium is paid while the health of the Insured remains as stated in this Policy Change Application, as provided in the Life Receipt and Temporary Insurance Agreement.

VARIABLE LIFE: I understand that the amount or the duration of the death benefit (or both) of the policy applied for may increase or decrease depending on the investment results of the sub-accounts of the separate account. I understand that the actual cash value of the policy applied for is not guaranteed and increases and decreases depending on the investment results. There is no minimum actual cash value for the policy values invested in these sub-accounts.

AUTHORIZATION: I authorize any physician, medical practitioner, hospital, clinic or other health care provider, pharmacy, pharmacy benefits manager, insurance or reinsuring company, consumer reporting agency, the Medical Information Bureau, Inc. (MIB), or employer which has any records or knowledge of my physical or mental health, and/or the physical or mental health of each minor child listed as the Proposed Insured, to give all such information and any other non-medical information relating to such persons to Minnesota Life Insurance Company or its reinsurers. This shall include ALL INFORMATION as to any medical history, consultations, diagnoses, prognoses, prescriptions or treatments and tests, including information regarding alcohol or drug abuse and AIDS or AIDS-related conditions. To facilitate rapid submission of such information, I authorize all said sources, except MIB, to give such records or knowledge to any agency employed by Minnesota Life Insurance Company to collect and transmit such information.

I understand this information is to be used for the purpose of determining eligibility for insurance and may be used for determining eligibility for benefits. I understand this information may be made available to Underwriting, Claims, support staff, licensed representatives, and firms of Minnesota Life Insurance Company. I authorize Minnesota Life Insurance Company or its reinsurers to release any such information to reinsuring companies, the MIB, or other persons or organizations performing business or legal services in connection with my application, claim or as may be otherwise lawfully required or as I may further authorize.

I agree this authorization shall be valid for twenty-four months from the date it is signed. I may revoke this authorization at any time by sending a written request addressed to the Individual Underwriting Department, Minnesota Life Insurance Company, 400 Robert Street North, St. Paul, MN 55101-2098. I understand that a revocation is not effective to the extent that any action has been taken in reliance on this Authorization or to the extent that Minnesota Life Insurance Company has a legal right to contest a claim under an insurance policy or to contest the policy itself.

I understand that I, or my legal representative, have the right to request and receive a copy of this authorization and that a photocopy of this authorization shall be as valid as the original. I understand that no sales representative has the company's authorization, to accept risk, pass on insurability, or make, or void, waive or change any conditions or provisions of the application, policy or receipt, as applicable.

I acknowledge that I have been given the Your Privacy Is Important To Us notice.

I understand that a copy of this entire application, including Part 2, will be attached to the policy and delivered to the policyowner.

FRAUD WARNING: 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.

<input type="checkbox"/> Change Service Representative (Print name/code only if policy is being reassigned)	Representative name	Firm/rep code	
Insured signature	Date	City	State
X Owner signature (if other than Insured) (give title if signed on behalf of a business)	Date	City	State
X Assignee signature (give title if signed on behalf of a business)	Date	City	State
X Irrevocable beneficiary signature (give title if signed on behalf of a business)	Date	City	State
X Parent/conservator/guardian signature (juvenile applications)	Date	City	State

Is replacement of existing life insurance, annuity or mutual fund involved in this application? Yes No

I believe that the information provided by this applicant is true and accurate. I certify I have accurately recorded all information given by the Insured(s).

Licensed representative signature	Firm/rep code	Date
X		

Application Part 3
Agreements and Authorizations
Individual Life Insurance

MINNESOTA LIFE

Minnesota Life Insurance Company - A Securian Company
 Life New Business • 400 Robert Street North • St. Paul, Minnesota 55101-2098

Proposed insured name (last, first, middle)

AGREEMENTS: I have read, or had read to me the statements and answers recorded on my application. They are given to obtain this insurance and are, to the best of my knowledge and belief, true and complete and correctly recorded. I understand that any false statement or misrepresentation on this application may result in loss of coverage under this policy subject to the incontestability provision. I agree that they will become part of this application and any policy issued on it. The insurance applied for will not take effect unless the policy is issued and delivered and the full first premium is paid while the health of the Proposed Insured remains as stated in this application. **If such conditions are met, the insurance will take effect as of the earlier of the Policy Date specified in the policy or the date the policy is delivered to me; the only exception to this is provided in the Life Receipt and Temporary Insurance Agreement, issued if the premium is paid in advance.**

VARIABLE LIFE: I understand that the amount or the duration of the death benefit (or both) of the policy applied for may increase or decrease depending on the investment results of the sub-accounts of the separate account. I understand that the actual cash value of the policy applied for is not guaranteed and increases and decreases depending on the investment results. There is no minimum actual cash value for the policy values invested in these sub-accounts.

AUTHORIZATION: I authorize any physician, medical practitioner, hospital, clinic or other health care provider, pharmacy, pharmacy benefits manager, insurance or reinsuring company, consumer reporting agency, the Medical Information Bureau, Inc. (MIB), or employer which has any records or knowledge of my physical or mental health, and/or the physical or mental health of each minor child listed as the Proposed Insured, to give all such information and any other non-medical information relating to such persons to Minnesota Life Insurance Company or its reinsurers. This shall include ALL INFORMATION as to any medical history, consultations, diagnoses, prognoses, prescriptions or treatments and tests, including information regarding alcohol or drug abuse and AIDS or AIDS-related conditions. To facilitate rapid submission of such information, I authorize all said sources, except MIB, to give such records or knowledge to any agency employed by Minnesota Life Insurance Company to collect and transmit such information.

I understand this information is to be used for the purpose of determining eligibility for insurance and may be used for determining eligibility for benefits. I understand this information may be made available to Underwriting, Claims, support staff, licensed representatives, and firms of Minnesota Life Insurance Company. I authorize Minnesota Life Insurance Company or its reinsurers to release any such information to reinsuring companies, the MIB, or other persons or organizations performing business or legal services in connection with my application, claim or as may be otherwise lawfully required or as I may further authorize.

I agree this authorization shall be valid for twenty-four months from the date it is signed. I may revoke this authorization at any time by sending a written request addressed to the Individual Underwriting Department, Minnesota Life Insurance Company, 400 Robert Street North, St. Paul, MN 55101-2098. I understand that a revocation is not effective to the extent that any action has been taken in reliance on this Authorization or to the extent that Minnesota Life Insurance Company has a legal right to contest a claim under an insurance policy or to contest the policy itself.

I understand that I, or my legal representative, have the right to request and receive a copy of this authorization and that a photocopy of this authorization shall be as valid as the original. I understand that no sales representative has the company's authorization, to accept risk, pass on insurability or make, or void, waive or change any conditions or provisions of the application, policy or receipt, as applicable.

I acknowledge that I have been given the Your Privacy Is Important To Us notice.

I understand that a copy of this entire application, including Part 2, will be attached to the policy and delivered to the policyowner.

FRAUD WARNING: 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.

Proposed insured signature X	Date	City	State
Owner signature (if other than proposed insured) (give title if signed on behalf of a business) X	Date	City	State
Parent/conservator/guardian signature (juvenile applications) X	Date	City	State

Is replacement of existing life insurance, annuity or mutual fund involved in this application? Yes No

I believe that the information provided by this applicant is true and accurate. I certify I have accurately recorded all information given by the Proposed Insured(s).

Licensed representative signature X	Date
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Policy Change Application
No Underwriting Required
Individual Life Insurance

MINNESOTA LIFE

Minnesota Life Insurance Company - A Securian Company
 Individual Life Policy Administration • 400 Robert Street North • St. Paul, Minnesota 55101-2098

A. Request Information <i>Make all checks payable to Minnesota Life.</i>	Policy number(s)	Insured name (last, first, middle)	
	Money submitted with application \$ _____ <input type="checkbox"/> Receipt Given	Effective date of change <input type="checkbox"/> Current Date <input type="checkbox"/> Date Of Next EFT/APP Draw <input type="checkbox"/> Other (Indicate mm/yy and reason) _____	
B. Owner Information	Owner name (last, first, middle)		
	Telephone number <input type="checkbox"/> Primary <input type="checkbox"/> Secondary	E-mail address	
C. Address Adjustments	<input type="checkbox"/> Change Owner Home Address		
	<input type="checkbox"/> Add/Change Mailing Address (Check One): <input type="checkbox"/> Premium Notices Only <input type="checkbox"/> All Correspondence Other Than Premium Notice <input type="checkbox"/> All Mail		
	Name (last, first, middle)		
	Address		
	City	State	Zip
D. Face Amount Adjustments	<input type="checkbox"/> Change Face Amount: \$ _____ (Unless otherwise indicated, for Adjustable products, we will maintain the premium and adjust the plan.)		
	<input type="checkbox"/> Cost Of Living Alternate Exercise <input type="checkbox"/> AIO/AIOW/FAIA/GIO Exercise		
	<input type="checkbox"/> Inflation Agreement Exercise <input type="checkbox"/> Alternate Option Date: _____ (Attach Proof)		
E. Premium and Billing Information	Premium Adjustment <input type="checkbox"/> Change Total Annual Planned Premium Amount: \$ _____ (Unless otherwise indicated, for Adjustable products, we will maintain the face amount and adjust the plan.)		
	Payment Method		
	<input type="checkbox"/> Annual	<input type="checkbox"/> Monthly Electronic Funds Transfer (EFT/APP) Plan Number: _____ (If new plan, submit EFT/APP Authorization)	
	<input type="checkbox"/> Semi-Annual	<input type="checkbox"/> List Bill Plan Number: _____ (If new plan, submit List Bill form)	
	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Payroll Deduction Plan (PRD) Plan Number: _____	
	Source of Funds		
	<input type="checkbox"/> Earnings	<input type="checkbox"/> Sale of Investments	
	<input type="checkbox"/> Existing Insurance	<input type="checkbox"/> Savings	
	<input type="checkbox"/> Gift/Inheritance	<input type="checkbox"/> Other _____	
	<input type="checkbox"/> Retirement Funds		
Non-Repeating Premium (NRP) Regular NRP \$ _____ <input type="checkbox"/> Increase Face By NRP Amount <input type="checkbox"/> Do Not Increase Face By NRP Amount			
Billable Non-Repeating Premium (Billable NRP) (If base premium is paid through a list bill, the NRP must also be billed through the same list bill.) Total Annual Billable NRP \$ _____ (Minimum annual \$600 NRP required. Minimum annual \$2,400 base premium required.) Payment Method			
<input type="checkbox"/> Annual	<input type="checkbox"/> Monthly Electronic Funds Transfer (EFT/APP) Plan Number _____ (If new plan, submit EFT/APP Authorization)		
<input type="checkbox"/> Semi-Annual	<input type="checkbox"/> Payroll Deduction Plan (PRD) Plan Number _____		
<input type="checkbox"/> Quarterly			

K. Additional Agreements

Select only those agreements available on the products applied for.

	<input type="checkbox"/> Maintain Current Annual Premium	<input type="checkbox"/> Change Current Annual Premium Accordingly			NEW AMOUNT
		ADD	REMOVE	CHANGE AMOUNT	
Accelerated Benefit Agreement (Submit ABA Outline of Coverage form)	<input type="checkbox"/>	<input type="checkbox"/>			
Accidental Death Benefit Agreement			<input type="checkbox"/>		
Additional Insurance Agreement			<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
Adjustable Survivorship Life Agreement			<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
Business Continuation Agreement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
Business Value Enhancement Agreement				<input type="checkbox"/>	\$ _____
Children's Term or Family Term Children's Agreement			<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
Cost of Living Agreement			<input type="checkbox"/>		
Death Benefit Guarantee Agreement*	<input type="checkbox"/>	<input type="checkbox"/>			
Early Values Agreement*	<input type="checkbox"/>				
Enhanced Guaranteed Agreement	<input type="checkbox"/>	<input type="checkbox"/>			
Enhanced Guaranteed Choice Agreement	<input type="checkbox"/>	<input type="checkbox"/>			
Estate Preservation Agreement			<input type="checkbox"/>		
Estate Preservation Choice Agreement			<input type="checkbox"/>		
Exchange of Insureds Agreement	<input type="checkbox"/>	<input type="checkbox"/>			
Extended Conversion Agreement			<input type="checkbox"/>		
Face Amount Increase Agreement			<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
Family Term - Spouse Agreement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
First to Die Agreement			<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
Guaranteed Insurability Option Agreement			<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
Guaranteed Insurability Option Agreement with Waiver			<input type="checkbox"/>		
Guaranteed Protection Waiver			<input type="checkbox"/>		
Inflation Agreement			<input type="checkbox"/>		
Interest Accumulation Agreement			<input type="checkbox"/>	<input type="checkbox"/>	_____ %
Long-Term Care Agreement (Submit LTC Supplemental Application)			<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
Overloan Protection Agreement	<input type="checkbox"/>	<input type="checkbox"/>			
Policy Enhancement Agreement (Indicate a whole number from 3 to 10%)				<input type="checkbox"/>	_____ %
Policy Split Agreement			<input type="checkbox"/>		
Premium Deposit Account Agreement (Submit Premium Deposit Account Information form)	<input type="checkbox"/>	<input type="checkbox"/>			
Single Life Term Agreement			<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
Single Premium Paid Up Additional Insurance Agreement	<input type="checkbox"/>	<input type="checkbox"/>			
Surrender Value Enhancement Agreement			<input type="checkbox"/>		
Term Insurance Agreement			<input type="checkbox"/>		
Waiver of Charges Agreement			<input type="checkbox"/>		
Waiver of Premium Agreement			<input type="checkbox"/>		
Other: _____					

*Can only be added when converting term insurance to a new policy.

L. Life Insurance In Force and Replacement

Submit appropriate replacement forms (not needed if replacing group coverage).

Excluding this policy, does the Insured have any life insurance, annuity or mutual fund in force or pending?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Excluding this policy, has there been, or will there be, replacement of any existing life insurance, annuity or mutual fund, as a result of this application? (Replacement includes, but is not limited to, a lapse, surrender, 1035 Exchange, loan, withdrawal, or other change to any existing life insurance or annuity.) If yes, provide details on the Replacement Disclosure Statement.	<input type="checkbox"/> Yes	<input type="checkbox"/> No

M. Additional Remarks	
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N. Home Office Endorsements	<p>Home Office Corrections or Additions</p> <p>Acceptance of the policy shall ratify changes entered here by Minnesota Life. Not to be used for change in age, amount, gender, classification, plan or benefits unless agreed to in writing.</p>
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O. Agreements	<p>AGREEMENTS: I have read, or had read to me the statements and answers recorded on my application. They are given to obtain this insurance and are, to the best of my knowledge and belief, true, complete, and correctly recorded. I agree that they will become part of this application and any policy issued on it.</p> <p>VARIABLE LIFE: I understand that the amount or the duration of the death benefit (or both) of the policy applied for may increase or decrease depending on the investment results of the sub-accounts of the separate account. I understand that the actual cash value of the policy applied for is not guaranteed and increases and decreases depending on the investment results. There is no minimum actual cash value for the policy values invested in these sub-accounts.</p> <p>FRAUD WARNING: 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.</p>
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<input type="checkbox"/> Change Service Representative (Print name/code only if policy is being reassigned)	Representative name	Firm/rep code
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Owner signature (give title if signed on behalf of a business) X	Date	City	State
Assignee signature (give title if signed on behalf of a business) X	Date	City	State
Irrevocable beneficiary signature (give title if signed on behalf of a business) X	Date	City	State
Parent/conservator/guardian signature (juvenile applications) X	Date	City	State

I believe that the information provided by this applicant is true and accurate. I certify I have accurately recorded all information given by the Owner(s).

Licensed representative signature X	Firm/rep code	Date
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Policy Change Application Part 1
Underwriting Required

Individual Life Insurance

MINNESOTA LIFE

Minnesota Life Insurance Company - A Securian Company
 Individual Life Policy Administration • 400 Robert Street North • St. Paul, Minnesota 55101-2098

A. Request Information	Policy number(s)	Insured name (last, first, middle)	
	Money submitted with application \$ _____ <input type="checkbox"/> Receipt Given	Effective date of change <input type="checkbox"/> Current Date <input type="checkbox"/> Date Of Next EFT/APP Draw <input type="checkbox"/> Other (Indicate mm/yy and reason) _____	
B. Owner Information	Owner name (last, first, middle)		
	Telephone number <input type="checkbox"/> Primary <input type="checkbox"/> Secondary	E-mail address	
C. Address Adjustments	<input type="checkbox"/> Change Owner Home Address <input type="checkbox"/> Add/Change Mailing Address (Check One): <input type="checkbox"/> Premium Notices Only <input type="checkbox"/> All Correspondence Other Than Premium Notice <input type="checkbox"/> All Mail		
	Name (last, first, middle)		
	Address		
	City	State	Zip
D. Face Amount Adjustments	<input type="checkbox"/> Change Face Amount: \$ _____ (Unless otherwise indicated, for Adjustable products, we will maintain the premium and adjust the plan.)		
	<input type="checkbox"/> Cost Of Living Alternate Exercise <input type="checkbox"/> AIO/AIOW/FAIA/GIO Exercise <input type="checkbox"/> Inflation Agreement Exercise <input type="checkbox"/> Alternate Option Date: _____ (Attach Proof)		
	<input type="checkbox"/> Change Total Annual Planned Premium Amount: \$ _____ (Unless otherwise indicated, for Adjustable products, we will maintain the face amount and adjust the plan.)		
E. Premium and Billing Information	Premium Adjustment		
	<input type="checkbox"/> Change Total Annual Planned Premium Amount: \$ _____ (Unless otherwise indicated, for Adjustable products, we will maintain the face amount and adjust the plan.)		
	Payment Method		
	<input type="checkbox"/> Annual	<input type="checkbox"/> Monthly Electronic Funds Transfer (EFT/APP) Plan Number: _____ (If new plan, submit EFT/APP Authorization)	
	<input type="checkbox"/> Semi-Annual	<input type="checkbox"/> List Bill Plan Number: _____ (If new plan, submit List Bill form)	
	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Payroll Deduction Plan (PRD) Plan Number: _____	
	Source of Funds		
	<input type="checkbox"/> Earnings	<input type="checkbox"/> Sale of Investments	
	<input type="checkbox"/> Existing Insurance	<input type="checkbox"/> Savings	
	<input type="checkbox"/> Gift/Inheritance	<input type="checkbox"/> Other _____	
<input type="checkbox"/> Retirement Funds			
Non-Repeating Premium (NRP)			
Regular NRP \$ _____	<input type="checkbox"/> Increase Face By NRP Amount	<input type="checkbox"/> Do Not Increase Face By NRP Amount	
Billable Non-Repeating Premium (Billable NRP)			
(If base premium is paid through a list bill, the NRP must also be billed through the same list bill.)			
Total Annual Billable NRP \$ _____			
(Minimum annual \$600 NRP required. Minimum annual \$2,400 base premium required.)			
Payment Method			
<input type="checkbox"/> Annual	<input type="checkbox"/> Monthly Electronic Funds Transfer (EFT/APP) Plan Number _____ (If new plan, submit EFT/APP Authorization)		
<input type="checkbox"/> Semi-Annual	<input type="checkbox"/> Payroll Deduction Plan (PRD) Plan Number _____		
<input type="checkbox"/> Quarterly			

J. Other Adjustments

Change Death Benefit Option To:
 Cash/Level Protection/Increasing Sum of Premiums

Change Dividend Option To:

The Protection death benefit option generally requires underwriting. If changing from Level Death Benefit Option the face amount will decrease. To maintain current face amount check below (underwriting is required):
 Maintain Face Amount

Improve Risk Class
 Maintain current annual premium
 Reduce current annual premium

Add Non-Smoker/Non-Tobacco Designation

1. Do you currently smoke any cigarettes or have you smoked any cigarettes in the past 12 months? Yes No

2. Do you currently use any tobacco or have you used any tobacco in the past 12 months? Yes No

I understand that a material misrepresentation, including but not limited to, statements regarding my tobacco status, may result in the cancellation of insurance and non-payment of any claim.

Reinstate
I understand that this application will be attached to and considered part of the policy to which it applies. Also, I understand that this policy will be contestable, as to representations in this application, from the date of reinstatement for the time period stated in the incontestable provision of the policy.

Automatic Premium Loan Provision Add Remove

K. Additional Agreements

Select only those agreements available on the products applied for.

	ADD	REMOVE	CHANGE AMOUNT	NEW AMOUNT
<input type="checkbox"/> Maintain Current Annual Premium				
<input type="checkbox"/> Change Current Annual Premium Accordingly				
Accelerated Benefit Agreement (Submit ABA Outline of Coverage form)	<input type="checkbox"/>	<input type="checkbox"/>		
Accidental Death Benefit Agreement*	<input type="checkbox"/>	<input type="checkbox"/>		
Additional Insurance Agreement*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
Adjustable Survivorship Life Agreement (Complete Application for Designated Life)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
Business Continuation Agreement (Complete Application for Designated Life)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
Business Value Enhancement Agreement			<input type="checkbox"/>	\$ _____
Children's Term or Family Term Children's Agreement (Submit Family/Children's Term Application)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
Cost of Living Agreement	<input type="checkbox"/>	<input type="checkbox"/>		
Death Benefit Guarantee Agreement*	<input type="checkbox"/>	<input type="checkbox"/>		
Early Values Agreement*	<input type="checkbox"/>			
Enhanced Guaranteed Agreement	<input type="checkbox"/>	<input type="checkbox"/>		
Enhanced Guaranteed Choice Agreement	<input type="checkbox"/>	<input type="checkbox"/>		
Estate Preservation Agreement*	<input type="checkbox"/>	<input type="checkbox"/>		
Estate Preservation Choice Agreement	<input type="checkbox"/>	<input type="checkbox"/>		
Exchange of Insureds Agreement	<input type="checkbox"/>	<input type="checkbox"/>		
Extended Conversion Agreement		<input type="checkbox"/>		
Face Amount Increase Agreement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
Family Term - Spouse Agreement (Submit Family/Children's Term Application)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
First to Die Agreement		<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
Guaranteed Insurability Option Agreement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
Guaranteed Insurability Option Agreement with Waiver	<input type="checkbox"/>	<input type="checkbox"/>		
Guaranteed Protection Waiver	<input type="checkbox"/>	<input type="checkbox"/>		
Inflation Agreement	<input type="checkbox"/>	<input type="checkbox"/>		
Interest Accumulation Agreement*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____ %

Long-Term Care Agreement (Submit LTC Supplemental Application)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
Overloan Protection Agreement	<input type="checkbox"/>	<input type="checkbox"/>		
Policy Enhancement Agreement (Indicate a whole number from 3 to 10%)	<input type="checkbox"/>		<input type="checkbox"/>	_____ %
Policy Split Agreement		<input type="checkbox"/>		
Premium Deposit Account Agreement (Submit Premium Deposit Account Information form)	<input type="checkbox"/>	<input type="checkbox"/>		
Single Life Term Agreement		<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
Single Premium Paid Up Additional Insurance Agreement	<input type="checkbox"/>	<input type="checkbox"/>		
Surrender Value Enhancement Agreement*	<input type="checkbox"/>	<input type="checkbox"/>		
Term Insurance Agreement*	<input type="checkbox"/>	<input type="checkbox"/>		
Waiver of Charges Agreement	<input type="checkbox"/>	<input type="checkbox"/>		
Waiver of Premium Agreement	<input type="checkbox"/>	<input type="checkbox"/>		
Other: _____				
*Can only be added when converting term insurance to a new policy.				

L. Life Insurance In Force and Replacement

Submit appropriate replacement forms (not needed if replacing group coverage).

Excluding this policy, does the Insured have any life insurance, annuity or mutual fund in force or pending, including life insurance sold or assigned, or is in the process of being sold or assigned, to a life settlement, viatical or secondary market provider? If yes, provide details in the chart below. Yes No

Excluding this policy, has there been, or will there be, replacement of any existing life insurance, annuity or mutual fund, as a result of this application? (Replacement includes, but is not limited to, a lapse, surrender, 1035 Exchange, loan, withdrawal, or other change to any existing life insurance or annuity.) If yes, provide details in the chart below. Yes No

Life Insurance In Force

Full Company Name	Amount	Year Issued	Type	Will it be Replaced?
			<input type="checkbox"/> Individual or <input type="checkbox"/> Group <input type="checkbox"/> Personal or <input type="checkbox"/> Business	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Individual or <input type="checkbox"/> Group <input type="checkbox"/> Personal or <input type="checkbox"/> Business	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Individual or <input type="checkbox"/> Group <input type="checkbox"/> Personal or <input type="checkbox"/> Business	<input type="checkbox"/> Yes <input type="checkbox"/> No

M. Insured Underwriting Information

Driver's license number _____ State of issue _____ Expiration date _____

Birthplace (state or, if outside the US, country) _____

Occupation _____ Income _____

1. Is the insured a US citizen? Yes No
If no, citizen of _____
Indicate visa type _____

2. Does the insured plan to travel or reside outside the US in the next two years? Yes No
If yes, provide the city(s) and country(s), dates, length of stay, and purpose of travel:

3. Has the insured within the last five years, or does the proposed insured plan, within two years, to engage in piloting a plane? If yes, complete the Military and Aviation Statement. Yes No

	<p>4. Has the insured within the last five years, or does the proposed insured plan, within two years, to engage in skin diving (snorkel, scuba, or other), sky diving, mountain/rock climbing, horse racing, rodeo, polo, bull fighting, bungee jumping, BASE jumping, canyoneering, boxing, professional wrestling, extreme skiing or racing (motor vehicle or boat)?</p> <p>5. Is the insured in the Armed Forces, National Guard, or Reserves? If yes, complete the Military and Aviation Statement.</p> <p>6. Has the insured applied for insurance within the last six months? If yes, provide details below.</p> <p>7. Has the insured applied for life insurance in the past five years that was declined or rated? If yes, provide details below.</p> <p>8. Has the insured, within the past five years, been convicted of a driving while intoxicated violation, had a driver's license restricted or revoked, or been convicted of a moving violation? If yes, provide dates and details below.</p> <p>9. Except for traffic violations, has the insured ever been convicted of a misdemeanor or felony? If yes, provide dates and details below.</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>N. Additional Remarks</p>		
<p>O. Home Office Endorsements</p>	<p>Home Office Corrections or Additions</p> <p>Acceptance of the policy shall ratify changes entered here by Minnesota Life. Not to be used for change in age, gender, amount, classification, plan or benefits unless agreed to in writing.</p>	

Application Part 2
Individual Life Insurance

MINNESOTA LIFE

Minnesota Life Insurance Company - A Securian Company
 Life New Business • 400 Robert Street North • St. Paul, Minnesota 55101-2098

Proposed insured name (last, first, middle)	Date of birth
---	---------------

Firm that arranged this exam

		Yes	No										
1. A. Have you ever smoked cigarettes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>										
<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 2px;">Current smoker</td> <td style="width:20%; padding: 2px;">Past smoker</td> <td style="width:20%; padding: 2px;">Packs per day</td> <td style="width:40%; padding: 2px;">Date last cigarette smoked (MM, DD, YY)</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td></td> <td></td> </tr> </table>	Current smoker	Past smoker	Packs per day	Date last cigarette smoked (MM, DD, YY)	<input type="checkbox"/>	<input type="checkbox"/>							
Current smoker	Past smoker	Packs per day	Date last cigarette smoked (MM, DD, YY)										
<input type="checkbox"/>	<input type="checkbox"/>												
B. Have you ever used tobacco, other than cigarettes, in any form?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>										
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What type	Current user	Past user	How much	Date of last use (MM, DD, YY)									
	<input type="checkbox"/>	<input type="checkbox"/>											
2. Are you taking or do you take any prescription or non-prescription medications or drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>										
3. Have you ever had or been treated, diagnosed or given medical advice by a member of the medical profession for:													
A. Epilepsy; Alzheimer's; Huntington's; Parkinson's; Mild Cognitive Impairment (MCI); dementia; paralysis; sleep disorder; depression; stress disorders; anxiety disorders; or any other brain, nervous, mental or emotional disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>										
B. High blood pressure; chest pain; chest discomfort or tightness; heart attack; heart murmur; stroke; irregular heart beat; or any other disease or disorder of the heart or blood vessels?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>										
C. Asthma; shortness of breath; bronchitis; pneumonia; emphysema; chronic cough; or any other lung or respiratory disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>										
D. Abdominal pain; ulcer; colitis; cirrhosis; hepatitis; recurrent diarrhea; intestinal bleeding; or any other disease of the liver, gallbladder, pancreas, stomach, or intestines?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>										
E. Kidney stone; protein, sugar, blood or blood cells in the urine; or any disorder of the urinary tract, bladder or kidneys?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>										
F. Disorder or abnormality of the prostate, uterus, ovaries, or breasts; pregnancy complication; testicular disease; genital herpes, syphilis, gonorrhea, or other sexually transmitted disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>										
G. Diabetes; thyroid disorder; lymph node enlargement; skin disorder; or disorder of any other glands?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>										
H. Cancer; tumor; or cyst?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>										
I. Anemia, leukemia, or other blood disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>										
J. Back or neck pain; spinal strain or sprain; sciatica; arthritis; gout; carpal tunnel syndrome; or any bone, joint, or muscle disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>										
K. Disorder of the eyes, ears, nose or throat?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>										
L. Any physical deformity or defect?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>										
M. Any immune system diseases or disorders except those related to the Human Immunodeficiency Virus (HIV virus)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>										
N. Any chronic or recurrent fever, fatigue or viral illness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>										
4. Have you ever been diagnosed by a member of the medical profession or tested positive for the Human Immunodeficiency Virus (HIV virus) or Acquired Immune Deficiency Syndrome (AIDS)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>										
5. Do you consume alcoholic beverages? If yes, what kinds, how much and how often?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>										
6. Have you ever been advised to limit the use of alcohol or drugs; sought or received treatment, advice, or counseling for alcohol or drugs; or joined a group because of alcohol or drug use?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>										
7. Have you ever tried or used cocaine, heroin, marijuana, barbiturates or other controlled substances?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>										

8. Other than above, have you in the past five years:

- A. Consulted or been advised to consult a physician, psychiatrist, psychologist, therapist, counselor, chiropractor, or other health care practitioner? (Include regular check-ups.) Yes No
- B. Had a check-up, illness, or surgery, or been treated or evaluated at a hospital or any other health care facility? Yes No
- C. Had an EKG, x-ray, stress test, echocardiogram, angiography, blood studies or any other diagnostic test? Yes No
- D. Been advised to have any test, hospitalization, or surgery which was not completed? Yes No
- E. Had a CT Scan, MRI, EEG or any other diagnostic test for fainting spells, convulsions, seizures, headaches, or dizziness. Yes No

9. Family History: Make a note of diabetes, cancer, melanoma, heart, and kidney disease.

		Age(s)	Health History		Age(s)	Cause of Death
Father	Living			Deceased		
Mother						
Siblings						
Siblings						

10. Do you have a personal physician or belong to an H.M.O. or clinic? If so, please provide information below. Yes No

Name		Phone number	
Street address			
City		State	Zip code
Date last seen	Reason		

Give details of all yes answers, including doctors' names, addresses and dates.

I have read the statements and answers recorded on this Application Part 2; they are to the best of my knowledge and belief true, complete and correctly recorded. I agree that they will become part of this application and any policy issued on it.

Proposed insured signature	Date
X Witness	

Application Part 2
Individual Life Insurance

MINNESOTA LIFE

Minnesota Life Insurance Company - A Securian Company
 Life New Business • 400 Robert Street North • St. Paul, Minnesota 55101-2098

Proposed insured name (last, first, middle)	Date of birth
---	---------------

Height and weight	Change in past year	Cause of weight gain or loss
FT. IN. LBS.	LBS. <input type="checkbox"/> GAIN <input type="checkbox"/> LOSS	

	Yes	No					
1. A. Have you ever smoked cigarettes?	<input type="checkbox"/>	<input type="checkbox"/>					
<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Current smoker <input type="checkbox"/></td> <td style="width:20%; padding: 5px;">Past smoker <input type="checkbox"/></td> <td style="width:20%; padding: 5px;">Packs per day</td> <td style="width:40%; padding: 5px;">Date last cigarette smoked (MM, DD, YY)</td> </tr> </table>	Current smoker <input type="checkbox"/>	Past smoker <input type="checkbox"/>	Packs per day	Date last cigarette smoked (MM, DD, YY)			
Current smoker <input type="checkbox"/>	Past smoker <input type="checkbox"/>	Packs per day	Date last cigarette smoked (MM, DD, YY)				
B. Have you ever used tobacco, other than cigarettes, in any form?	<input type="checkbox"/>	<input type="checkbox"/>					
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What type	Current user <input type="checkbox"/>	Past user <input type="checkbox"/>	How much	Date of last use (MM, DD, YY)			
2. Are you taking or do you take any prescription or non-prescription medications or drugs?	<input type="checkbox"/>	<input type="checkbox"/>					
3. Have you ever had or been treated, diagnosed or given medical advice by a member of the medical profession for:							
A. Epilepsy; Alzheimer's; Huntington's; Parkinson's; Mild Cognitive Impairment (MCI); dementia; paralysis; sleep disorder; depression; stress disorders; anxiety disorder; or any other brain, nervous, mental or emotional disorder?	<input type="checkbox"/>	<input type="checkbox"/>					
B. High blood pressure; chest pain; chest discomfort or tightness; heart attack; heart murmur; stroke; irregular heart beat; or any other disease or disorder of the heart or blood vessels?	<input type="checkbox"/>	<input type="checkbox"/>					
C. Asthma; shortness of breath; bronchitis; pneumonia; emphysema; chronic cough; or any other lung or respiratory disorder?	<input type="checkbox"/>	<input type="checkbox"/>					
D. Abdominal pain; ulcer; colitis; cirrhosis; hepatitis; recurrent diarrhea; intestinal bleeding; or any other disease of the liver, gallbladder, pancreas, stomach, or intestines?	<input type="checkbox"/>	<input type="checkbox"/>					
E. Kidney stone; protein, sugar, blood or blood cells in the urine; or any disorder of the urinary tract, bladder or kidneys?	<input type="checkbox"/>	<input type="checkbox"/>					
F. Disorder or abnormality of the prostate, uterus, ovaries, or breasts; pregnancy complication; testicular disease; genital herpes, syphilis, gonorrhea, or other sexually transmitted disease?	<input type="checkbox"/>	<input type="checkbox"/>					
G. Diabetes; thyroid disorder; lymph node enlargement; skin disorder; or disorder of any other glands?	<input type="checkbox"/>	<input type="checkbox"/>					
H. Cancer; tumor; or cyst?	<input type="checkbox"/>	<input type="checkbox"/>					
I. Anemia, leukemia, or other blood disorder?	<input type="checkbox"/>	<input type="checkbox"/>					
J. Back or neck pain; spinal strain or sprain; sciatica; arthritis; gout; carpal tunnel syndrome; or any bone, joint, or muscle disorder?	<input type="checkbox"/>	<input type="checkbox"/>					
K. Disorder of the eyes, ears, nose or throat?	<input type="checkbox"/>	<input type="checkbox"/>					
L. Any physical deformity or defect?	<input type="checkbox"/>	<input type="checkbox"/>					
M. Any immune system diseases or disorders except those related to the Human Immunodeficiency Syndrome (HIV virus)?	<input type="checkbox"/>	<input type="checkbox"/>					
N. Any chronic or recurrent fever, fatigue or viral illness?	<input type="checkbox"/>	<input type="checkbox"/>					
4. Have you ever been diagnosed by a member of the medical profession or tested positive for the Human Immunodeficiency Virus (HIV virus) or Acquired Immune Deficiency Syndrome (AIDS)?	<input type="checkbox"/>	<input type="checkbox"/>					
5. Do you consume alcoholic beverages? If yes, what kinds, how much and how often?	<input type="checkbox"/>	<input type="checkbox"/>					
6. Have you ever been advised to limit the use of alcohol or drugs; sought or received treatment, advice, or counseling for alcohol or drugs; or joined a group because of alcohol or drug use?	<input type="checkbox"/>	<input type="checkbox"/>					
7. Have you ever tried or used cocaine, heroin, marijuana, barbiturates or other controlled substances except as prescribed by a physician?	<input type="checkbox"/>	<input type="checkbox"/>					

8. Other than above, have you in the past five years:
- | | | |
|--|--------------------------|--------------------------|
| | Yes | No |
| A. Consulted or been advised to consult a physician, psychiatrist, psychologist, therapist, counselor, chiropractor, or other health care practitioner? (Include regular check-ups.) | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Had a check-up, illness, or surgery, or been treated or evaluated at a hospital or any other health care facility? | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Had an EKG, x-ray, stress test, echocardiogram, angiography, blood studies or any other diagnostic test? | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Been advised to have any test, hospitalization, or surgery which was not completed? | <input type="checkbox"/> | <input type="checkbox"/> |
| E. Had a CT Scan, MRI, EEG or any other diagnostic test for fainting spells, convulsions, seizures, headaches, or dizziness? | <input type="checkbox"/> | <input type="checkbox"/> |

9. Family History: Make a note of diabetes, cancer, melanoma, heart, and kidney disease.

		Age(s)	Health History		Age(s)	Cause of Death
Father	Living			Deceased		
Mother						
Siblings						
Siblings						

10. Do you have a personal physician or belong to an H.M.O. or clinic? If so, please provide information below.

Name		Phone number	
Street address			
City		State	Zip code
Date last seen		Reason	

Give details of all yes answers, including doctors' names, addresses and dates.

Application Part 2
Individual Life Insurance

MINNESOTA LIFE

Minnesota Life Insurance Company - A Securian Company
 Life New Business • 400 Robert Street North • St. Paul, Minnesota 55101-2098

Proposed insured name (last, first, middle)	Date of birth
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Height and weight	Change in past year	Cause of weight gain or loss
FT. IN. LBS.	LBS. <input type="checkbox"/> GAIN <input type="checkbox"/> LOSS	

	Yes	No					
1. A. Have you ever smoked cigarettes?	<input type="checkbox"/>	<input type="checkbox"/>					
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2. Are you taking or do you take any prescription or non-prescription medications or drugs?	<input type="checkbox"/>	<input type="checkbox"/>					
3. Have you ever had or been treated, diagnosed or given medical advice by a member of the medical profession for:							
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B. High blood pressure; chest pain; chest discomfort or tightness; heart attack; heart murmur; stroke; irregular heart beat; or any other disease or disorder of the heart or blood vessels?	<input type="checkbox"/>	<input type="checkbox"/>					
C. Asthma; shortness of breath; bronchitis; pneumonia; emphysema; chronic cough; or any other lung or respiratory disorder?	<input type="checkbox"/>	<input type="checkbox"/>					
D. Abdominal pain; ulcer; colitis; cirrhosis; hepatitis; recurrent diarrhea; intestinal bleeding; or any other disease of the liver, gallbladder, pancreas, stomach, or intestines?	<input type="checkbox"/>	<input type="checkbox"/>					
E. Kidney stone; protein, sugar, blood or blood cells in the urine; or any disorder of the urinary tract, bladder or kidneys?	<input type="checkbox"/>	<input type="checkbox"/>					
F. Disorder or abnormality of the prostate, uterus, ovaries, or breasts; pregnancy complication; testicular disease; genital herpes, syphilis, gonorrhea, or other sexually transmitted disease?	<input type="checkbox"/>	<input type="checkbox"/>					
G. Diabetes; thyroid disorder; lymph node enlargement; skin disorder; or disorder of any other glands?	<input type="checkbox"/>	<input type="checkbox"/>					
H. Cancer; tumor; or cyst?	<input type="checkbox"/>	<input type="checkbox"/>					
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J. Back or neck pain; spinal strain or sprain; sciatica; arthritis; gout; carpal tunnel syndrome; or any bone, joint, or muscle disorder?	<input type="checkbox"/>	<input type="checkbox"/>					
K. Disorder of the eyes, ears, nose or throat?	<input type="checkbox"/>	<input type="checkbox"/>					
L. Any physical deformity or defect?	<input type="checkbox"/>	<input type="checkbox"/>					
M. Any immune system diseases or disorders except those related to the Human Immunodeficiency Syndrome (HIV virus)?	<input type="checkbox"/>	<input type="checkbox"/>					
N. Any chronic or recurrent fever, fatigue or viral illness?	<input type="checkbox"/>	<input type="checkbox"/>					
4. Have you ever been diagnosed by a member of the medical profession or tested positive for the Human Immunodeficiency Virus (HIV virus) or Acquired Immune Deficiency Syndrome (AIDS)?	<input type="checkbox"/>	<input type="checkbox"/>					
5. Do you consume alcoholic beverages? If yes, what kinds, how much and how often?	<input type="checkbox"/>	<input type="checkbox"/>					
6. During the past 10 years:							
A. Have you been advised to limit the use of alcohol or drugs; sought or received treatment, advice, or counseling for alcohol or drugs; or joined a group because of alcohol or drug use?	<input type="checkbox"/>	<input type="checkbox"/>					
B. Have you tried or used cocaine, heroin, marijuana, barbiturates or other controlled substances?	<input type="checkbox"/>	<input type="checkbox"/>					

Yes No

7. Other than above, have you in the past five years:

- A. Consulted or been advised to consult a physician, psychiatrist, psychologist, therapist, counselor, chiropractor, or other health care practitioner? (Include regular check-ups.) Yes No
- B. Had a check-up, illness, or surgery, or been treated or evaluated at a hospital or any other health care facility? Yes No
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8. Family History: Make a note of diabetes, cancer, melanoma, heart, and kidney disease.

		Age(s)	Health History		Age(s)	Cause of Death
Father	Living			Deceased		
Mother						
Siblings						
Siblings						

9. Do you have a personal physician or belong to an H.M.O. or clinic? If so, please provide information below. Yes No

Name		Phone number	
Street address			
City		State	Zip code
Date last seen	Reason		

Give details of all yes answers, including doctors' names, addresses and dates.

I have read the statements and answers recorded on this Application Part 2; they are to the best of my knowledge and belief true, complete and correctly recorded. I agree that they will become part of this application and any policy issued on it.

Proposed insured signature X	Date
Witness	

Application Part 1
Individual Life Insurance

Minnesota Life Insurance Company - A Securian Company
 Life New Business • 400 Robert Street North • St. Paul, Minnesota 55101-2098

MINNESOTA LIFE

A. Proposed Insured Information	Proposed insured name (last, first, middle)			
	Social Security number	Date of birth (month, day, year)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
	Driver's license number	Issue state	Expiration date	
	Primary telephone number		Secondary telephone number	
	Birthplace (state or, if outside the US, country)	E-mail address		
	Street address (no P.O. Box)	City	State	Zip code
	Occupation	Years in occupation	Income	Net worth
	B. Product	Product applied for		Base face amount \$
Total annual planned premium		Plan of insurance (if applicable)		
Death benefit qualification test (if applicable, defaults to GPT if none selected) <input type="checkbox"/> Guideline Premium Test (GPT) <input type="checkbox"/> Cash Value Accumulation Test (CVAT)				
Death benefit option (If applicable, defaults to Cash/Level if none selected) <input type="checkbox"/> Cash/Level <input type="checkbox"/> Protection/Increasing <input type="checkbox"/> Sum of Premiums				
Dividend option (if applicable, defaults to Paid-Up Additions for Secure Whole Life)				
C. Additional Benefits and Agreements	<input type="checkbox"/> Accelerated Benefit Agreement (Submit ABA Outline of Coverage form) <input type="checkbox"/> Accidental Death Benefit Agreement \$ _____ (Coverage Amount) <input type="checkbox"/> Additional Insurance Agreement \$ _____ (Coverage Amount) <input type="checkbox"/> Business Value Enhancement Agreement Select one: <input type="checkbox"/> Maximum Single Premium <input type="checkbox"/> Level Premium with PDA (Submit Premium Deposit Account Information form) <input type="checkbox"/> Children's Term or Family Term - Child Agreement (Submit Family/Children's Application) \$ _____ (Coverage Amount) <input type="checkbox"/> Death Benefit Guarantee Agreement <input type="checkbox"/> Early Values Agreement <input type="checkbox"/> Estate Preservation Agreement \$ _____ (Coverage Amount) Face Amount (Not to exceed 122% of base amount) <input type="checkbox"/> Estate Preservation Choice Agreement \$ _____ (Coverage Amount) Face Amount (Not to exceed 122% of base amount) <input type="checkbox"/> Exchange of Insureds Agreement <input type="checkbox"/> Extended Conversion Agreement <input type="checkbox"/> Face Amount Increase Agreement			
	<input type="checkbox"/> First to Die Agreement \$ _____ (Coverage Amount) <input type="checkbox"/> Guaranteed Insurability Option Agreement \$ _____ (Coverage Amount) <input type="checkbox"/> Guaranteed Insurability Option Agreement with Waiver \$ _____ (Coverage Amount) <input type="checkbox"/> Inflation Agreement <input type="checkbox"/> Long-Term Care Agreement (Submit LTC Supplemental Application) <input type="checkbox"/> Overloan Protection Agreement <input type="checkbox"/> Premium Deposit Account Agreement (Submit Premium Deposit Account Information form) <input type="checkbox"/> Single Life Term Agreement \$ _____ (Coverage Amount) <input type="checkbox"/> Single Premium Paid-Up Additional Insurance Agreement \$ _____ (Premium Amount) <input type="checkbox"/> Surrender Value Enhancement Agreement <input type="checkbox"/> Term Insurance Agreement \$ _____ (Premium Amount) <input type="checkbox"/> Waiver of Charges Agreement <input type="checkbox"/> Waiver of Premium Agreement <input type="checkbox"/> Other _____ <input type="checkbox"/> Other _____			

THE FOLLOWING BENEFITS AND AGREEMENTS WILL BE ADDED IF AVAILABLE FOR YOUR POLICY, UNLESS YOU CHOOSE TO OMIT THEM:

Omit Automatic Premium Loan Provision Omit Policy Split Agreement

D. Special Dating

Date to save age
 Specific date (month/day/year): _____ (cannot select 29th, 30th, or 31st of the month)

Are there any other Minnesota Life applications associated with this application? Yes No

If yes, please provide Proposed Insured(s) full name(s) and whether the policies should have the same issue date.

E. Life Insurance In Force and Replacement

Submit appropriate replacement forms (not needed if replacing group coverage).

Excluding this policy, does the Proposed Insured have any life insurance, annuity or mutual fund in force or pending, including life insurance sold or assigned, or is in the process of being sold or assigned, to a life settlement, viatical or secondary market provider? If yes, provide details in the chart below. Yes No

Excluding this policy, has there been, or will there be, replacement of any existing life insurance, annuity or mutual fund, as a result of this application? (Replacement includes, but is not limited to, a lapse, surrender, 1035 Exchange, loan, withdrawal, or other change to any existing life insurance or annuity.) If yes, provide details in the chart below. Yes No

Life Insurance In Force

Full Company Name	Amount	Year Issued	Type	Will it be Replaced?
			<input type="checkbox"/> Individual or <input type="checkbox"/> Group <input type="checkbox"/> Personal or <input type="checkbox"/> Business	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Individual or <input type="checkbox"/> Group <input type="checkbox"/> Personal or <input type="checkbox"/> Business	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Individual or <input type="checkbox"/> Group <input type="checkbox"/> Personal or <input type="checkbox"/> Business	<input type="checkbox"/> Yes <input type="checkbox"/> No

F. Beneficiary Information

If the beneficiary is a trust, give complete trust name and date trust established.

	Beneficiary First and Last Name	Relationship to Proposed Insured	SSN/TIN (If known)	Percentage
Primary				
Contingent				

G. Owner Information

Submit the appropriate trust, corporate, or non-corporate form(s).

Only complete this section if the Owner is different than the Insured.

Owner name (last, first, middle)

- Individual
- Trust (submit Certification of Trustee Authority form)
- Corporate (submit Corporate/Non-Profit Resolution and Employer Notification Regarding the Potential Taxation of Death Benefit forms)
- Partnership (submit Partnership/LLC Resolution and Employer Notification Regarding the Potential Taxation of Death Benefit forms)
- Other _____

Social Security or tax ID number

Date of birth or trust date

Street address (no P.O. box)

City

State

Zip code

Relationship to proposed insured

Telephone number

E-mail address

H. Premium and Billing Information

Premium Notice Should Be Sent To:

- Proposed Insured Address in Section A
- Owner's Business/Employer Address (Indicate below)
- Owner Address in Section G
- Other (Indicate below)

Name

Address

City

State

Zip code

Payment Method:

- Annual
- Quarterly
- Semi-Annual
- Monthly Electronic Funds Transfer (EFT) Plan Number _____
(If new plan, submit EFT Authorization)
- List Bill Plan Number _____ (if new plan, submit List Bill Setup form)

Source of Funds:

- Earnings
- Existing Insurance
- Gift/Inheritance
- Retirement Funds
- Sale of Investments
- Savings
- Other _____

Third Party Notification (optional):

If you wish, you may give us the name and address of a person whom you designate to also receive notice of an overdue premium or pending lapse. (Indicate below)

Name

Address

City

State

Zip code

I. Additional Premium

Universal Life and Whole Life Additional Premium (excluding 1035)

\$ _____

1035 Exchange

(If yes, submit 1035 Exchange Agreement form)

- Yes
- No

J. Money Submitted with Application <i>Make all checks payable to Minnesota Life.</i>	Has the Owner paid money with this application to the representative? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, amount: \$ _____ Was a Life Receipt and Temporary Insurance Agreement given? <input type="checkbox"/> Yes <input type="checkbox"/> No			
K. Special Mailing Address	If mail (other than the premium notice) should be sent somewhere other than the Owner's Home Address, please indicate here. <input type="checkbox"/> Owner's Business Address <input type="checkbox"/> Other - Indicate Name and Address Name (last, first, middle) _____ Address _____ <table style="width: 100%; border: none;"> <tr> <td style="border: none; width: 60%;">City _____</td> <td style="border: none; width: 15%;">State _____</td> <td style="border: none; width: 25%;">Zip code _____</td> </tr> </table>	City _____	State _____	Zip code _____
City _____	State _____	Zip code _____		
L. Request for Illustration <i>Complete for non-variable products, excluding term.</i>	Choose one of the following: (For Policy Exchanges, only the first option is available.) <input type="checkbox"/> An illustration matching the policy applied for was presented to the Owner/Applicant and a signed copy is included with this application. The Owner/Applicant has received a copy. <input type="checkbox"/> An illustration was presented or provided to the Owner/Applicant, but is different from the policy applied for. An illustration conforming to the policy as issued will be provided to the Owner/Applicant no later than at the time of policy delivery. <input type="checkbox"/> No illustration conforming to the policy as applied for was shown or provided to the Owner/Applicant prior to or at the time of taking this application. An illustration conforming to the policy as issued will be provided to the Owner/Applicant no later than at the time of policy delivery.			
M. Proposed Insured Underwriting Information	1. Is the proposed insured a US citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, citizen of _____ Indicate visa type _____ 2. Does the proposed insured plan to travel or reside outside the US in the next two years? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide the city(s) and country(s), dates, length of stay, and purpose of travel: _____ _____ 3. Has the proposed insured within the last five years, or does the proposed insured plan, within the next two years, to engage in piloting a plane? If yes, complete the Military and Aviation Statement. <input type="checkbox"/> Yes <input type="checkbox"/> No 4. Has the proposed insured within the last five years, or does the proposed insured plan, within the next two years, to engage in skin diving (snorkel, scuba, or other), sky diving, mountain/rock climbing, horse racing, rodeo, polo, bull fighting, bungee jumping, BASE jumping, canyoneering, boxing, professional wrestling, extreme skiing, or racing (motor vehicle or boat)? If yes, complete Sports and Avocation Statement. <input type="checkbox"/> Yes <input type="checkbox"/> No 5. Is the proposed insured in the Armed Forces, National Guard, or Reserves? If yes, complete Military and Aviation Statement. <input type="checkbox"/> Yes <input type="checkbox"/> No 6. Has the proposed insured applied for insurance within the last six months? If yes, provide details below. <input type="checkbox"/> Yes <input type="checkbox"/> No _____ _____ 7. Has the proposed insured applied for life insurance in the past five years that was declined or rated? If yes, provide details below. <input type="checkbox"/> Yes <input type="checkbox"/> No _____ _____			

	<p>8. Has the proposed insured, within the past five years, been convicted of a driving while intoxicated violation, had a driver's license restricted or revoked, or been convicted of a moving violation? If yes, provide dates and details below.</p> <p>_____</p> <p>_____</p> <p>9. Except for traffic violations, has the proposed insured ever been convicted of a misdemeanor or felony? If yes, provide dates and details below.</p> <p>_____</p> <p>_____</p> <p>10. Will the Proposed Owner and/or beneficiary, and/or any entity on the Proposed Owner's behalf, receive any compensation, whether via the form of cash, property, an agreement to pay money in the future, a percentage of the death benefit, or otherwise if this policy is issued?</p> <p>11. Has the Proposed Owner been involved in any discussion about the possible sale or assignment of this policy or a beneficial interest in a trust, LLC, or other entity created on the owner's behalf? If yes, provide details and a copy of the applicable entity's controlling documents.</p> <p>_____</p> <p>_____</p> <p>12. Is this policy being funded via a premium financing loan or with funds borrowed, advanced or paid from another person or entity? If yes, submit the Premium Financing Advisor Attestation and Premium Financing Client Disclosure forms.</p> <p>13. Have you had a life expectancy report or evaluation done by an outside entity or company? If yes, please explain why the expectancy report was obtained.</p> <p>_____</p> <p>_____</p> <p>14. Is this policy in accordance with your insurance objectives and your anticipated financial needs?</p> <p>15. Has the representative discussed whether this policy is suitable for you?</p> <p>16. Reason for Purchasing Policy:</p> <p>a. Accumulation</p> <p>b. Business Planning/Key Person</p> <p>c. Charitable Giving</p> <p>d. Death Benefit Protection</p> <p>e. Estate Planning</p> <p>f. Retirement/Deferred Compensation</p> <p>g. Other _____</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>N. Additional Remarks</p>		
<p>O. Home Office Endorsements</p>	<p>Home Office Corrections or Additions</p> <p>Acceptance of the policy shall ratify changes entered here by Minnesota Life. Not to be used for change in age, gender, amount, classification, plan or benefits unless agreed to in writing.</p>	

Application 1A

Individual Life Insurance

MINNESOTA LIFE

Minnesota Life Insurance Company - A Securian Company
 Life New Business • 400 Robert Street North • St. Paul, Minnesota 55101-2098

Section A: Proposed Insured Information

Proposed insured name (last, first, middle)

Social Security number	Income	Net worth	Date of birth (mm/dd/yyyy)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Primary telephone number	Secondary telephone number	Driver's license number	Issue state	Expiration date
Occupation			Years in occupation	
Street address (no P.O. Box)		City	State	Zip code
Email address				

1. Birthplace (state or, if outside the U.S., country) _____

2. Is the Proposed Insured a U.S. citizen? If no, citizen of: _____ Yes No
 Visa type _____

Section B: Owner Information - Complete if Owner is not the Proposed Insured. Submit entity owner forms when appropriate.

Owner name (last, first, middle)

Date of birth/trust (mm/dd/yyyy)	Social Security number or tax ID no.	Relationship to proposed insured	Primary telephone number
<input type="checkbox"/> Individual <input type="checkbox"/> Trust <input type="checkbox"/> Corporate <input type="checkbox"/> Partnership <input type="checkbox"/> Other _____			
Street address (no P.O. Box)		City	State
Email address			

Section C: Products and Additional Agreements - Only select agreements applicable to the chosen product

Product applied for	Base face amount
UNIVERSAL LIFE ONLY	WHOLE LIFE ONLY
Total annual planned premium	Additional premium (exclude 1035 funds)
Additional premium (exclude 1035 funds)	Dividend Option (select one):
Death benefit option (select one):	<input type="checkbox"/> Accumulations
<input type="checkbox"/> Level	<input type="checkbox"/> Cash
<input type="checkbox"/> Increasing	<input type="checkbox"/> Paid Up Additional (default if none selected)
<input type="checkbox"/> Sum of Premiums	<input type="checkbox"/> Reduce Premium, Balance to Cash
Death Benefit Qualification Test (select one):	<input type="checkbox"/> Reduce Premium, Balance to Paid Up Additions
<input type="checkbox"/> Guideline Premium Test (GPT)	<input type="checkbox"/> Loan Repay with Balance to Cash
<input type="checkbox"/> Cash Value Accumulation Test (CVAT)	<input type="checkbox"/> Loan Repay with Balance to Paid Up Additions

AGREEMENTS APPLIED FOR:

- Accelerated Benefit Agreement
(Submit ABA Outline of Coverage form)
- Accidental Death Benefit Agreement
Coverage Amount: _____
- Additional Insurance Agreement
Coverage Amount: _____
- Business Value Enhancement Agreement
Select one:
 - Maximum Single Premium
 - Level Premium with PDA
(Submit Premium Deposit Account Information form)
- Children's Term or Family Term - Child Agreement
(Submit Family/Children's Term Application)
Coverage Amount: _____
- Death Benefit Guarantee Agreement
- Early Values Agreement

- Estate Preservation Agreement
Coverage Amount: _____
Face Amount (Not to exceed 122% of base amount)
- Estate Preservation Choice Agreement
Coverage Amount: _____
Face Amount (Not to exceed 122% of base amount)
- Exchange of Insureds Agreement
- Extended Conversion Agreement
- First To Die Agreement
Coverage Amount: _____
- Guaranteed Insurability Option Agreement
Coverage Amount: _____
- Guaranteed Insurability Option Agreement with Waiver
Coverage Amount: _____
- Inflation Agreement

- Long-Term Care Agreement
(Submit LTC Supplemental Application)
- Overloan Protection Agreement
- Premium Deposit Account Agreement (Submit Premium Deposit Account Information form)
- Single Life Term Agreement
Coverage Amount: _____
- Single Premium Paid Up Additional Insurance Agreement
Premium Amount: _____
- Surrender Value Enhancement Agreement
- Term Insurance Agreement
Coverage Amount: _____
- Waiver of Charges Agreement
- Waiver of Premium Agreement
- Other: _____
- Other: _____

THE FOLLOWING BENEFITS AND AGREEMENTS *WILL BE ADDED* IF AVAILABLE FOR YOUR POLICY, UNLESS YOU CHOOSE TO OMIT THEM:

- Omit Automatic Premium Loan Provision
- Omit Policy Split Agreement

Section D: Premium and Billing Information

Payment method:

- New Monthly Electronic Funds Transfer
- Quarterly Semi-Annual Annual
- Other (credit card payments not accepted) _____

Source of Funds:

- Earnings
- Existing Insurance
- Gift/Inheritance
- Retirement Funds
- Sale of Investments
- Savings
- Other _____

Premium notice should be sent to:

- Proposed insured address in Section A
- Owner address in Section B
- Other (complete payer information)

- Overdue premium or pending lapse notice should also be sent to a third party addressee (complete third party addressee information)

Payer or third party addressee name	Address	City	State	Zip code

Section E: Beneficiary Information - *If beneficiary is a trust, complete trust name & date trust established*

	Beneficiary First and Last Name	Relationship to Proposed Insured	SSN/TIN (If known)	Percentage
Primary				
Contingent				

Section F: Life Insurance In Force and Replacement

Excluding this policy, does the Proposed Insured have any life insurance, annuity or mutual fund in force or pending, including life insurance sold or assigned to, or is in the process of being sold or assigned to, a life settlement, viatical or secondary market provider?

Yes No

If yes, complete the *In Force Coverage and Replacement Chart*.

Excluding this policy, has there been, or will there be, replacement of any existing life insurance, annuity or mutual fund as a result of this application? (Replacement includes, but is not limited to, a lapse, surrender, 1035 Exchange, loan, withdrawal, or other change to any existing life insurance or annuity.)

Yes No

If yes, submit state replacement forms. (NOTE: State replacement forms are not required when replacing group coverage, except in FL, MI, and WA.)

1035 Exchange? Yes No

If yes, also submit the 1035 Exchange Agreement form.

<i>In Force Coverage and Replacement Chart</i>				
Full Company Name & Policy Number	Face Amount	Year Issued	Type	Replacing?
			<input type="checkbox"/> Individual or <input type="checkbox"/> Group <input type="checkbox"/> Personal or <input type="checkbox"/> Business	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Individual or <input type="checkbox"/> Group <input type="checkbox"/> Personal or <input type="checkbox"/> Business	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Individual or <input type="checkbox"/> Group <input type="checkbox"/> Personal or <input type="checkbox"/> Business	<input type="checkbox"/> Yes <input type="checkbox"/> No

Section G: Specific Policy Date Request

Are there any other Minnesota Life applications associated with this application?

Yes No

If yes, provide proposed insured(s) full name(s) and whether the policies should have the same issue date

Date to save age Specific date (mm/dd/yyyy): _____ (cannot select 29th, 30th, or 31st of month)

Section H: STOLI and Premium Financing

1. Will the Proposed Owner and/or beneficiary, and/or any entity on the Proposed Owner's behalf, receive any compensation, whether via the form of cash, property, an agreement to pay money in the future, a percentage of the death benefit, or otherwise if this policy is issued? Yes No

2. Has the Proposed Owner been involved in any discussion about the possible sale or assignment of this policy or beneficial interest in a trust, LLC, or other entity created on the Owner's behalf? If yes, provide details and a copy of the applicable entity's controlling documents: Yes No

3. Is this policy being funded via a premium financing loan or with funds borrowed, advanced, or paid from another person or entity? If yes, submit the Premium Financing Advisor Attestation and Premium Financing Client Disclosure forms Yes No

4. Have you had a life expectancy report or evaluation done by an outside entity or company? If yes, please explain why the expectancy report was obtained. Yes No

Section I: Suitability

1. Is this policy in accordance with your insurance objectives and your anticipated financial needs? Yes No
2. Has the representative discussed whether this policy is suitable for you? Yes No
3. Reason for purchasing policy:
- a. Accumulation Yes No
 - b. Business Planning/Key Person Yes No
 - c. Charitable Giving Yes No
 - d. Death Benefit Protection Yes No
 - e. Estate Planning Yes No
 - f. Retirement/Deferred Compensation Yes No
 - g. Other _____ Yes No

Section J: Request for Illustration - Not required for variable or term products

Please choose one of the following:

- An Illustration was signed and matches the policy applied for. A copy is included with this application and a copy has been left with the applicant.
- An illustration was shown or provided, but is different from the policy applied for. An illustration conforming to the policy as issued will be provided no later than at the time of policy delivery.
- No illustration conforming to the policy as applied for was shown or provided prior to or at the time of this application. An illustration conforming to the policy as issued will be provided no later than at the time of policy delivery.

Section K: Money Submitted

Has the owner paid money with this application 1A to the representative?

Yes No

If yes, amount

\$

Was a life receipt and temporary insurance agreement given?

Yes No

Section L: Authorization, Agreements, and Signatures

AGREEMENTS: I have read, or had read to me the statements and answers recorded on this Application 1A. They are given to obtain this insurance and are, to the best of my knowledge and belief, true and complete and correctly recorded. I understand that any false statement or misrepresentation on this Application 1A and the Application 1B may result in loss of coverage under this policy subject to the incontestability provision. I agree that they will become part of this Application 1A and the Application 1B and any policy issued on it. The insurance applied for will not take effect unless the policy is issued and delivered and the full first premium is paid while the health of the Proposed Insured remains as stated in the application. **If such conditions are met, the insurance will take effect as of the earlier of the Policy Date specified in the policy or the date the policy is delivered to me; the only exception to this is provided in the Life Receipt and Temporary Insurance Agreement, issued if the premium is paid in advance.**

VARIABLE LIFE: I understand that the amount or the duration of the death benefit (or both) of the policy applied for may increase or decrease depending on the investment results of the sub-accounts of the separate account. I understand that the actual cash value of the policy applied for is not guaranteed and increases and decreases depending on the investment results. There is no minimum actual cash value for the policy values invested in these sub-accounts.

AUTHORIZATION: I authorize any physician, medical practitioner, hospital, clinic or other health care provider, pharmacy, pharmacy benefits manager, insurance or reinsuring company, consumer reporting agency, the Medical Information Bureau, Inc. (MIB), or employer which has any records or knowledge of my physical or mental health, and/or the physical or mental health of each minor child listed as the Proposed Insured, to give all such information and any other non-medical information relating to such persons to Minnesota Life Insurance Company or its reinsurers. This shall include ALL INFORMATION as to any medical history, consultations, diagnoses, prognoses, prescriptions or treatments and tests, including information regarding alcohol or drug abuse and AIDS or AIDS-related conditions. To facilitate rapid submission of such information, I authorize all said sources, except MIB, to give such records or knowledge to any agency employed by Minnesota Life Insurance Company to collect and transmit such information.

I understand this information is to be used for the purpose of determining eligibility for insurance and may be used for determining eligibility for benefits. I understand this information may be made available to Underwriting, Claims, support staff, licensed representatives and firms of Minnesota Life. I authorize Minnesota Life Insurance Company or its reinsurers to release any such information to reinsuring companies, the MIB, or other persons or organizations performing business or legal services in connection with my Application 1A and Application 1B, claim or as may be otherwise lawfully required or as I may further authorize.

I agree this Authorization shall be valid for twenty-four months from the date it is signed. I may revoke this Authorization at any time by sending a written request addressed to the Individual Underwriting Department, Minnesota Life Insurance Company, 400 Robert Street North, St. Paul, MN 55101-2098. I understand that a revocation is not effective to the extent that any action has been taken in reliance on this Authorization or to the extent that Minnesota Life Insurance Company has a legal right to contest a claim under an insurance policy or to contest the policy itself.

I understand that I, or my legal representative, have the right to request and receive a copy of this Authorization and that a photocopy of this Authorization shall be as valid as the original. I understand that no sales representative has the company's authorization, to accept risk, pass on insurability, or make, or void, waive or change any conditions or provisions of the application, policy or receipt, as applicable.

I acknowledge that I have been given the Your Privacy Is Important To Us notice.

I understand that a copy of this entire application, including Part 1B, will be attached to the policy and delivered to the policyowner.

FRAUD WARNING: 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.

Proposed insured signature X	City	State	Date
Parent/conservator/guardian signature (juvenile applications) X	City	State	Date
Owner signature (required if other than proposed insured; give title if signed on behalf of a business) X	City	State	Date

Is replacement of existing life insurance, annuity or mutual fund involved in this application? Yes No

I believe that the information provided by this Applicant is true and accurate. I certify I have accurately recorded all information given by the Proposed Insured(s).

Licensed representative signature X	Date	Business telephone number	Firm/rep code
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Application 1B Individual Life Insurance

MINNESOTA LIFE

Minnesota Life Insurance Company - A Securian Company
Life New Business • 400 Robert Street North • St. Paul, Minnesota 55101-2098

Section A: Proposed Insured Information

1. Does the Proposed Insured plan to travel or reside outside the U.S. in the next two years? (If yes, complete the Foreign Residence and Travel Questionnaire.) Yes No
2. Has the Proposed Insured within the last five years, or does the Proposed Insured plan, within the next two years, to engage in piloting a plane? (If yes, complete the Military/Aviation Statement.) Yes No
3. Has the Proposed Insured within the last five years, or does the Proposed Insured plan, within the next two years, to engage in skin diving (snorkel, scuba or other), sky diving, mountain/rock climbing, horse racing, rodeo, polo, bull fighting, bungee jumping, BASE jumping, canyoneering, boxing, professional wrestling, extreme skiing or racing (motor vehicle or boat)? (If yes, complete the Sports/Avocation Statement.) Yes No
4. Is the Proposed Insured in the Armed Forces, National Guard, or Reserves? (If yes, complete the Military/Aviation Statement.) Yes No
5. Has the Proposed Insured applied for insurance within the last six months? If yes, provide details: Yes No

6. Has the Proposed Insured applied for life insurance in the past five years that was declined or rated? If yes, provide details: Yes No

7. Has the Proposed Insured, within the past five years, been convicted of a 'driving while intoxicated' violation, had a driver's license restricted or revoked, or been convicted of a moving violation? If yes, provide dates and details: Yes No

8. Except for traffic violations, has the Proposed Insured ever been convicted of a misdemeanor or felony? If yes, provide dates and details: Yes No

Section B: Mailing Address - Complete if mail (other than the premium notice) should be sent elsewhere than the Owner's address in Section B.

Mail recipient name	Address	City	State	Zip code

Section C: Home Office Endorsement

Acceptance of the policy shall ratify changes entered here by Minnesota Life. Not to be used for change in age, gender, amount, classification, plan, or benefits unless agreed to in writing.

Section D: Additional Information

Section E: Agreement

I have read the statements and answers recorded on this Application 1B; they are to the best of my knowledge and belief true, complete and correctly recorded. I agree that they will become part of my application and any policy issued on it.

Proposed insured signature X	Date
Representative signature (witness) X	Date

Supplemental Information to the Application
Individual Life Insurance

Minnesota Life Insurance Company - A Securian Company
Life New Business • 400 Robert Street North • St. Paul, Minnesota 55101-2098

MINNESOTA LIFE

Proposed primary insured name	Social Security number
-------------------------------	------------------------

ADDITIONAL INFORMATION

Dated at _____ City _____ State _____ this _____ day of _____ Month _____, _____ Year

Signature of proposed insured X	Signature of proposed owner (if other than proposed insured) X
Signature of parent or legal guardian (if proposed insured is underage) X	Signature of additional insured X
Signature of representative X	

SERFF Tracking Number: MNNL-128074946 State: Arkansas
 Filing Company: Minnesota Life Insurance Company State Tracking Number:
 Company Tracking Number: 12-400
 TOI: L041 Individual Life - Term Sub-TOI: L041.103 Renewable - Single Life -
 Fixed/Indeterminate Premium
 Product Name: Individual Term Life Policy
 Project Name/Number: 2012 Term Refresh/12-400

Supporting Document Schedules

Item Status: **Status**
Date:

Satisfied - Item: Flesch Certification

Comments:

Attachments:

Certification of Compliance.pdf
 Certification of Readability.pdf

Item Status: **Status**
Date:

Satisfied - Item: Application

Comments:

The applications to be used with the policy are attached in the Form Schedule.

Item Status: **Status**
Date:

Satisfied - Item: Life & Annuity - Actuarial Memo

Comments:

Attached are the Actuarial Memorandums for the policy and agreements as well as rates charged for the different age bands and risk classes.

Attachments:

Actuarial Memo 12-920 - Extended Conversion Agreement.pdf
 Actuarial Memo 12-400 - Term Policy.pdf
 Actuarial Memo 12-900 - Waiver of Premium.pdf
 Base Premium Rates.pdf

Item Status: **Status**
Date:

Satisfied - Item: Statement of Variability

Comments:

Attachment:

Statement of Variability.pdf

SERFF Tracking Number: MNNL-128074946 State: Arkansas
 Filing Company: Minnesota Life Insurance Company State Tracking Number:
 Company Tracking Number: 12-400
 TOI: L041 Individual Life - Term Sub-TOI: L041.103 Renewable - Single Life -
 Fixed/Indeterminate Premium
 Product Name: Individual Term Life Policy
 Project Name/Number: 2012 Term Refresh/12-400

Item Status: **Status**
Date:

Satisfied - Item: Exhibit - Tele-Interview Script

Comments:

The attached document is the Tele-Interview questions asked by an outside vendor to either complete the medical Part 2 of the application or obtain more detail on a positive answer to a question on the Part 2 Application.

This tele-interview script was provided with our 2010 application filing, as required by the Compact Standard. The script has been revised slightly to coincide with the revisions made to Part 2 - medical questions in the applications. The Part 2 has been revised to be consistent with other applications approved with a recent new product filing. The new or revised questions are highlighted in blue for ease of review.

Attachment:

72569 Rev 1-2012 TI Scripts 12-2011 Heirarchy.pdf

Item Status: **Status**
Date:

Satisfied - Item: Exhibit - Brief Description -
 Electronic Signature Application
 Process

Comments:

Attached are our Electronic Signature processes.

Attachments:

E-Signature Process Description.pdf
 MN Life eSig Client Only Version.pdf

Item Status: **Status**
Date:

Satisfied - Item: Exhibit - Statement of Policy Cost
 and Benefit Information

Comments:

the Term Policy is not sold with an Illustration. Attached is the Statement of Policy Cost and Benefit Information form.

Attachment:

Statement of Policy Cost and Benefit Information.pdf

Securian Financial Group, Inc.
400 Robert Street North
St. Paul, MN 55101-2098
www.securian.com
651.665.3500



CERTIFICATION OF COMPLIANCE

Minnesota Life Insurance Company certifies that it has reviewed and is in compliance with the following Arkansas Rules and Regulations and Statutes.

Rule and Regulation 19
Rule and Regulation 49
Rule and Regulation 33
Arkansas Statute 23-80-206
Arkansas Statute 23-79-138

Unfair Sex Discrimination
Guaranty Association Notice
Universal Life Insurance
Flesch Certification
Contact Notice

Name: Susan C. Johnson
Susan C. Johnson

Title: Assistant Secretary

Date: February 7, 2012



CERTIFICATION OF READABILITY

This is to certify that the attached Advantage Elite Select Term Policy, Waiver of Premium Agreement, Extended Conversion Agreement, and Applications Part 1, Part 2, Part 3, Part 1A, Part 1B, and Supplemental Information to the Application, Form Numbers 12-400, 12-900, 12-920, F59410 Rev 1-2012, F59534 Rev 1-2012, F59536 Rev 1-2012, F59537 Rev 1-2012, F59538 Rev 1-2012, F59572 Rev 1-2012, F59573 Rev 1-2012, F59573-T Rev 1-2012, F65324 Rev 1-2012, F72540 Rev 1-2012, F72541 Rev 1-2012, and F72587 Rev 1-2012 have achieved Flesch Reading Ease Scores of 52.2, 53.9, 57, 54.1, 53.6, 50.2, 52.2, 50.1, 51.2, 50, 50.1, 52.7, 50.5, 61.8 and 53.8 and comply with the requirements of Ark. Stat. Ann. §66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.



Signature (Must be an Officer)

Name: Susan C. Johnson

Title: Assistant Secretary

Date: February 7, 2012

If an insurer chooses to score certain forms as separate from the policy with which they may be used, this information must be contained in the certificate.

If a policy is scored by a method other than the Flesch reading ease score, use of the alternate method shall be explained in detail.

**ADVANTAGE ELITE SELECT
TERM POLICY FORM 12-400
STATEMENT of VARIABILITY
for
POLICY DATA PAGES**

SECTION:	VARIABLE DATA	Explanation
Insured	36 characters	Individual Insured's Name.
Issue Age	Varies by level premium period and Face Amount Band Face Amounts 100,000 – 249,999: 5 yr = 16 through 55 10 yr = 16 through 55 15 yr = 16 through 55 20 yr = 16 through 55 30 yr = 16 through 45 Face Amounts 250,000 and above: 5 yr = 16 through 80 10 yr = 16 through 80 15 yr = 16 through 70 20 yr = 16 through 65 30 yr = 16 through 50	Age of insured when policy is issued.
Gender	Male Female Unisex	Defines Gender for rates. Unisex will be used in states where required or when issued in qualified pension plan.
Policy Number	7 digit number unique to each policy	Always ends in a "W."
Policy Date	Effective Date of the Policy Coverage	Date insured chooses coverage to be effective.
Risk Class	Varies by Face Amount Band Face Amounts 100,000 – 249,999: Express Issue Standard, Non-Tobacco Express Issue Standard, Tobacco Face Amounts 250,000 and above: Preferred Select, Non-Tobacco Preferred, Non-Tobacco Preferred, Tobacco Standard, Plus Non-Tobacco Standard, Non-Tobacco Standard, Tobacco Special Risk XXX%, Non-Tobacco Special Risk XXX%, Tobacco	The risk class and tobacco status are unique to each policy issue.
Face Amount	\$100,000 to \$999,999,999	Amount of Insurance selected by applicant.
Payment Options	Annual, Semi-Annual, Quarterly, Monthly	Payment frequency chosen by applicant.
Premium	Minimum premium – none required. Maximum premium is the amount required to support the face amount requested.	The amount actually paid for a given frequency.
Annual Premium by Frequency	Modal Premium Factors used are: Annual = Annual Semi-Annual = .52 Quarterly = .27 Monthly = .088	The amount actually paid for an entire year including the loading for the frequency. Displays for every coverage which has a separate premium.

SECTION:	VARIABLE DATA	Explanation
Basic Policy – Level Premium – Term Period	Description of various features and time frames on a given policy a. Level Premium Term Period (chosen by applicant; can be any one of following): 5 years 10 years 15 years 20 years 30 years b. Effective Date. c. Premium payable through.	a. Length of time premiums are level. b. Date level premium period begins. c. The last date the premiums will be level.
Renewal Privilege	Premium payable through	(a) Date through which premiums may be renewed; age 95.
Special Risk Premium	Table B thru Table P	Displays the total percentage of standard premium that will be paid for medical risks.
Cash Extra	Premium payable through [x]	Displays the date prior to coverage termination when the shorter term extra premium for avocation or occupation will end.
Cash Extra	Premium payable through the entire length of policy coverage	Displays the date when the permanent extra premium for avocation or occupation will end; it equals the date coverage ends.
Conversion Privilege	Privilege End Date (Duration from Issue (Varies by plan) 5 yr = 5 years 10 yr = 5 years 15 yr = 5 years 20 yr = 10 years 30 yr = 10 years	The end date of the privilege can be extended to the end of the level premium duration if the Extended Conversion Agreement (ECA) is active on the policy.
Conversion Privilege Period Begins and Ends	Privilege End Date (Duration from Issue (Varies by plan) 5 yr = 5 years 10 yr = 5 years 15 yr = 5 years 20 yr = 10 years 30 yr = 10 years	The conversion privilege begins one year after issue. The conversion privilege ends at the earliest of: age 75, the duration designated to the left if the policy does not have ECA, or the end of the level premium period if policy has ECA.
Additional Agreements	Extended Conversion Agreement Extended conversion period begins [MMDDYYYY] and ends [MMDDYYYY]	(a) Lists optional agreements available for this policy; (b) Only those Optional Agreements chosen by owner will print; (c) If no agreements chosen, this section will not print; (d) If the Extended Conversion Agreement is chosen, the dates the extended conversion period begins and ends will print.

SECTION:	VARIABLE DATA	Explanation
Waiver of Premium Agreement	a. Effective Date Premium payable through	(a) Date the Agreement was issued or added to the policy (b) Date the premiums for this agreement end; either policy termination or age 65 whichever is earlier.
Renewal Premiums	a. Itemizes each year's renewal premium by frequency. b. Displays length of time Waiver Premium is included if Waiver was chosen. c. Displays length of time Special Risk premium is included if policy is rated.	Renewal Premiums are shown for both Guaranteed Rates and Current Experience rates where allowed by state.

Exhibit

Pt 2 Quest	QuestID	QuestText	Yellow = Question on the Application; Green = Instructions for Interviewer Pink = Combined Question Blue = New Question
First line	55567	What is your height?	
	15494	What is your weight?	
Top Line	39256	Have you had weight loss or gain in the last 12 months?	
	3034	DO NOT ASK: Did applicant say yes to a gain in weight?	
	3035	How much weight did you gain?	
	6128	How much weight did you lose?	
	3032	What is the reason for your change in weight?	
Top Line	39256	Have you had weight loss or gain in the last 12 months?	
	39257	Do you have a history of an eating disorder?	
	39258	When was the disorder diagnosed?	
	39259	Have you ever received treatment for this disorder?	
	39260	When was treatment completed?	
	39261	What is the name and address of the facility which provided the treatment for the disorder?	
	4234	Do you or have you ever received psychotherapy or counseling?	
	6842	What is the date of the last treatment?	
	18291	What are the names and addresses of ALL treatment facilities/doctors seen for this illness?	
	10477	Have you missed work as a result of this illness?	
	10478	How many days of work have you missed this year due to this illness?	
	10479	Are your job duties or leisure activities restricted in any way because of this illness?	
	5997	Please give details.	
	187990	What is the name and address of the doctor or medical facility who has the records for this condition?	
	10480	When was the date of your last visit or treatment for this illness?	
1.A.	14855	Have you ever smoked cigarettes?	
	4001	Do you currently use Cigarettes?	
	4002	How many packs of cigarettes per day?	
	3995	When did you last smoke Cigarettes?	
	55861	Are you a past smoker or have you used cigarettes before in the past?	
	13530	How many packs of cigarettes per day?	
	55574	What is the month, date and year of your last cigarette smoked?	
1 B.	14857	Have you ever used tobacco, other than cigarettes, in any form?	
	55575	Are you a current user or past user of this "other tobacco" form?	
	55576	What type of product do you or did you use?	
	55577	How much?	
	55578	Date of last use:	
2	74701	Are you taking or do you take any prescription or non-prescription medications or drugs? (to include any herbs, vitamins, mineral supplements or other non-prescription remedies?)	
	56769	For your prescriptions, what are the names, dosages and reasons for taking them?	
	56770	For any non-prescription medications or drugs including herbs, vitamins, or mineral supplements, what are the names and reasons for taking these?	
	189820	What is the name and address of the physician that has prescribed this medication or is conducting the treatment?	
	12739	When were you last seen by this doctor?	
3.A.	14859	Have you ever had or been treated, diagnosed or given medical advice by a member of the medical profession for: Epilepsy, Alzheimer's; Huntington's; Parkinson's; Mild Cognitive Impairment (MCI), dementia; paralysis; sleep disorder, depression; stress disorders; anxiety disorders; or any brain, nervous, mental or emotional disorder?	
	14331	DO NOT ASK: Did applicant say yes to Epilepsy?	
	3123	What type of seizures?	
	10468	When did the seizures first occur?	
	10469	Has a cause for the seizure been determined?	
	10470	When was your last seizure?	
	3120	How often do you have seizures?	
	10471	What is the name and dosage of the medication you are taking?	
	10472	Have your job duties, leisure activities or your ability to drive been modified or changed in any way because of this condition?	
	179480	What is the name and address of the doctor being seen for this condition?	
	78288	DO NOT ASK: Did applicant say yes to Alzheimer's?	
	83549	When were you diagnosed?	

Exhibit

6155	Did you receive any medication or treatment?
6161	What was the name and dosage of the medication or type of treatment?
181330	What is the name and address of the doctor or medical facility who has the records regarding this condition?
78289	DO NOT ASK: Did applicant say yes to Huntington's?
83549	When were you diagnosed?
6155	Did you receive any medication or treatment?
6161	What was the name and dosage of the medication or type of treatment?
181330	What is the name and address of the doctor or medical facility who has the records regarding this condition?
78289	DO NOT ASK: Did applicant say yes to Parkinson's?
83549	When were you diagnosed?
6155	Did you receive any medication or treatment?
6161	What was the name and dosage of the medication or type of treatment?
181330	What is the name and address of the doctor or medical facility who has the records regarding this condition?
78289	DO NOT ASK: Did applicant say yes to Mild Cognitive Impairment?
83549	When were you diagnosed?
39253	Who diagnosed you with this condition? Please also provide the address and phone number of this doctor.
39254	Is she/he a psychiatrist, a psychologist, a counselor, or a general physician?
40032	Which category does this doctor fall under?
39508	Is/was the condition associated with any situational stressors?
17022	Please give details:
6155	Did you receive any medication or treatment?
6161	What was the name and dosage of the medication or type of treatment?
181330	What is the name and address of the doctor or medical facility who has the records regarding this condition?
78289	DO NOT ASK: Did applicant say yes to Dementia?
83549	When were you diagnosed?
39253	Who diagnosed you with this condition? Please also provide the address and phone number of this doctor.
39254	Is she/he a psychiatrist, a psychologist, a counselor, or a general physician?
40032	Which category does this doctor fall under?
39508	Is/was the condition associated with any situational stressors?
6155	Did you receive any medication or treatment?
6161	What was the name and dosage of the medication or type of treatment?
181330	What is the name and address of the doctor or medical facility who has the records regarding this condition?
14864	DO NOT ASK: Did the applicant answer Yes to Paralysis?
14865	What is the degree of your paralysis?
14866	Is this the result of an injury or a disease process?
14867	Do you have any history of respiratory, renal, bladder, or bowel function complications?
12639	Please give details.
12677	Did you receive any medication or treatment?
12678	What was the name and dosage of the medication or type of treatment?
180380	What is the name and address of the doctor or medical facility who has the records regarding this condition?
12679	Has there been any recurrence or current treatment?
10461	DO NOT ASK: Did the applicant say yes to Sleep Disorder?
39333	What sleep disorder was diagnosed?
180380	What is the name and address of the doctor or medical facility who has the records regarding this condition?
12677	Did you receive any medication or treatment?
12678	What was the name and dosage of the medication or type of treatment?
10461	DO NOT ASK: Did the applicant say to Sleep Apnea?
39347	Was a sleep study performed?
39348	When and What were the results of the sleep study?
39349	Where was the sleep study performed?
10462	Was surgery performed?
10463	Was a sleep study done after the surgery?
10464	What were the results of the sleep study?
39350	Where was the sleep study performed?

Exhibit

10465	Was a CPAP or BIPAP machine prescribed?
39507	How often do you use the machine?
10467	What type of medications are you currently taking?
182040	What is the name and address of the doctor or medical facility that has records for this condition?
10616	DO NOT ASK: Did the applicant say yes to Sleep Walking?
39347	Was a sleep study performed?
39348	When and What were the results of the sleep study?
39349	Where was the sleep study performed?
39253	Who diagnosed you with this condition? Please also provide the address and phone number of this doctor.
39254	Is she/he a psychiatrist, a psychologist, a counselor, or a general physician?
40032	Which category does this doctor fall under?
12677	Did you receive any medication or treatment?
10467	What type of medications are you currently taking?
182040	What is the name and address of the doctor or medical facility that has records for this condition?
61610	DO NOT ASK: Did the applicant say to Depression?
39253	Who diagnosed you with this condition? Please also provide the address and phone number of this doctor.
39254	Is she/he a psychiatrist, a psychologist, a counselor, or a general physician?
40032	Which category does this doctor fall under?
12677	Did you receive any medication or treatment?
10467	What type of medications are you currently taking?
44410	DO NOT ASK: Did the applicant say to Stress Disorders?
6194	What was the specific condition?
6195	Date of occurrence?
6196	Did you receive any medication or treatment?
6197	What was the name and dosage of the medication or type of treatment?
180970	Please provide the name and address of the doctor or medical facility who has the records regarding this condition.
6190	Has there been any recurrence or current treatment?
31780	DO NOT ASK: Did the applicant say to Anxiety Disorders?
6194	What was the specific condition?
6195	Date of occurrence?
6196	Did you receive any medication or treatment?
6197	What was the name and dosage of the medication or type of treatment?
180970	Please provide the name and address of the doctor or medical facility who has the records regarding this condition.
6190	Has there been any recurrence or current treatment?
14659	DO NOT ASK: Did the applicant answer Yes to any other brain, nervous, mental or emotional disorder?
6194	What was the specific condition?
6195	Date of occurrence?
6196	Did you receive any medication or treatment?
6197	What was the name and dosage of the medication or type of treatment?
180970	Please provide the name and address of the doctor or medical facility who has the records regarding this condition.
6190	Has there been any recurrence or current treatment?
10474	What was the actual diagnosis given to your condition?
6464	When was your condition diagnosed?
39253	Who diagnosed you with this condition? Please also provide the address and phone number of this doctor.
39254	Is she/he a psychiatrist, a psychologist, a counselor, or a general physician?
40032	Which category does this doctor fall under?
39508	Is/was the condition associated with any situational stressors?
17022	Please give details:
14878	Was this a single occurrence?
3610	Were you hospitalized?
10475	When were you hospitalized?
3222	What was the length of the hospital stay?
39255	What treatment was administered during your hospitalization?
10476	Do you take medication for this?

Exhibit

	6854	What was the name and dosage of the medication or type of treatment?
	3406	Has your medication(s) been changed in the last 2 years?
	3407	Why was the medication(s) changed?
3 B.	14876	High blood pressure; chest pain; chest discomfort or tightness; heart attack, heart murmur; stroke; irregular heart beat; or any other disease or disorder of the heart or blood vessels?
	6166	DO NOT ASK: Did the applicant answer Yes to high blood pressure?
	3562	When were you diagnosed?
	39283	What was the name and dosage (s) of the medication (s) or type of treatment?
	10421	How often are you required to take your medication?
	39284	Any recent changes in medication (s) and/or dosage (s)?
	14900	What was the change?
	14901	What was the reason for the change?
	10422	Have you ever required hospitalization or emergency room treatment for this condition?
	187560	What is the name and address of the doctor or medical facility who has the records for this condition?
	3221	When was the hospitalization?
	39285	Have you ever had or been advised to have a cardiac evaluation, stress test, or echocardiogram?
	6166	DO NOT ASK: Did the applicant answer Yes to Chest Pain?
	12656	What was the actual diagnosis?
	14430	When was this diagnosed?
	14887	Have you ever required hospitalization or emergency room treatment for this condition?
	187440	What is the name and address of the doctor or medical facility who has the records for this condition?
	14888	When was the hospitalization?
	14889	What medications are you currently taking?
	14890	Have any tests such as CT, MRI scan or other diagnostic tests been performed?
	11975	What type of test(s), date(s), and what were the results?
	14892	Do you have any physical or employment restrictions as a result of this condition?
	14327	What are your physical restrictions?
	179610	What is the name and address of the doctor being seen for this condition?
	14893	What was the date of your last check up?
	3333	DO NOT ASK: Did the applicant say yes to Chest Discomfort or Tightness?
	12656	What was the actual diagnosis?
	14430	When was this diagnosed?
	14887	Have you ever required hospitalization or emergency room treatment for this condition?
	187440	What is the name and address of the doctor or medical facility who has the records for this condition?
	14888	When was the hospitalization?
	14889	What medications are you currently taking?
	14890	Have any tests such as CT, MRI scan or other diagnostic tests been performed?
	11975	What type of test(s), date(s), and what were the results?
	14892	Do you have any physical or employment restrictions as a result of this condition?
	14327	What are your physical restrictions?
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	14893	What was the date of your last check up?
	3333	DO NOT ASK: Did the applicant say yes to Chest Discomfort or Tightness?
	12656	What was the actual diagnosis?
	14430	When was this diagnosed?
	14887	Have you ever required hospitalization or emergency room treatment for this condition?
	187440	What is the name and address of the doctor or medical facility who has the records for this condition?
	14888	When was the hospitalization?
	14889	What medications are you currently taking?
	14890	Have any tests such as CT, MRI scan or other diagnostic tests been performed?
	11975	What type of test(s), date(s), and what were the results?
	14892	Do you have any physical or employment restrictions as a result of this condition?
	14327	What are your physical restrictions?
	179610	What is the name and address of the doctor being seen for this condition?

Exhibit

14893	What was the date of your last check up?
14881	DO NOT ASK: Did applicant say yes to Heart attack and or Coronary Artery Disease?
10405	What was the actual diagnosis?
3458	When was it diagnosed?
14384	Have you ever required hospitalization or emergency room treatment for this condition?
187290	What is the name and address of the doctor or medical facility who has the records for this condition?
14386	When was the hospitalization?
10406	Did you require bypass surgery, angioplasty, cardiac catheterization or any other cardiovascular procedure?
10407	When was your most recent surgery or procedure?
10408	How many vessels were bypassed or angioplastied?
17671	Were stents implanted?
10409	What medications are you currently taking?
39262	When did you last have chest pain symptoms?
14882	Have you had any stress testing since the heart attack?
14883	When were the test(s) performed?
180180	What is the name and address of the doctor or medical facility who has records for this condition?
10410	Do you have any physical or employment restrictions as a result of this condition?
3524	Describe any restrictions you have.
14884	What is the name and address of the doctor/cardiologist being seen for this condition?
14885	Would your primary physician have records of your surgical procedure and/or heart history?
10411	What was the date of your last check up?
39307	DO NOT ASK: Did the applicant answer yes to heart murmur?
39308	When was the heart murmur diagnosed?
39309	Has it been audible on subsequent cardiac exams?
39310	Was an echocardiogram performed to evaluate the heart murmur?
39311	What symptoms or circumstances prompted the echocardiogram?
39312	When and What were the results of the echocardiogram?
39313	What heart valve abnormalities, if any, were discovered on the echocardiogram?
39314	Were any heart chamber or wall thickness abnormalities discovered?
39315	What other testing or procedures were performed because of the echocardiogram result?
39316	Were follow-up echocardiograms recommended?
39317	When are they planned?
39318	Do you need to take antibiotic medication before dental procedures?
39319	What physical restrictions, if any, were placed upon you due to the echocardiogram results?
39320	What is the name and address of the facility where the echocardiogram was performed?
39321	What is the name and address of the doctor or facility who has the echocardiogram results, the follow-up test results, and the medication information?
39322	What was the diagnosis given for the heart murmur?
39323	What medications, if any, were prescribed due to the heart murmur?
39324	Do you require antibiotics before dental procedures?
39325	What other testing or procedures, if any, were performed due to the heart murmur?
39326	What is the name and address of the doctor or facility who has the heart murmur results, the follow-up test results, and the medication information?
14886	DO NOT ASK: Did applicant say yes to Stroke and/or Transient Ischemic Attack (TIA)?
12656	What was the actual diagnosis?
14430	When was this diagnosed?
14887	Have you ever required hospitalization or emergency room treatment for this condition?
187440	What is the name and address of the doctor or medical facility who has the records for this condition?
14888	When was the hospitalization?
14889	What medications are you currently taking?
14890	Have any tests such as CT, MRI scan or other diagnostic tests?
11975	What type of test(s), date(s), and what were the results?
14891	Do you have any residual paralysis or memory loss?
14892	Do you have any physical or employment restrictions as a result of this condition?
14327	What are your physical restrictions?
179610	What is the name and address of the doctor being seen for this condition?

Exhibit

14893	What was the date of your last check up?
14894	DO NOT ASK: Did the applicant answer Yes to irregular heart rhythm and/or atrial fibrillation?
3387	When was the condition first diagnosed?
10417	How was it diagnosed?
3252	What type of medication or treatment is being taken?
3521	How often do you experience the symptoms?
3457	What was the date of your last episode?
39263	Please state which condition is present (atrial fibrillation/irregular heart rhythm/etc.) and state whether it is continuous or Intermittent?
14896	Have you had an echocardiogram and/or stress test done?
6348	DO NOT ASK: Did the applicant answer Yes to any other disease?
3505	What is the specific medical condition?
6140	Date of occurrence?
14902	Have you ever required hospitalization or emergency room treatment for this condition?
187730	What is the name and address of the doctor or medical facility who has the records for this condition?
6155	Did you receive any medication or treatment?
6161	What was the name and dosage of the medication or type of treatment?
3346	Has there been any recurrence or current treatment?
3333	DO NOT ASK: Did the applicant say yes to any other disorder?
3510	What is the specific medical condition?
6182	Date of occurrence?
6155	Did you receive any medication or treatment?
6161	What was the name and dosage of the medication or type of treatment?
181330	What is the name and address of the doctor or medical facility who has the records regarding this condition?
3346	Has there been any recurrence or current treatment?
39264	DO NOT ASK: Did the applicant say yes to echocardiogram?
39265	What symptoms or circumstances prompted the echocardiogram?
39266	When and What were the results of the echocardiogram?
39267	What heart valve abnormalities, if any, were discovered on the echocardiogram? Were any heart chamber or wall thickness abnormalities discovered?
39268	What other testing or procedures were performed or advised because of the echocardiogram result?
39299	Were any heart chamber or wall thickness abnormalities discovered?
39269	Were follow-up echocardiograms recommended?
39270	When are they planned?
39271	Do you need to take antibiotic medication before dental procedures?
39272	What physical restrictions, if any, were placed upon you due to the echocardiogram results?
39273	What is the name and address of the facility where the echocardiogram was performed?
39274	What is the name and address of the doctor or facility who has the echocardiogram results, the follow-up test results, and the medication information?
10423	What was your highest blood pressure reading and when was it recorded?
3175	What was your last blood pressure reading?
179770	What is the name and address of the doctor being seen for this condition?
3456	When did you last consult the doctor?
39275	DO NOT ASK: Did the applicant say yes to stress test?
39276	What symptoms or circumstances prompted the stress test?
39277	When and What were the results of the stress test?
39278	What other testing or procedures were performed because of the stress test result?
39279	What medications, if any, were prescribed because of the stress test result?
39280	What physical restrictions, if any, were placed upon you due to the stress test results?
39281	What is the name and address of the facility where the stress test was performed?
39282	What is the name and address of the doctor or facility who has the stress test results, the follow-up test results, and the medication information?
14897	Do you have a pacemaker and/or defibrillator?
14898	When was it inserted?
12227	What treatment(s) or medication(s) do you take for this condition?
179680	What is the name and address of the doctor being seen for this condition?
10420	When did you last consult the doctor?

Exhibit

	39286	DO NOT ASK: Did the applicant answer yes to cardiac evaluation?
	12035	What test(s) were to be performed?
	12666	What were the results?
	11196	When were the test(s) performed?
	12034	Why were the test(s) performed?
	180080	What is the name and address of the doctor or medical facility who has records for this condition?
3 C.	14905	Asthma, shortness of breath, bronchitis, pneumonia, emphysema, chronic cough, or any other lung or respiratory disorder?
	3324	DO NOT ASK: Did the applicant say yes to asthma?
	3211	Age at onset?
	55562	What is the frequency of your flare ups?
	55563	How long do your flare ups usually last?
	55564	Date of last flare up?
	55565	Are your lungs clear between flare ups?
	14907	Ever have status asthmaticus?
	14908	Ever diagnosed with chronic obstructive pulmonary disease? (COPD)
	6285	What is the name of the treatment/medication you are taking?
	14909	Have you ever used oral steroids? (prednisone)
	14910	How often and for what duration?
	10455	Have you ever been hospitalized or been treated at the emergency room for this condition?
	14911	How many times have you been hospitalized or been seen at an emergency room for this?
	14912	When were you last hospitalized or been to an emergency room?
	2799	How many days of work have you missed in the past year due to this condition?
	10458	Do you have any restrictions or limitations due to this condition?
	3632	What are your physical restrictions?
	181850	What is the name and address of the doctor or medical facility who has the records for this condition?
	10459	When did you last consult the doctor?
	10460	DO NOT ASK: Did the applicant say yes to Tuberculosis?
	3459	When was it diagnosed?
	3460	What type of treatment or medication was prescribed?
	3384	What was the date of the last treatment?
	11344	Do you currently take medication for this?
	6901	What was the name and dosage of the medication or type of treatment?
	179830	What is the name and address of the doctor being seen for this condition?
	10461	DO NOT ASK: Did the applicant say yes to Sleep Apnea?
	39347	Was a sleep study performed?
	39348	When and What were the results of the sleep study?
	39349	Where was the sleep study performed?
	10462	Was surgery performed?
	10463	Was a sleep study done after the surgery?
	10464	What were the results of the sleep study?
	39350	Where was the sleep study performed?
	10465	Was a CPAP or BIPAP machine prescribed?
	39507	How often do you use the machine?
	10467	What type of medications are you currently taking?
	182040	What is the name and address of the doctor or medical facility that has records for this condition?
	10509	DO NOT ASK: Did the applicant say yes to pneumonia?
	6202	Date of occurrence?
	6203	Did you receive any medication or treatment?
	6204	What was the name and dosage of the medication or type of treatment?
	182270	What is the name and address of the doctor or medical facility that has records for this condition?
	6205	Has there been any recurrence or current treatment?
	6318	DO NOT ASK: Did the applicant answer Yes to any other condition?
	3508	What is the specific medical condition?
	6159	Date of occurrence?

Exhibit

	6144	Did you receive any medication or treatment?
	6900	What was the name and dosage of the medication or type of treatment?
	182490	What is the name and address of the doctor or medical facility that has records for this condition?
	3345	Has there been any recurrence or current treatment?
3 D.	14913	Abdominal pain, ulcer, colitis, cirrhosis, hepatitis, recurrent diarrhea, intestinal bleeding, or any other disease of the liver, gallbladder, pancreas, stomach, or intestines?
	10481	DO NOT ASK: Did applicant say yes to Disorder of Stomach or Intestines?
	3511	What is the specific medical condition?
	6466	When was the condition diagnosed?
	10482	How many attacks or flare ups per year do you have?
	10483	What was the date of your last attack or flare up?
	10484	Were any special tests performed such as a CAT scan, Upper or Lower G.I. Series, Upper or Lower Endoscopy, or Colonoscopy?
	39351	DO NOT ASK: Did the applicant say yes to a colonoscopy/lower GI?
	39352	When and What was the result of the colonoscopy/lower GI?
	39353	What symptoms or circumstances prompted the colonoscopy/lower GI?
	39354	Were any polyps removed during the colonoscopy?
	39355	How many?
	39356	What type of polyp was removed?
	39357	What was the recommended follow-up time for the next colonoscopy?
	39358	Do you have a family history of colon polyps?
	39359	Who has a history of colon polyps?
	40103	Have you had, or are you planning to have a follow-up colonoscopy?
	40104	What were the results?
	40105	When is the next one scheduled?
	39360	What medications, if any, were prescribed due to the results of the colonoscopy/lower GI or due to the symptoms prompting the colonoscopy/lower GI?
	39361	What is the name and address of the facility where the colonoscopy/lower GI was performed?
	39362	What is the name and address of the doctor or facility who has the colonoscopy/lower GI results, the follow-up test results, and the medication information?
	39363	DO NOT ASK: Did the applicant say yes to an endoscopy/upper GI?
	39364	When and What was the result of the endoscopy/upper GI?
	39365	What symptoms or circumstances prompted the endoscopy/upper GI?
	39366	Was a biopsy taken during the endoscopy/upper GI?
	39367	Was Barrett's esophagus and/or dysplasia discovered on the biopsy finding?
	39368	Have you had, or are you planning to have a follow-up endoscopy?
	17124	What were the results?
	39369	When is the next one scheduled?
	45173	DO NOT ASK: Did the applicant say yes to other tests performed?
	181610	What tests were performed and what were the dates and results of these test(s)?
	39370	What medications, if any, were prescribed due to the results of the endoscopy or due to the symptoms prompting the endoscopy?
	39371	Have the symptoms resolved?
	14335	How often do they occur?
	39372	What is the name and address of the facility where the endoscopy/upper GI was performed?
	39373	What is the name and address of the doctor or facility who has the endoscopy/upper GI results, the follow-up test results, and the medication information?
	39374	Other than already noted, have you had any episodes of bleeding?
	10488	What are the dates of the episodes?
	10489	Have you ever been hospitalized or received treatment at the emergency room for this condition?
	10490	When were you hospitalized for this?
	39375	Other than already noted, have you had surgery or a procedure for this condition?
	10492	When was the surgery performed?
	10493	Did the surgery correct the problem?
	39376	Did you receive any medication or treatment not already noted?
	6850	What was the name and dosage of the medication or type of treatment?
	39377	DO NOT ASK: Has applicant said yes to taking oral steroids?
	14914	Have you ever used oral steroids? (prednisone)
	14915	How often and for what duration?
	10494	Have your job duties or leisure activities been modified in any way because of this condition?

Exhibit

	6035	Please give details.
	39378	DO NOT ASK: Has applicant already given doctor information?
	182750	What is the name and address of the doctor or medical facility who has the records for this condition?
	10443	DO NOT ASK: Did applicant say yes to Hepatitis?
	10444	When were you diagnosed as having Hepatitis?
	10445	What type of Hepatitis were you diagnosed with?
	14916	Interviewer: Did they say yes to Hepatitis B?
	14917	Have you been told you have chronic hepatitis?
	14918	Have you been told you're a Hepatitis B carrier?
	14919	Interviewer: Did they say yes to Hepatitis C?
	14920	Have you ever had viral load testing?
	14345	What were the dates and results of these tests?
	10446	Have you ever had a liver biopsy?
	10447	When was the biopsy performed?
	10448	What were the results of the biopsy?
	10449	Have you been given any treatment for this condition?
	14921	What type of treatment were you given?
	10451	Is any further treatment or testing being planned or considered?
	5996	Please give details.
	10452	Has this affected your ability to perform fulltime employment or any other normal activities?
	14559	DO NOT ASK: Did the applicant answer Yes to any other condition?
	14302	What is the specific medical condition?
	14303	Date of occurrence?
	14304	Did you receive any medication or treatment?
	14305	What was the name and dosage of the medication or type of treatment?
	183120	What is the name and address of the medical facility or physician who has the medical records for this condition?
	14307	Has there been any recurrence or current treatment?
3 E.	14922	Kidney stone, protein, sugar, blood or blood cells in the urine, or any disorder of the urinary tract, bladder or kidneys?
	38665	DO NOT ASK: Did applicant say Kidney Stones?
	39379	How many stones have you had?
	14688	Date of occurrence?
	12743	Did you receive any medication or treatment?
	12744	What was the name and dosage of the medication or type of treatment?
	182751	What is the name and address of the doctor or medical facility who has the records for this condition?
	14472	When did you last consult the doctor?
	10495	DO NOT ASK: Did applicant say yes to Disorder of Kidneys?
	6158	What was the specific condition?
	10496	When did the condition first appear?
	10497	How was the condition treated?
	10498	When was the medication or operation performed?
	6233	Did you receive any treatment, hospitalization or medication?
	6481	What was the name and dosage of the medication or type of treatment?
	14923	Have you had an IVP (intravenous pyelogram), cystoscopy or other investigations?
	14214	Please provide date(s) and details:
	183390	What is the name and address of the doctor or medical facility who has the records for this condition?
	10499	When did you last consult the doctor?
	6860	DO NOT ASK: Did the applicant answer Yes to any other condition?
	6186	What was the specific condition?
	6187	Date of occurrence?
	6188	Did you receive any medication or treatment?
	6189	What was the name and dosage of the medication or type of treatment?
	14924	Have you had an IVP (intravenous pyelogram), cystoscopy or other investigations?
	14216	Please provide date(s) and details:
	183550	What is the name and address of the doctor or medical facility who has the records for this condition?

Exhibit

	6198	Has there been any recurrence or current treatment?
3 F.	14925	Disorder or abnormality of the prostate, uterus, ovaries, or breasts, pregnancy complication, testicular disease, genital herpes, syphilis, gonorrhea, or other sexually transmitted disease?
	14926	DO NOT ASK: Did applicant answer yes to cervical cancer or abnormal PAP?
	14927	What was the date and result of the abnormal PAP?
	14928	Any abnormal PAP's prior to this?
	11915	How many times, and what were the dates?
	14929	Have follow-up pap smears (if done) been normal?
	39380	How many times and what were the dates?
	14930	Have you had any special procedures such as LEEP procedure or colposcopy?
	12229	What type of test(s), date(s), and what were the results?
	14931	How often do you have PAP tests done and when is the next one recommended?
	183780	What is the name and address of the doctor or medical facility or physician who has the medical records for this condition?
	14932	DO NOT ASK? Did applicant answer yes to breast cancer?
	14933	When was the Cancer/tumor diagnosed?
	14934	What is the size, grade, and stage of the tumor/cancer?
	14935	Had the tumor spread to the lymph nodes or any other area?
	14242	What type of treatment did you receive?
	14936	Did you undergo radiation therapy or chemotherapy?
	14937	Did you have a mastectomy or lumpectomy?
	14635	What is the date of the last treatment?
	14938	Have you had routine follow-up mammograms?
	14939	Date of last mammogram?
	14638	Is any further treatment required?
	14940	Do you use tamoxifen currently?
	11017	Has there been any recurrence or current treatment?
	183970	What is the name and address of the doctor or medical facility who has the records for this condition?
	14941	DO NOT ASK? Did applicant answer yes to prostate cancer?
	14942	When was the cancer/tumor diagnosed?
	14943	What is the size, grade, and stage of the tumor/cancer?
	14944	Do you know what the Gleason score was?
	14945	Had the tumor spread to the lymph nodes or any other area?
	3710	What type of treatment did you receive?
	14653	What is the date of the last treatment?
	14946	What are the dates and results of your most recent PSA testing?
	14656	Is any further treatment required?
	11037	Has there been any recurrence or current treatment?
	184130	What is the name and address of the doctor or medical facility or physician who has the medical records for this condition?
	14947	DO NOT ASK: Did the applicant say Yes to any other condition?
	14351	What is the specific medical condition?
	14352	Date of occurrence?
	14353	Did you receive any medication or treatment?
	14354	What was the name and dosage of the medication or type of treatment?
	14948	Have you had any tests done for this condition?
	12241	What type of test(s), date(s), and what were the results?
	184310	What is the name and address of the doctor or medical facility who has the records for this condition?
	14356	Has there been any recurrence or current treatment?
3. G.	14949	Diabetes, thyroid disorder, lymph node enlargement, skin disorder, or disorder of any other glands?
	10429	DO NOT ASK: Did the applicant say yes to Diabetes?
	10430	At what age was the diabetes first discovered?
	14950	What type of diabetes was diagnosed?
	10431	How is it being controlled?
	14951	Have there been any changes in treatment?
	14952	What was the change?

Exhibit

	3228	Have you ever been hospitalized for this condition?
	3223	What was the reason for hospitalization?
	10432	When were you hospitalized?
	180920	What is the name and addresses of the hospital(s) where you were seen?
	3157	How often do you check your blood sugar?
	39381	What was your last A1C reading and when was it last measured?
	39382	Any episodes of hypoglycemia?
	39383	How many and what were the dates?
	39384	Did you ever lose consciousness?
	10433	Have you had any problems with your eyes, skin, kidneys, heart, circulation, blood pressure, or numbness and tingling in your limbs or feet?
	6150	What was the specific condition?
	10434	Where was the problem located?
	3530	When did the symptoms begin?
	184530	What is the name and address of the doctor or medical facility who has the records for this condition?
	10435	When did you last consult the doctor?
	13261	DO NOT ASK: Did the applicant say Yes to Thyroid?
	10512	Was your condition diagnosed as Hypothyroidism or Hyperthyroidism?
	3563	When were you diagnosed?
	10513	How was the condition treated initially?
	10514	How are you currently being treated and with what?
	184710	What is the name and address of the doctor or medical facility or physician who has the records for this condition?
	14416	DO NOT ASK: Did the applicant answer Yes to any other condition?
	14417	What is the specific medical condition?
	14953	Inspector: Is this a skin disorder?
	39385	Any history of suspicious moles?
	14954	Is there any history of familial dysplastic nevus syndrome?
	14418	Date of occurrence?
	14419	Did you receive any medication or treatment?
	14420	What was the name and dosage of the medication or type of treatment?
	184910	What is the name and address of the doctor or medical facility who has the records for this condition?
	14422	Has there been any recurrence or current treatment?
3 H.	14955	Cancer, tumor, or cyst?
	14956	DO NOT ASK: Did applicant answer yes to cervical cancer or abnormal PAP?
	14957	What was the date and result of the abnormal PAP?
	14958	Any abnormal PAP's prior to this?
	11951	How many times, and what were the dates?
	14959	Have follow-up pap smears (if done) been normal?
	39386	How many times and what were the dates?
	14960	Have you had any special procedures such as LEEP procedure or colposcopy?
	12252	What type of test(s), date(s), and what were the results?
	14961	How often do you have PAP tests done and when is the next one recommended?
	185080	What is the name and address of the doctor or medical facility who has the records for this condition?
	14962	DO NOT ASK? Did applicant answer yes to breast cancer?
	14963	When was the Cancer/tumor diagnosed?
	14964	What is the size, grade, and stage of the tumor/cancer?
	14965	Had the tumor spread to the lymph nodes or any other area?
	3711	What type of treatment did you receive?
	14966	Did you undergo radiation therapy or chemotherapy?
	14967	Did you have a mastectomy or lumpectomy?
	14679	What is the date of the last treatment?
	14968	Have you had routine follow-up mammograms?
	14969	Date of last mammogram?
	39387	Were you told it was normal?
	14970	Is any further treatment required?

Exhibit

	14971	Do you use tamoxifen currently?
	11057	Has there been any recurrence or current treatment?
	185230	What is the name and address of the medical facility or physician who has the medical records regarding this condition?
	14972	DO NOT ASK? Did applicant answer yes to prostate cancer?
	14973	When was the cancer/tumor diagnosed?
	14974	What is the size, grade, and stage of the tumor/cancer?
	14975	Do you know what the Gleason score was?
	14976	Had the tumor spread to the lymph nodes or any other area?
	3712	What type of treatment did you receive?
	14977	What is the date of the last treatment?
	14978	What are the dates and results of your most recent PSA testing?
	14979	Is any further treatment required?
	11077	Has there been any recurrence or current treatment?
	185450	What is the name and address of the medical facility or physician who has the medical records regarding this condition?
	14980	DO NOT ASK: Did applicant answer yes to skin cancer?
	14981	What was the specific condition?
	14982	Where is the location of the tumor/cyst?
	14983	Is there any history of familial dysplastic nevus syndrome?
	14984	When was the tumor/cyst diagnosed?
	14625	Was a biopsy performed?
	14985	Was the tumor/cyst benign or malignant?
	14986	What is the size, grade, and stage of the tumor/cyst?
	14634	Had the tumor spread to the lymph nodes or any other area?
	3713	What type of treatment did you receive?
	14987	What is the date of the last treatment?
	14988	Is any further treatment required?
	14989	Has the tumor/cyst returned?
	185650	What is the name and address of the doctor or medical facility who has the records for this condition?
	12674	DO NOT ASK: Did the applicant answer Yes to any other condition?
	6139	What was the specific condition?
	14990	Where is the location of the tumor/cyst?
	14991	When was the tumor/cyst diagnosed?
	10426	Was a biopsy performed?
	14992	Was the tumor/cyst benign or malignant?
	6226	What is the size, grade, and stage of the tumor?
	10427	Had the tumor spread to the lymph nodes or any other area?
	4245	What type of treatment did you receive?
	3715	What is the date of the last treatment?
	3718	Is any further treatment required?
	14993	Has the tumor/cyst returned?
	185750	What is the name and address of the doctor or medical facility who has the records for this condition?
3 .i.	14994	Anemia, leukemia, or other blood disorder?
	14995	DO NOT ASK: Did the applicant say yes to Leukemia?
	14758	When was this diagnosed?
	14996	What type of leukemia, if known were you diagnosed with?
	14997	What type of treatment or medication are you currently taking?
	14998	When did you last have a blood count done?
	12710	Have you ever been hospitalized for this condition?
	12712	When were you hospitalized?
	12720	Have you ever had a blood transfusion?
	14999	How often do you require blood transfusions?
	14457	What are the dates of all transfusions?
	185870	What is the name and address of the medical facility or physician who has the medical records for this condition?
	15515	What is the date of the last treatment?

Exhibit

	10436	DO NOT ASK: Did the applicant say yes to Anemia?
	3517	What type of anemia do you have?
	10437	What type of treatment or medication are you currently taking?
	15516	Have you had any tests done for this condition?
	12262	What type of test(s), date(s), and what were the results?
	3595	When did you last have a blood count done?
	10438	Have you ever been hospitalized for this condition?
	10439	Why were you hospitalized?
	10440	When were you hospitalized?
	3170	Have you ever had a blood transfusion?
	10441	How often do you require blood transfusions?
	10442	What are the dates of your transfusions?
	185960	What is the name and address of the doctor or medical facility who has the records for this condition?
	3736	What is the date of the last treatment?
	6315	DO NOT ASK: Did the applicant answer Yes to any other condition?
	3506	What is the specific medical condition?
	6151	Date of occurrence?
	6152	Did you receive any medication or treatment?
	6153	What was the name and dosage of the medication or type of treatment?
	186170	What is the name and address of the doctor or medical facility who has the records for this condition?
	6154	Has there been any recurrence or current treatment?
3.J.	15517	Back or neck pain, spinal strain or sprain, sciatica, arthritis, gout, carpal tunnel syndrome, or any bone, joint, or muscle disorder?
	3330	DO NOT ASK: Did the applicant say yes to arthritis?
	3509	What type of arthritis do you have?
	3591	What type of medication or treatment was originally prescribed?
	15518	Have you ever used oral steroids? (prednisone)
	15519	How often and for what duration?
	39388	Have you ever used methotrexate?
	39389	How often and for what duration?
	39390	Have you ever used plaquenil?
	39391	How often and for what duration?
	10516	What part of your body does the arthritis affect?
	10517	Has the arthritis caused any disability?
	10518	Do you use any medical appliances such as a wheelchair, walker, cane or are you confined to a hospital bed?
	6473	Please give details.
	10519	Have you been forced to miss work because of this condition?
	10520	How many days of work have you missed in the past year due to this condition?
	179350	What is the name and address of the doctor being seen for this condition?
	10521	When did you last consult the doctor?
	10522	DO NOT ASK: Did applicant say yes to Neck or Back Pain?
	39392	Do you currently have pain?
	39393	What is the level of pain on a scale of 1-10?
	10523	Is this the result of an injury or a disease process?
	6167	What was the name and dosage of the medication or type of treatment?
	10524	Have any surgical procedures been done or being planned for this condition?
	10525	What type of procedure was done or is planned?
	10526	When was the surgery or when is it scheduled for?
	10527	Have you been disabled or had to restrict your job duties in any way because of this condition?
	6474	Please give details.
	179440	What is the name and address of the doctor being seen for this condition?
	3462	When did you last consult the doctor?
	14514	DO NOT ASK: Did the applicant answer Yes to any other condition?
	14490	What is the specific medical condition?
	14491	Date of occurrence?

Exhibit

	14492	Did you receive any medication or treatment?
	14493	What was the name and dosage of the medication or type of treatment?
	186300	What is the name and address of the doctor or medical facility who has the records for this condition?
	14495	Has there been any recurrence or current treatment?
3. K.	15520	Disorder of the eyes, ears, nose, or throat?
	14515	What is the specific medical condition?
	14516	Date of occurrence?
	14517	Did you receive any medication or treatment?
	14518	What was the name and dosage of the medication or type of treatment?
	186500	What is the name and address of the doctor or medical facility who has the records for this condition?
	14520	Has there been any recurrence or current treatment?
3.L.	15521	Any physical deformity or defect?
	14560	What is the specific medical condition?
	14561	Date of occurrence?
	14562	Did you receive any medication or treatment?
	14563	What was the name and dosage of the medication or type of treatment?
	186650	What is the name and address of the doctor or medical facility who has the records for this condition?
	14565	Has there been any recurrence or current treatment?
3. M.	15522	Any immune system diseases or disorders except those related to the Human Immunodeficiency Syndrome (HIV virus)?
	14502	What was the specific condition?
	14614	Date of occurrence?
	14615	Did you receive any medication or treatment?
	14616	What was the name and dosage of the medication or type of treatment?
	186760	What is the name and address of the doctor or medical facility who has the records for this condition?
	14618	Has there been any recurrence or current treatment?
3. N.	15524	Any chronic or recurrent fever, fatigue or viral illness?
	14660	What is the specific medical condition?
	14661	Date of occurrence?
	14662	Did you receive any medication or treatment?
	14663	What was the name and dosage of the medication or type of treatment?
	187000	What is the name and address of the doctor or medical facility who has the records for this condition?
	14665	Has there been any recurrence or current treatment?
4	15523	Have you ever been diagnosed by a member of the medical profession or tested positive for the Human Immunodeficiency Syndrome (HIV virus) or Acquired Immune Deficiency Syndrome (AIDS)?
	3797	What is the date of diagnosis or positive HIV test?
	186870	What is the name and address of the doctor or medical facility who has the records for this condition?
5	15525	Do you consume alcoholic beverages?
	14219	What type of alcohol is consumed?
	14221	How often do you drink?
	4108	How much alcohol is consumed per week?
6	15527	Have you ever been advised to limit the use of alcohol or drugs, sought or received treatment, advice, or counseling for alcohol or drugs, or joined a group because of alcohol or drug use?
	15528	DO NOT ASK: Did applicant say yes to any of the above questions regarding alcohol?
	10500	When did you receive treatment for alcohol abuse?
	10501	What type of treatment did you receive?
	4250	Do you currently receive treatment or counseling?
	4155	Are you currently in AA?
	10502	Did you ever have a relapse after receiving treatment?
	10503	When was your relapse?
	4219	When did you last drink alcohol?
	4126	How much alcohol was consumed?
	4125	What type of alcohol did you use?
	187995	What is the name and address of the doctor or medical facility who has the records for this condition?
7	15526	Have you ever tried or used cocaine, heroin, marijuana, barbituates or other controlled substances except as prescribed by a physician?

Exhibit

	4131	What type of drug was used?
	4132	How much of the drug was used?
	4133	When was the drug last used?
	4134	What is the length of drug use?
	15529	DO NOT ASK: Did applicant say yes to any of the above questions regarding drugs?
	10504	When did you receive treatment for drug abuse?
	10505	What type of treatment did you receive?
	4171	What was the type of unprescribed drug used?
	4173	When was the last time you used the unprescribed drug?
	10506	Are you currently a member of Narcotics Anonymous?
	10507	Did you ever have a relapse after receiving treatment?
	10508	When was your relapse?
	187860	What is the name and address of the doctor or medical facility who has the records for this condition?
8.A.	15530	Other than previously mentioned, have you in the past five years: Consulted or been advised to consult a physician, psychiatrist, psychologist, therapist, counselor, chiropractor, or other health care practitioner (include regular checkups)
	6201	What was the specific condition?
	6210	Date of occurrence?
	39394	Duration of the illness or occurrence?
	6211	Did you receive any medication or treatment?
	6172	What was the name and dosage of the medication or type of treatment?
	33103	Are you currently taking this medication?
	185575	When did you last take the medication?
	187120	What is the name and address of the doctor or medical facility who has the records for this condition?
	39395	When did you last see this doctor or medical facility?
	39396	How often did you see this doctor or medical facility?
	6212	Has there been any recurrence or current treatment?
8. B.	15531	Had a checkup, illness, or surgery, or been treated or evaluated at a hospital or any other health care facility?
	39397	What was the reason for the treatment or evaluation?
	39398	When was the treatment given or evaluation performed?
	39798	When and What was the result?
	39399	How many times were you seen for this treatment?
	39400	What medications were prescribed as a result of this treatment, evaluation or check-up?
	188500	What is the name and addresses of the hospital(s) where you were seen?
8. C.	15532	Had an EKG, x-ray, stress test, echocardiogram, angiography, blood studies or any other diagnostic test?
	39401	DO NOT ASK: Did applicant say yes to EKG?
	39402	What symptoms or circumstances prompted the EKG?
	39403	When and What was the result of the EKG?
	39404	What other testing was performed or advised because of the EKG result?
	39405	What medications, if any, were prescribed because of the EKG result?
	39406	What is the name and address of the doctor or medical facility who has the results of the EKG, the follow-up test results, and the medication information?
	39407	DO NOT ASK: Did applicant say yes to x-ray?
	39408	What symptoms or circumstances prompted the x-ray?
	39409	When and What were the results of the x-ray?
	39410	What other testing was performed or advised because of the x-ray result?
	39411	What medications, if any, were prescribed because of the x-ray result?
	39412	What is the name and address of the facility where the x-ray was performed?
	39413	What is the name and address of the doctor or facility who has the results of the x-ray, the follow-up test results, and the medication information?
	39414	DO NOT ASK: Did applicant say yes to stress test?
	39415	What symptoms or circumstances prompted the stress test?
	39416	When and What were the results of the stress test?
	39417	What other testing or procedures were performed or advised because of the stress test result?

Exhibit

39418	What medications, if any, were prescribed because of the stress test result?
39419	What physical restrictions, if any, were placed upon you due to the stress test results?
39420	What is the name and address of the facility where the stress test was performed?
39421	What is the name and address of the doctor or facility who has the stress test results, the follow-up test results, and the medication information?
39422	DO NOT ASK: Did applicant say yes to echocardiogram?
39423	What symptoms or circumstances prompted the echocardiogram?
39424	When and What were the results of the echocardiogram?
39425	What heart valve abnormalities, if any, were discovered on the echocardiogram?
39426	Were any heart chamber or wall thickness abnormalities discovered?
39427	What other testing or procedures were performed because of the echocardiogram result?
39428	Were follow-up echocardiograms recommended?
39429	When are they planned?
39430	Do you need to take antibiotic medication before dental procedures?
39431	What physical restrictions, if any, were placed upon you due to the echocardiogram results?
39432	What is the name and address of the facility where the echocardiogram was performed?
39433	What is the name and address of the doctor or facility who has the echocardiogram results, the follow-up test results, and the medication information?
39434	DO NOT ASK: Did applicant say yes to angiography?
39435	What symptoms or circumstances prompted the angiography?
39436	When and What were the results of the angiography?
39437	Was an angioplasty, a stent, or bypass done due to findings of the angiography?
39438	How many vessels were involved?
39439	What medications, if any, were prescribed in conjunction with the angiography?
39440	What physical restrictions, if any, were placed upon you due to the results of the angiography?
39441	What is the name and address of the facility where the angiography was performed?
39442	What is the name and address of the doctor or facility who has the angiography results, the follow-up test results, and the medication information?
39443	DO NOT ASK: Did applicant say yes to blood studies?
39444	What blood studies were performed?
39445	What symptoms or circumstances prompted the blood studies?
39446	When and What were the results of the blood studies?
39447	Were you referred to any other physicians and/or facilities due to the blood study results?
39448	What is the name and address of these physicians and/or facilities?
39449	What medications were prescribed due to the blood study results?
39450	What physical restrictions, if any, were placed upon you due to the results of the blood studies?
39451	What is the name and address of the facility where the blood studies were performed?
39452	What is the name and address of the doctor or facility who has the blood study results, the follow-up test results, and the medication information?
39461	DO NOT ASK: Was the test a colonoscopy/lower GI?
39462	WHEN and What was the result of the colonoscopy/lower GI?
39463	What symptoms or circumstances prompted the colonoscopy/lower GI?
39464	Were any polyps removed during the colonoscopy?
39465	How many?
39466	What type of polyp was removed?
39467	What was the recommended follow-up time for the next colonoscopy?
39468	Do you have a family history of colon polyps?
39469	Who has a history of colon polyps?
40172	Have you had, or are you planning to have a follow-up colonoscopy?
40173	What were the results?
40174	When is the next one scheduled?
39470	What medications, if any, were prescribed due to the results of the colonoscopy/lower GI or due to the symptoms prompt in the colonoscopy/lower GI?
39471	What is the name and address of the facility where the colonoscopy/lower GI was performed?

Exhibit

	39472	What is the name and address of the doctor or facility who has the colonoscopy/lower GI results, the follow-up test? results, and the medication information?
	39473	DO NOT ASK: Was the test an endoscopy/upper GI?
	39474	When and What was the result of the endoscopy/upper GI?
	39475	What symptoms or circumstances prompted the endoscopy/upper GI?
	39476	Was a biopsy taken during the endoscopy/upper GI?
	39477	Was Barrett's esophagus and/or dysplasia discovered on the biopsy finding?
	39478	Have you had, been advised to have, or are you planning to have a follow-up endoscopy?
	17130	What were the results?
	39479	When is the next one scheduled?
	39480	What medications, if any, were prescribed due to the results of the endoscopy or due to the symptoms prompting the endoscopy?
	39481	Have the symptoms resolved?
	16954	How often do they occur?
	39483	What is the name and address of the facility where the endoscopy/upper GI was performed?
	39484	What is the name and address of the doctor or facility who has the endoscopy/upper GI results, the follow-up test results, and the medication information?
	39485	DO NOT ASK: Was the test an MRI or CT scan?
	39486	When and What was the result of the MRI/CT scan?
	39487	What symptoms or circumstances prompted the MRI/CT scan?
	39488	Were additional testing or procedures performed or advised due to the results of the MRI/CT Scan?
	39489	What additional testing or procedures were performed or advised?
	39490	What were the results of the additional testing or procedures?
	39491	What referrals, if any, were made to another physician due to the MRI/CT scan results?
	39492	What medications, if any, were prescribed due to the results of the MRI/CT scan or the symptoms which prompted the MRI/CT scan?
	39493	What is the name and address of the facility where the MRI/CT scan was performed?
	39494	What is the name and address of the doctor(s) or facility(ies) who has (have) the MRI/CT scan results, the follow-up test results, and the medication information?
	39495	DO NOT ASK: Was the test an ultrasound or mammogram?
	39496	When and What was the result of the ultrasound or mammogram?
	39497	What symptoms or circumstances prompted the ultrasound/mammogram?
	39498	Were additional testing or procedures performed or advised due to the results of the ultrasound/mammogram?
	39499	What additional testing or procedures were performed or advised?
	39500	What was the result of the additional testing or procedures?
	39501	What medications, if any, were prescribed because of the ultrasound/mammogram results?
	39502	What referrals, if any were made to another physician due to the ultrasound/mammogram results?
	39503	When is your next ultrasound/mammography scheduled?
	39504	What is the name and address of the facility where the ultrasound/mammogram was performed?
	39505	What is the name and address of the physician or facility who has the ultrasound/mammogram results, the follow-up test results, and the medication information?
	39506	DO NOT ASK: Did the applicant say yes to any other tests?
	15533	What test(s) were done?
	10529	Why were the test(s) performed?
	10995	What were the results of the test(s)?
	14389	When were the test(s) performed?
	189390	What is the name and address of the doctor or medical facility who has the records regarding this test/treatment?
8 D.	15534	Been advised to have any test, hospitalization, or surgery which was not completed?
	15535	What type of test/surgical operation were you recommended to have?
	15536	What was the reason for the test/surgery?
	15537	What is the name and address of the doctor who recommended the test/surgery?
	10536	Have you fully recovered?
	15538	Why did you elect not to have the test/surgery?
	16723	What was the reason for the hospitalization?
	15537	What is the name and address of the doctor who recommended the hospitalization?
	10536	Have you fully recovered?

Exhibit

	15538	Why did you elect not to have the hospitalization?
8.E.	14531	Had a CT Scan, MRI, EEG or any other diagnostic test for fainting spells, convulsions, seizures, headaches, or dizziness?
	39485	DO NOT ASK: Was the test an MRI or CT scan?
	39486	When and What was the result of the MRI/CT scan?
	39487	What symptoms or circumstances prompted the MRI/CT scan?
	39488	Were additional testing or procedures performed or advised due to the results of the MRI/CT Scan?
	39489	What additional testing or procedures were performed or advised?
	39490	What were the results of the additional testing or procedures?
	39491	What referrals, if any, were made to another physician due to the MRI/CT scan results?
	39492	What medications, if any, were prescribed due to the results of the MRI/CT scan or the symptoms which prompted the MRI/CT scan?
	39493	What is the name and address of the facility where the MRI/CT scan was performed?
	39494	What is the name and address of the doctor(s) or facility(ies) who has (have) the MRI/CT scan results, the follow-up test results, and the medication information?
	38398	DO NOT ASK: Did the applicant say yes to an EEG test being completed?
	39185	What was the result of the EEG?
	39186	What symptoms or circumstances prompted the EEG?
	39187	Were any additional testing or procedures performed due to the results of the EEG?
	39188	What additional testing or procedures were performed?
	39189	What were the results of the additional testing or procedures?
	39190	What referrals, if any, were made to another physician due to the EEG results?
	39191	What medications, if any, were prescribed due to the results of the EEG or the symptoms which prompted the EEG?
	39193	What is the name and address of the doctor(s) or facility(ies) who has (have) the EEG results, the follow-up test results, and the medication information?
	12676	Date of occurrence?
	12731	Did you receive any medication or treatment?
	12732	What was the name and dosage of the medication or type of treatment?
	12626	Has there been any recurrence or current treatment?
	39453	DO NOT ASK: Was the test a heart CT scan?
	39454	What was the calcium index score on the heart CT scan?
	39455	When and What symptoms or circumstances prompted the heart CT scan?
	39456	What additional testing, if any, was performed or advised due to the heart CT scan?
	39457	What medications, if any, were prescribed due to the heart CT scan results?
	39458	What physical restrictions, if any, were placed upon you due to the heart CT scan results?
	39459	What is the name and address of the facility where the heart CT scan was performed?
	39460	What is the name and address of the doctor or facility who has the heart CT scan results, the follow-up test results, and the medication information?
	14860	DO NOT ASK: Did the applicant answer Yes to Convulsions or Seizures?
	3123	What type of seizures?
	10468	When did the seizures first occur?
	10469	Has a cause for the seizure been determined?
	10470	When was your last seizure?
	3120	How often do you have seizures?
	10471	What is the name and dosage of the medication you are taking?
	10472	Have your job duties, leisure activities or your ability to drive been modified or changed in any way because of this condition?
	179480	What is the name and address of the doctor being seen for this condition?
	14860	DO NOT ASK: Did the applicant answer Yes to Headaches?
	14861	What type of headaches do you have?
	14862	What symptoms did you experience?
	14680	Have you missed work as a result of this illness?
	14863	Have any tests such as CT, MRI scan or other diagnostic tests been performed?
	14868	DO NOT ASK: Did the applicant answer Yes to Fainting and/or Dizziness?
	12699	What was the specific condition?
	12207	Have you had any tests done for this condition?
	39194	What type of tests have you had?

Exhibit

	10995	What were the results of the test(s)?
	14389	When were the test(s) performed?
	189390	What is the name and address of the doctor or medical facility who has the records regarding this test/treatment?
9		Family History
	6108	Is your father still living?
	6147	How old is your father?
	30563	What is the status of your father's health?
	6110	How old was your father when he died?
	30564	What was his cause of death?
	67655	Has/was he ever diagnosed with diabetes, cancer, melanoma, heart, and/or kidney disease?
	67656	Please provide details
	6112	Is your mother still living?
	6148	How old is your mother?
	30565	What is the status of your mother's health?
	6114	How old was your mother when she died?
	30566	What was her cause of death?
	67657	Has/was she ever diagnosed with diabetes, cancer, melanoma, heart, and/or kidney disease?
	67658	Please provide details
	6117	How many siblings do you have that are still living?
	3292	What are their ages?
	30567	What is the status of each one's health?
	6116	How many siblings do you have that are no longer living?
	6119	How old was each sibling when he/she died?
	30568	What was their cause of death?
	67659	Was any sibling ever diagnosed with diabetes, cancer, melanoma, heart, and/or kidney disease?
	67660	Please provide details
10	15539	Do you have a personal physician or belong to an H.M.O. or clinic?
	1576	What is the name, address and phone # of your personal physician, clinic or medical facility?
	3026	Date of last Consultation:
	15542	What was the reason, diagnosis or treatment?
	48734	INTERVIEWER: Was this interview conducted in English or Spanish?
	42931	INTERVIEWER: What language was this interview conducted in?
	53783	Was LANGUAGE LINE used?
	9000	Special Attention

Exhibit

QuestID	QuestText
15789	Do you fly as a pilot or plan to do so?
15790	Have you completed an aviation statement with your agent?
15791	Do you participate in any hazardous sports such as scuba diving, any flying sports or racing activities?
15792	Have you completed an avocation statement with your agent?
55579	Have you had any moving violations in the last 5 years?
4301	How many moving violations were there in that time frame?
4302	What type of moving violations were they?
4303	When did the moving violations occur?
55580	Has your drivers license ever been suspended or revoked?
4311	When was your license suspended or revoked?
4312	Why was your license suspended or revoked?
4313	How long was your license suspended or revoked?
55581	Have you ever had a DUI or DWI?
15647	How many DWIs have you had?
15648	When was the DWI?
15649	Have you had any court-ordered DWI driving classes or treatment?
55582	Have you had any traffic accidents in the last 3 years?
38403	How many accidents have you had?
38404	When did the accidents occur?
55583	Please give details including type of accidents and injuries sustained:
15795	Have you ever been arrested or convicted of a crime?
13277	What was the date(s)?
15390	What was the charge?
12104	What was the reason?
15796	Were you convicted?
4333	What crime were you convicted of committing?
15387	In which city and state were you convicted?
13659	Did the conviction include probation or parole?
13660	What are the dates of the probation/parole?
4334	Were you incarcerated?
4335	When did your incarceration begin?
4336	When did your incarceration end?
15797	Have you ever been refused insurance, charged an additional premium, or had a policy issued with exclusions or riders?
14141	What happened? (declined, postponed, restrictions, rated, etc.)
10981	What type of insurance did you apply for?
14142	What company was this with?

Exhibit

14143	What was the date?
14144	What was the reason?
1310	Are you a USA citizen?
15798	What is your country of origin?
1318	What type of visa do you hold?
1315	What is your visa number?
1328	How long have you resided in the U.S.?
15799	Do you plan to travel or reside outside of the U.S. in the next three years?
55845	What are your estimated travel dates?
14135	What cities/countries do you intend to visit?
14136	How long do you intend to visit each city/country?
14137	How often do you visit each city/country?
14139	What is the purpose for your travels?
15800	Have you declared personal or corporate bankruptcy in the last 5 years?
8081	When did you declare bankruptcy?
8083	What type of bankruptcy was declared?
12605	Has it been discharged?
12606	What date was it discharged on?
8055	What is your annual earned income?
7350	Do you have any unearned income?
7351	What is your total unearned income?
15801	What is your estimated net worth excluding your home?
15802	Is any life application now being submitted to another company?
11009	What company is it with?
13613	Policy Type:
11010	What is the amount of that policy?
10683	Are there any further policies?
11029	What company is it with?
13615	Policy Type:
11030	What is the amount of that policy?
10689	Are there any further policies?
11049	What company is it with?
13617	Policy Type:
11050	What is the amount of that policy?
10698	Are there any further policies?
12614	Please give details about other policies:
15803	Do you have any life insurance in force now?

Exhibit

6682	What company is the policy with?
11592	Amount?
11979	Will this policy be replaced?
15804	Was the agent informed?
6684	Do you have any other policies in force?
6502	What company is the policy with?
11595	Amount?
11980	Will this policy be replaced?
15805	Was the agent informed?
6051	Do you have any other policies in force?
6685	Give details for all additional policies:
9000	Special Attention

Exhibit

ParentQuest	bMainQuest	QuestID	QuestText
	TRUE	15789	Do you fly as a pilot or plan to do so?
15789	FALSE	15790	Have you completed an aviation statement with your agent?
	TRUE	15791	Do you participate in any hazardous sports such as scuba diving, any flying sports or racing activities?
	FALSE	15792	Have you completed an avocation statement with your agent?
15793	TRUE	55579	Have you had any moving violations in the last 5 years?
55579	FALSE	4301	How many moving violations were there in that time frame?
55579	FALSE	4302	What type of moving violations were they?
55579	FALSE	4303	When did the moving violations occur?
15793	TRUE	55580	Has your drivers license ever been suspended or revoked?
55580	FALSE	4311	When was your license suspended or revoked?
55580	FALSE	4312	Why was your license suspended or revoked?
55580	FALSE	4313	How long was your license suspended or revoked?
15793	TRUE	55581	Have you ever had a DUI or DWI?
55581	FALSE	15647	How many DWIs have you had?
55581	FALSE	15648	When was the DWI?
55581	FALSE	15649	Have you had any court-ordered DWI driving classes or treatment?
	TRUE	55582	Have you had any traffic accidents in the last 3 years?
55582	FALSE	38403	How many accidents have you had?
55582	FALSE	38404	When did the accidents occur?
55582	FALSE	55583	Please give details including type of accidents and injuries sustained:
	TRUE	15795	Have you ever been arrested or convicted of a crime?
15795	FALSE	13277	What was the date(s)?
15795	FALSE	15390	What was the charge?
15795	FALSE	12104	What was the reason?
15795	FALSE	15796	Were you convicted?
15796	FALSE	4333	What crime were you convicted of committing?
15796	FALSE	15387	In which city and state were you convicted?
15796	FALSE	13659	Did the conviction include probation or parole?
13659	FALSE	13660	What are the dates of the probation/parole?
15795	FALSE	4334	Were you incarcerated?
4334	FALSE	4335	When did your incarceration begin?
4334	FALSE	4336	When did your incarceration end?
	TRUE	15797	Have you ever been refused insurance, charged an additional premium, or had a policy issued with exclusions or riders?
15797	FALSE	14141	What happened? (declined, postponed, restrictions, rated, etc.)
15797	FALSE	10981	What type of insurance did you apply for?

Exhibit

15797	FALSE	14142	What company was this with?
15797	FALSE	14143	What was the date?
1310	FALSE	15798	What is your country of origin?
1310	FALSE	1318	What type of visa do you hold?
1310	FALSE	1315	What is your visa number?
1310	FALSE	1328	How long have you resided in the U.S.?
	TRUE	15799	Do you plan to travel or reside outside of the U.S. in the next three years?
15799	FALSE	55845	What are your estimated travel dates?
15799	FALSE	14135	What cities/countries do you intend to visit?
15799	FALSE	14136	How long do you intend to visit each city/country?
15799	FALSE	14137	How often do you visit each city/country?
15799	FALSE	14139	What is the purpose for your travels?
	TRUE	15800	Have you declared personal or corporate bankruptcy in the last 5 years?
15800	FALSE	8081	When did you declare bankruptcy?
15800	FALSE	8083	What type of bankruptcy was declared?
15800	FALSE	12605	Has it been discharged?
12605	FALSE	12606	What date was it discharged on?
	TRUE	8055	What is your annual earned income?
	TRUE	7350	Do you have any unearned income?
7350	FALSE	7351	What is your total unearned income?
	TRUE	15801	What is your estimated net worth excluding your home?
	TRUE	14799	Are you currently employed?
14799	FALSE	55566	Please describe your duties.
14799	FALSE	2016	DO NOT ASK: Are any of the duties hazardous?
14799	FALSE	2030	Type of business?
14799	FALSE	2032	Are you the owner/operator of the business?
2032	FALSE	2050	How many employees are there?
14799	FALSE	2018	Have you been employed with your current employer for less than 5 years?
2018	FALSE	2021	What was the name of your previous employer?
2018	FALSE	2022	How many years were you employed at your previous employer?
2018	FALSE	2025	What was your title with your previous employer?
14799	FALSE	2040	Are you currently employed by or active in any other businesses/enterprises?
2040	FALSE	2041	What is the name of your other employer?
2040	FALSE	55568	What is the address of this employer?
2040	FALSE	55569	What is your job title at this employer?
2040	FALSE	55570	What are your duties at this employer?
2040	FALSE	55571	How long have you been employed with this employer?

Exhibit

2040	FALSE	55572	How many hours do you work per week at this employer?
2040	FALSE	55573	What is your income from this employer?
	TRUE	15802	Is any life application now being submitted to another company?
15802	FALSE	11009	What company is it with?
15802	FALSE	13613	Policy Type:
15802	FALSE	11010	What is the amount of that policy?
15802	FALSE	10683	Are there any further policies?
10683	FALSE	11029	What company is it with?
10683	FALSE	13615	Policy Type:
10683	FALSE	11030	What is the amount of that policy?
15802	FALSE	10689	Are there any further policies?
10689	FALSE	11049	What company is it with?
10689	FALSE	13617	Policy Type:
10689	FALSE	11050	What is the amount of that policy?
15802	FALSE	10698	Are there any further policies?
10698	FALSE	12614	Please give details about other policies:
	TRUE	15803	Do you have any life insurance in force now?
15803	FALSE	6682	What company is the policy with?
15803	FALSE	11592	Amount?
15803	FALSE	11979	Will this policy be replaced?
15803	FALSE	15804	Was the agent informed?
15803	FALSE	6684	Do you have any other policies in force?
6684	FALSE	6502	What company is the policy with?
6684	FALSE	11595	Amount?
6684	FALSE	11980	Will this policy be replaced?
6684	FALSE	15805	Was the agent informed?
15803	FALSE	6051	Do you have any other policies in force?
6051	FALSE	6685	Give details for all additional policies:
	TRUE	9000	Special Attention

Exhibit

QuestID	QuestText
55584	The amount of life insurance you are applying for requires me to obtain some additional financial information regarding your income, assets and liabilities. We will start with your earned income.... (INTERVIEWER: Begin IncNet)
9000	Special Attention

Exhibit

QuestID	QuestText
45539	Do you authorize Minnesota Life to discuss information contained in this telephone interview with your Licensed Representative or his/her Minnesota Life firm?
55847	As part of the application process, we need to schedule an abbreviated paramedical exam. The exam will include a blood draw and urine collection.
55848	Remember to drink plenty of water prior to this collection. For the most accurate results, the blood draw should occur at least 8 hours after your last meal. The exam will also include...
55849	a blood pressure check along with height and weight measurements. The exam may also include an EKG. By scheduling the exam with us now, it will ensure that there are no added delays to your application process.
34531	Let's look to see what appointments are available in your area:
9555	Schedule Appointment
10383	Where would you like this exam to take place?
10384	Location:
10385	Zip Code:
9532	Thank you for your time. The information I collected from you today will go to our underwriting department for evaluation. Your MNL representative will contact you when a decision has been made regarding your qualification for this insurance coverage.
10396	Additional Instructions for the Paramed:
36878	INTERVIEWER: Are you sure you want to stop the recording process at this time?
9000	Special Attention

Exhibit

Minnesota Life Insurance Company

Client E-Signature Process

Minnesota Life will be using *iPipeline* as the vendor that will facilitate capturing our E-Signature. This vendor has set up secure electronic application processing for several other insurance companies. The process that will be followed is below:

1. The licensed advisor who made the sale of the life insurance product will send the client an email. Within this email is a secured link that the client will click. This link will bring them to a secured website.
2. Once in the secured website that client will need to verify the last four digits of their social security number in order to access the E-Signature process.
3. Once the last four digits of the SSN is confirmed, the client will still be in the secured website and will have access to E-Sign their application.
4. The first screen the client will see will ask them to "elect in" to the E-Signature process, at this time the client has the ability to select "no" and state they do not want to use E-Signature. If they select no, a confirmation screen will be presented to them giving them a button to confirm they do not want to proceed.
5. If the client elects to proceed and use the E-Signature process, they are then asked to read the "Terms and Conditions and Electronic Signature Consent" screen. They are also asked to review their application. They must click the "I agree" button to confirm they have read the screen and reviewed their application.
6. Once they have viewed the information on the application, they are given the opportunity to correct any information displayed by contacting the advisor.
7. If they have no changes, they then are asked to proceed to signing the application electronically.
8. Again, at this time the client is given the option to opt out of this electronic process.
9. If they select to proceed, the client is asked again to verify the last 4 digits of their Social Security Number and then they are allowed to E-Sign the application.
10. Once the E-Signature has taken place the client is then allowed to reopen the application and review the final application with their E-Signature. It is at this time that the client can choose to print and/or save a copy of their application.



iPipeline's E-Signature Specification for Minnesota Life



Confidentiality Statement

This document contains information that is confidential and proprietary, and is not for distribution.

Section 1 – Overview

Minnesota Life will be collecting electronic signatures on life insurance forms in their project via a process known as E-Signature. This process enables individual signors to review forms and attach electronic signatures via email, eliminating the need for “wet signatures” on applications and supplemental forms.

The processes to define signature parties, gather signatures from those parties, and ultimately submit a completed application package to Minnesota Life is defined in this document.

This document details each component of the E-Signature process, including:

- Collecting Party Signatures

Workflow Diagram

Figure 1 illustrates the high-level signature process surrounding the electronic signature process in Minnesota Life platform.

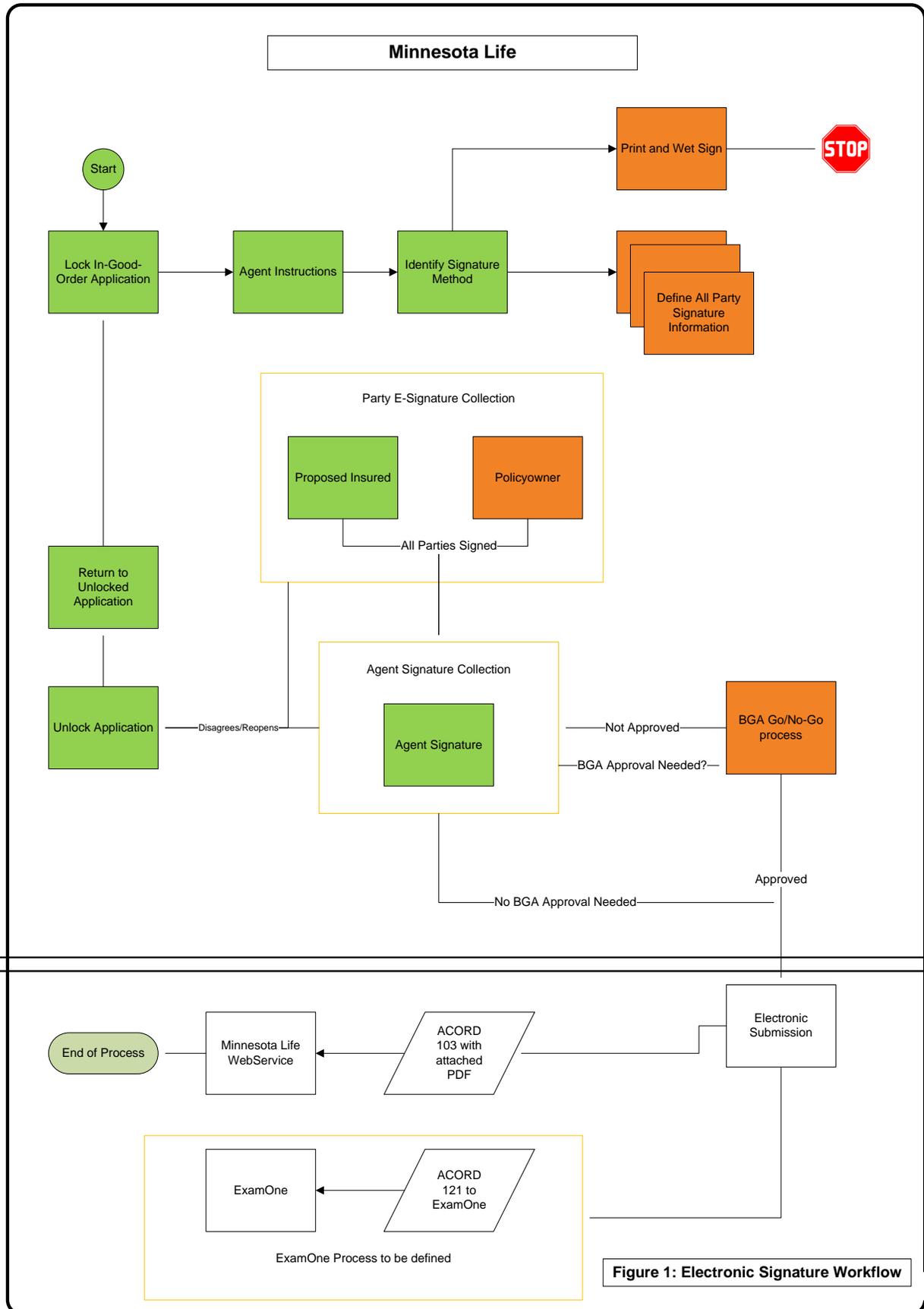


Figure 1: Electronic Signature Workflow

Parties to Sign

For the Minnesota Life products, there will be up to a maximum of four parties that will sign the application. They are as follows:

- Primary Insured
- Owner (if different than insured; may be individual, trustee, or power of attorney)
- Payor (if different than insured and owner)
- Producer

Some forms that have signature lines indicating an Owner signature is required, but not necessarily the Insured. In these cases, the Primary Insured signature will be mapped to these fields when the Owner and Insured are the same person.

Example Forms to Sign

There are several different form types that require signatures from one or more parties. Each of these forms will have a signature(s) mapped to it. These are as follows:

Form Type	Parties to Sign (Generic & State-specific)
Application for Life Insurance	Primary Insured Owner Producer
Authorizations, Acknowledgement and Limited Insurance Agreement	Primary Insured Producer
Aviation Questionnaire	Primary Insured
Avocation Questionnaire	Primary Insured
EFT Enrollment	Owner
ePay Authorization	Owner
Illustration Certification	Owner
HIV Consent	Primary Insured
Important Notice Regarding Replacement	Owner
Replacement Sales Material Checklist	Owner

Table 1: Forms to sign and signor details

The process starts for the client when he/she receives an email from the Producer:

Primary Insured Signature Email

Once the Producer clicks on the “**Send Message**” button, an email is generated to the primary insured that was identified containing three sections of information. First is the static text that is part of each signature email, second is the custom text that the producer entered (if applicable), and last is the specific URL that the Primary Insured clicks on to start the electronic signature process.

Figure 2 illustrates a sample of this email.

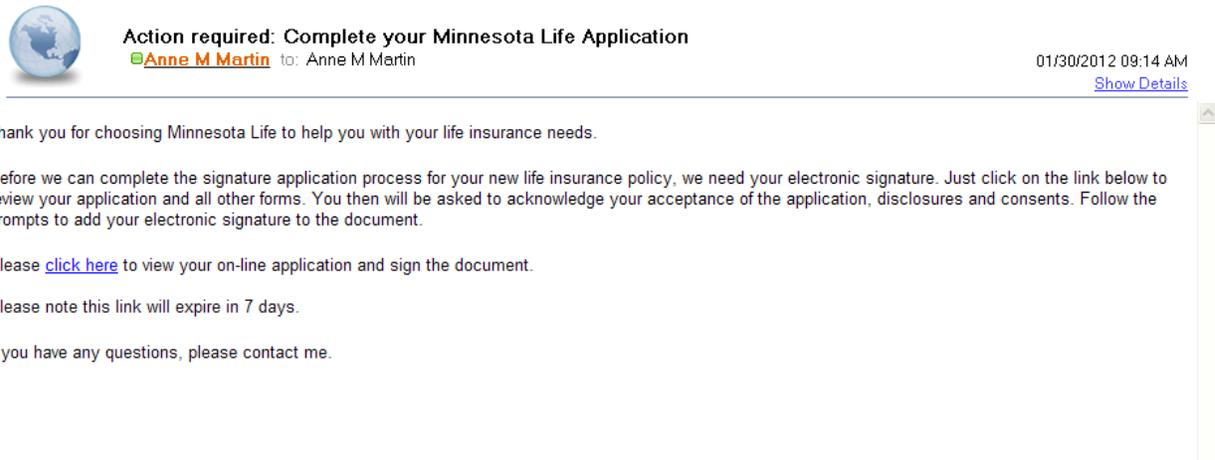


Figure 2: Email to Primary Insured

The URL contained in this email will last for seven calendar days until expiration. In addition, the URL will expire if any of the following events happen:

- Successful completion of the e-Signature process
- Any signer completely declines the e-Signature process
- Regeneration of a new email to the same party
- Completion of three unsuccessful login attempts

Primary Owner Signature Definition Screen

The Primary Owner Signature Definition screen is only displayed if the owner is different than the insured. It is virtually the same as the Primary Insured Signature Definition screen, with the exception of references to Owner instead of Insured.

Primary Owner Signature Email

Once the Producer clicks on the “Send Message” button, an email is generated to the Primary Owner. This email is virtually the same as that described in the “Primary Insured Signature Email” section earlier in this document.

Once each signature email has been sent, the signature collection process can begin for each party. This section details the screens that each party will access during the signature collection process for all parties other than the signing producer.

Workflow Diagram

Figure 3 illustrates the steps and actions taken when the Primary Insured and Primary Owner go through the electronic signature process. The process is virtually identical for both parties.

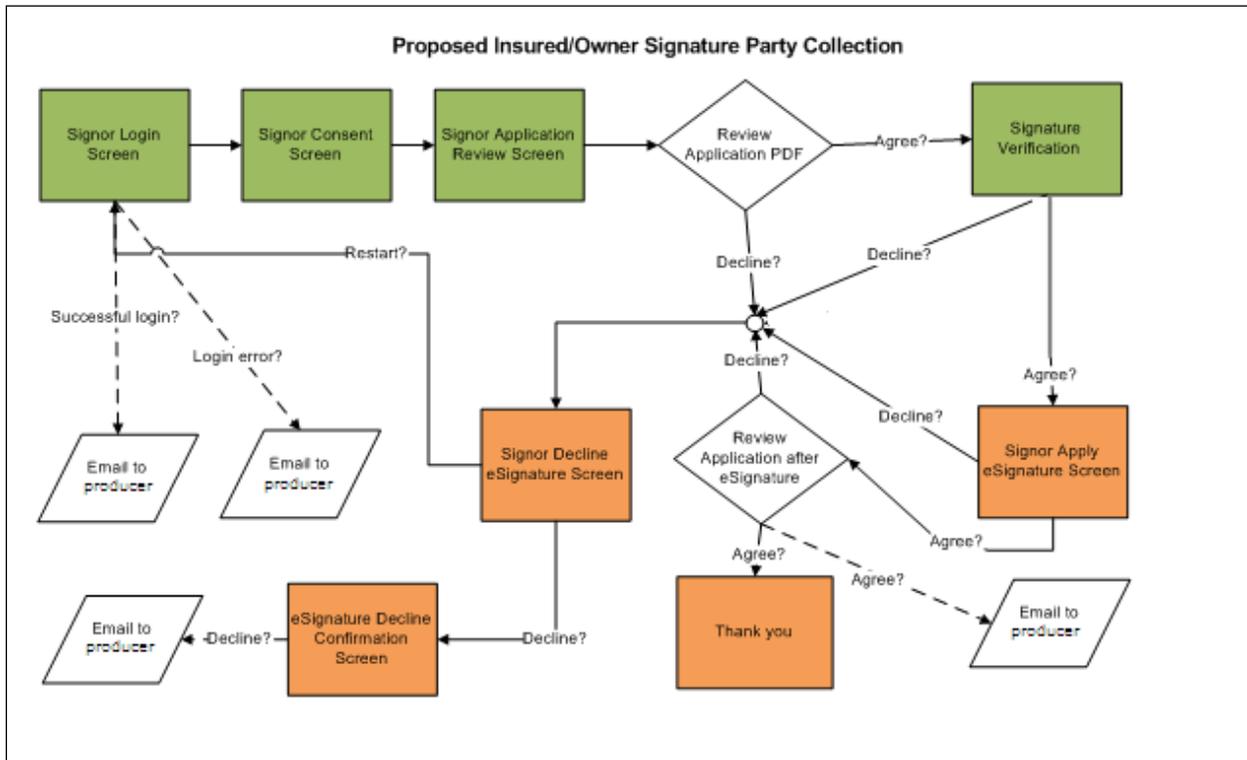
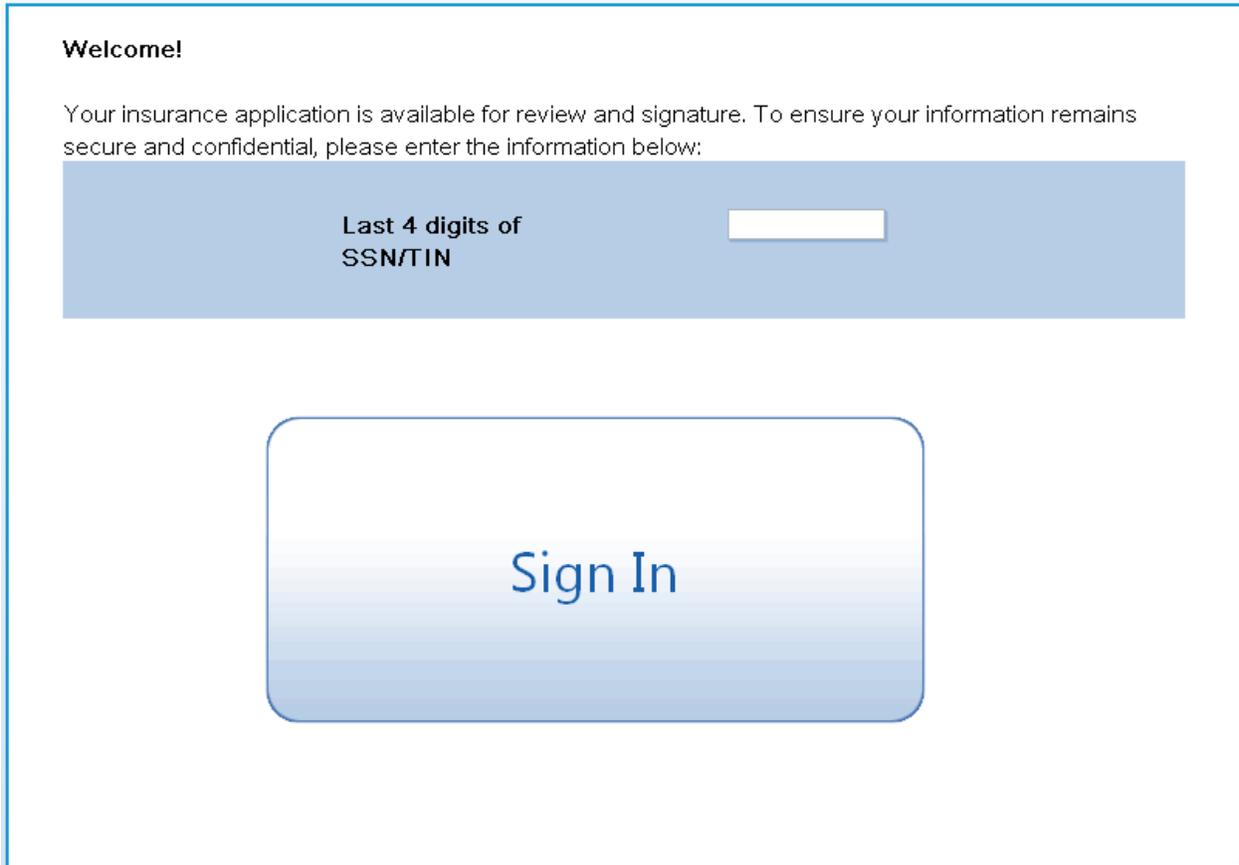


Figure 3: Insured and Owner Signature Collection Workflow

Primary Insured/Owner Login Screen

Upon clicking on the email that contains the link to start the e-Signature process, the Primary Insured or Owner is brought to a login screen. On this page, they are prompted to enter the PIN (last 4 digits of the SSN).



The login screen features a blue header with the text "Welcome!". Below this, a message states: "Your insurance application is available for review and signature. To ensure your information remains secure and confidential, please enter the information below:". A light blue input field is positioned below the message, containing the text "Last 4 digits of SSN/TIN" and a white rectangular input area. At the bottom of the screen, there is a large, rounded rectangular button with a blue gradient and the text "Sign In".

Figure 4: Insured and Owner Login

If the Primary Insured or Owner enters the wrong PIN, a message is displayed on the screen informing them. After three incorrect login attempts, the user will be locked out. The producer will receive an email notification that the customer has locked their application and that a new email will need to be regenerated by the producer.

Primary Insured/Owner Consent Screen and Application Review

Welcome

Welcome, eSignature Test,

To begin the signature process, please read the **Terms and Conditions and Electronic Signature Consent** and indicate below whether you agree to their terms. You should print and retain a copy of these documents for future reference.

Terms and Conditions and Electronic Signature Consent

THE FOLLOWING TERMS AND CONDITIONS GOVERN YOUR ON-LINE APPLICATION FOR LIFE INSURANCE WITH MINNESOTA LIFE INSURANCE COMPANY.

TERMS

By typing the last four digits of your Social Security number and clicking the "I Agree" button below, you agree to be legally bound as if you had signed them with a hand written signature and

[Print](#)

Please review your application and all other forms in their entirety for accuracy and to make sure you completely understand and agree with what they say.

If you need to change or update any information or if you have questions, please contact your representative after reviewing your application and reading each of the pages that are to be e-Signed, please check the box indicating you have read it and then select either "I Agree" or "I Decline".

I have reviewed the application and other forms and read each of the pages that are to be e-signed. I have read the Terms of Use and Electronic Signature Consent provided above. I have indicated below whether I "Agree" or "Decline" the terms of these documents.

Figure 5: Terms and Conditions and Electronic Signature Consent & Review Your Application

After a successful login to the system, the Primary Insured or Owner is shown the "Welcome" screen. This allows the Primary Insured or Owner to read, view and print the Terms and Conditions and Electronic Signature Consent and review their application. This screen is identical for all signing parties.

The user has the ability to read, view and print the Terms & Conditions and eSignature Consent and the application.

The Primary Insured or Owner has the ability to review the complete application PDF document, indicate that they have done so, and then agree to attach their signature to the application or decline doing so.

The user sees the “Review Your Application” button (as shown in Figure 5). Clicking on this button launches the application PDF document in a separate window for the user to review as well as enabling the checkbox for the user to indicate that they have reviewed the form.

Once the user has reviewed the form and indicates as such by clicking on the “I have reviewed the application and read each of the pages that are to be e-signed and I have read the Terms of Use and eSignature Consent” checkbox, the “I Agree” button is enabled (as shown in Figure 5). The “I Decline” button has been active the entire time, in case the user decides to opt out of the signature process.

The user has the ability to Decline signing the application at this point, regardless if they have not read or agreed to the “Terms & Conditions and eSignature Consent” If they choose to do so, they can click the “I Decline” button at any time.

Figure 6: Terms and Conditions and Electronic Signature Consent

Minnesota Life Language for Terms and Conditions and Electronic Signature Consent will say:

Terms and Conditions and Electronic Signature Consent

THE FOLLOWING TERMS AND CONDITIONS GOVERN YOUR ON-LINE APPLICATION FOR LIFE INSURANCE WITH MINNESOTA LIFE INSURANCE COMPANY.

TERMS

By typing the last four digits of your Social Security number and clicking the “I Agree” button below, you agree to be legally bound as if you had signed them with a hand written signature and you acknowledge that you have reviewed and agree to these terms and conditions. You may print out a copy of this Consent to retain for your record. If you have any questions or would prefer a hard copy of this Consent or your electronic application, please contact your insurance sales representative.

CONDITIONS

Your consent is required. You must consent to electronically receiving and submitting a Life Insurance Application Form in order to continue your on-line application. If, after you read the Terms and Conditions below, you wish to consent to electronic delivery and execution of the Minnesota Life Insurance Company Application, please fill in the requested information and click on “I Agree”, where indicated below.

If you do not want to sign your application on-line, you should exit this screen by clicking the "I Decline" button at the bottom of the page. Your electronic application process will be discontinued.

CONSENT

By entering the last four digits of my Social Security Number and clicking the "I Agree" button below, I confirm the following statements:

I agree to the electronic delivery of the attached documents and to the usage of electronic transmissions and records for current and future transmissions pertaining to my insurance application to Minnesota Life Insurance Company through the internet, effective on the date I fill in the last four digits of my Social Security Number and click the "I Agree" button.

WITHDRAWING CONSENT

I understand that I have the right to withdraw such consent at any time by making such request by contacting the Individual Underwriting Department, Minnesota Life Insurance Company, 400 Robert St N, St Paul MN 55101-2098 and providing my full name, United States postal address and telephone number.

I understand that I have the option to print and retain paper copies of any electronically transmitted submissions concerning my application or by contacting Minnesota Life at Individual Underwriting Department, 400 Robert St N, St Paul MN 55101-2098 and providing my full name, United States postal address and telephone number.

I understand that in the event my personal contact information changes or any error is detected, I must immediately notify Minnesota Life Insurance Company of the changes at Individual Underwriting Department, 400 Robert St N, St Paul MN 55101-2098 and providing my full name, United States postal address and telephone number.

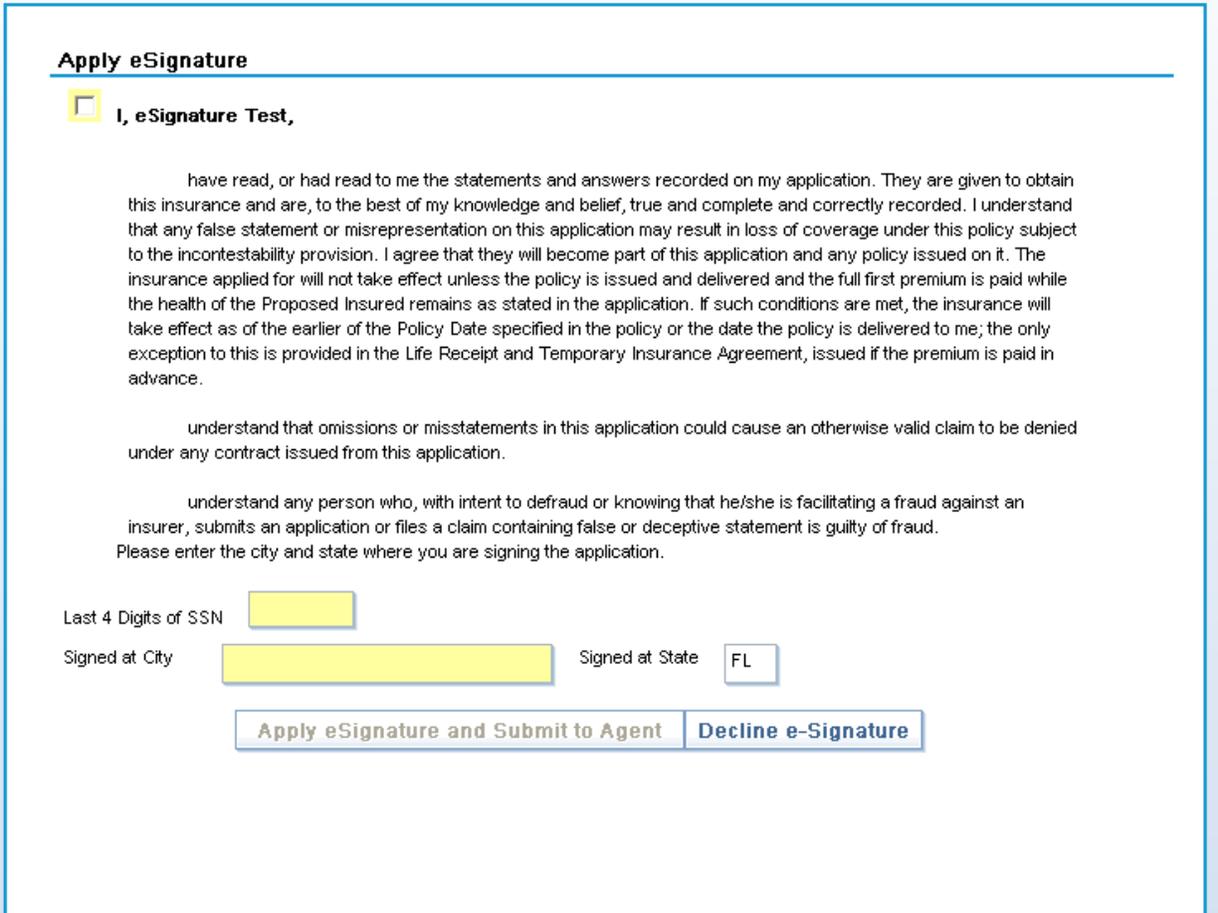
I understand that to access and transmit my application electronically I must have access to a personal computer that is capable of supporting Internet access and a compatible browser application along with my personal email address.

I acknowledge that reading and accepting these terms and conditions demonstrate my ability to access information electronically.

Primary Insured/Owner Signature Verification screen

After the user indicates that they have reviewed the application and read each of the pages that are to be eSigned, they are brought to the “Signature Verification” screen. Upon initial entry to the screen (as shown in Figure 7), it displays a checkbox for the user to agree that the statements and answers on the application are true, complete and correctly recorded. This screen also displays required input fields for the city and last 4 digits of SSN. The screen also shows a “Decline e-Signature Process” and a grayed-out “Apply e-Signature” button.

After the checkbox is checked and the user has entered the “Signed at City” and the last 4 digits of their SSN, the “Apply e-Signature” button is enabled (as shown in Figure 7). Clicking on this button takes the user to the next step of the e-Signature process, which is the “Review application after e-Signature” Screen. Clicking on “Decline e-Signature Process” brings the user to the “Decline e-Signature” screen.



Apply eSignature

I, eSignature Test,

have read, or had read to me the statements and answers recorded on my application. They are given to obtain this insurance and are, to the best of my knowledge and belief, true and complete and correctly recorded. I understand that any false statement or misrepresentation on this application may result in loss of coverage under this policy subject to the incontestability provision. I agree that they will become part of this application and any policy issued on it. The insurance applied for will not take effect unless the policy is issued and delivered and the full first premium is paid while the health of the Proposed Insured remains as stated in the application. If such conditions are met, the insurance will take effect as of the earlier of the Policy Date specified in the policy or the date the policy is delivered to me; the only exception to this is provided in the Life Receipt and Temporary Insurance Agreement, issued if the premium is paid in advance.

understand that omissions or misstatements in this application could cause an otherwise valid claim to be denied under any contract issued from this application.

understand any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statement is guilty of fraud. Please enter the city and state where you are signing the application.

Last 4 Digits of SSN

Signed at City Signed at State

Figure 7: Primary Insured/Owner Signature Verification screen (part 1)

Apply eSignature

I, eSignature Test,

have read, or had read to me the statements and answers recorded on my application. They are given to obtain this insurance and are, to the best of my knowledge and belief, true and complete and correctly recorded. I understand that any false statement or misrepresentation on this application may result in loss of coverage under this policy subject to the incontestability provision. I agree that they will become part of this application and any policy issued on it. The insurance applied for will not take effect unless the policy is issued and delivered and the full first premium is paid while the health of the Proposed Insured remains as stated in the application. If such conditions are met, the insurance will take effect as of the earlier of the Policy Date specified in the policy or the date the policy is delivered to me; the only exception to this is provided in the Life Receipt and Temporary Insurance Agreement, issued if the premium is paid in advance.

understand that omissions or misstatements in this application could cause an otherwise valid claim to be denied under any contract issued from this application.

understand any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statement is guilty of fraud. Please enter the city and state where you are signing the application.

Last 4 Digits of SSN

Signed at City Signed at State

Figure 8: Primary Insured/Owner Signature Verification screen (part 2)

Text of the e-Signature

All areas of each form where signatures are required will have the electronic signatures for each concerned party, formatted as follows:

eSigned by <Primary Insured/Owner First Name> <Primary Insured/Owner Last Name> on <Date> at <Time> <GMT>

The date will be in short numerical format with four digit year, such as "1/9/2010". The time will be in a 24 hour numerical format using GMT time, such as "13:45 GMT".

The following is a complete sample of how the full e-Signature will appear on a signature line:

eSigned by Joe Smith on 3/25/2010 at 13:30 GMT

NOTE: The font size and the location may vary with respect to the space available on the signature spot of the form.

Thank You Screen

This screen (as shown in Figure 9) is the last screen that the signing party sees in the e-Signature process after clicking the “Submit to Representative” button on the “Review application after e-Signature” screen. The user may click on the “Close Window” button to exit the application.

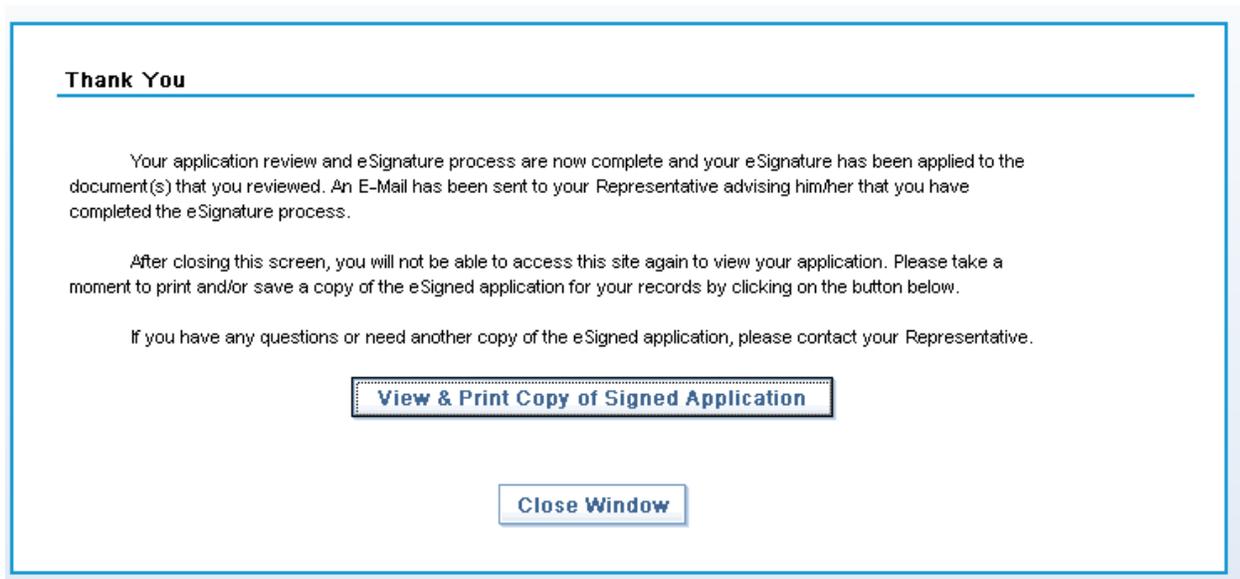


Figure 9: Thank you screen

Primary Insured/Owner Decline e-Signature screen

If the user indicates that they wish to decline the e-Signature from Welcome – Consent, Application Review, Signature Verification or Review Application after e-Signature screens, they are brought to the “Decline e-Signature” screen. This screen allows the user to confirm that they wish to cancel the e-Signature process, or cancel the decline and resume the e-Signature process. Figure 10 shows this screen.



Decline eSignature

If you decide to decline and cancel the eSignature process, the following will happen:
All signatures will be removed from the application and the authorization process restarts

Your agent will be notified via email that you declined and cancelled the eSignature process

You will not be able to access your application on this secure Website until your agent contacts you

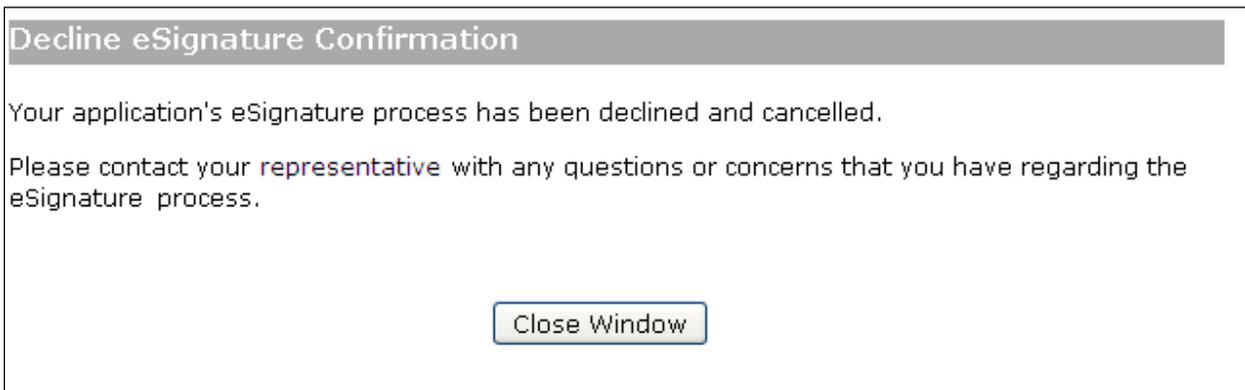
Do you wish to continue with declining and cancelling the eSignature process?

No - Resume eSignature Process **Yes - Cancel eSignature Process**

Figure 10: Primary Insured/Owner Decline e-Signature screen

Primary Insured/Owner Decline e-Signature Confirmation screen

If the user confirms that they wish to cancel the e-Signature from the “Decline e-Signature” screen, they are brought to the “Decline e-Signature Confirmation” screen. This screen confirms that the e-Signature process has been cancelled, and is the last screen for the user in the e-Signature process if they cancel the e-Signature. Figure 11 shows this screen.



Decline eSignature Confirmation

Your application's eSignature process has been declined and cancelled.

Please contact your **representative** with any questions or concerns that you have regarding the eSignature process.

Close Window

Figure 11: Primary Insured/Owner Decline e-Signature Confirmation screen

One of the signors of this document has declined to sign electronically. Please contact your agent for new signing instructions.

Figure 12: Message displayed when url accessed after declining e-signature

Statement of Policy Cost and Benefit Information

Insured: JOHN JAMES DOE
Male Age 35

Date: January 1, 2012
Policy Number: 1-000-000W

Prepared by:

Your Representative is:

Minnesota Life Insurance Company
400 Robert Street North
St Paul MN 55101-2098
651-665-3500

MARY LOUISE JONES
THE XYZ OFFICE BLDG
ABC LANE
OAKBROOK, IL 60523
(555) 123-4000

The policy you have applied for is a term policy with level premiums for [twenty-years] that is annually renewable thereafter.

To assist you in evaluating your policy we are providing this information.

Policy Year	Guaranteed Basis Annual Premium	Current Basis Annual Premium	Face Amount
01	[\$500.00]	[\$500.00]	\$1,000,000
02	[\$500.00]	[\$500.00]	\$1,000,000
03	[\$500.00]	[\$500.00]	\$1,000,000
04	[\$500.00]	[\$500.00]	\$1,000,000
05	[\$500.00]	[\$500.00]	\$1,000,000
10	[\$500.00]	[\$500.00]	\$1,000,000
20	[\$500.00]	[\$500.00]	\$1,000,000
Age 65	[\$46,470]	[\$18,990]	\$1,000,000

* Life Insurance
Surrender Cost Index

* Life Insurance Net
Payment Cost Index

10 Year
20 Year

[\$0.5]
[\$0.5]

[\$0.5]
[\$0.5]

[This policy also contains the following additional agreements: Extended Conversion Agreement and Waiver of Premium Agreement. The premium for these agreements is included in the Basic Policy Annual Premium shown above.]

* An explanation of the intended use of these figures is provided in the Life Insurance Buyers Guide. The indexes are useful only for the comparison of similar policies.

SERFF Tracking Number: MNNL-128074946 State: Arkansas
 Filing Company: Minnesota Life Insurance Company State Tracking Number:
 Company Tracking Number: 12-400
 TOI: L041 Individual Life - Term Sub-TOI: L041.103 Renewable - Single Life -
 Fixed/Indeterminate Premium
 Product Name: Individual Term Life Policy
 Project Name/Number: 2012 Term Refresh/12-400

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)
02/07/2012	Form	Advantage Elite Select Term Policy	02/16/2012	12-400 Advantage Elite Select Term Policy.pdf (Superseded)

ADVANTAGE ELITE SELECT TERM POLICY

Face Amount payable at death during the term period

Premiums as stated on the Policy Information Page

Conversion Privilege

Renewal Privilege

Nonparticipating

**READ YOUR POLICY CAREFULLY
THIS IS A LEGAL CONTRACT**

Subject to the provisions of this policy, we promise to pay to the beneficiary the face amount when we receive proof satisfactory to us that the insured died during the term period shown on the Policy Information Page.

We make this promise and issue this policy in consideration of the application for this policy and the payment of the premiums.

The owner and the beneficiary are as named in the initial application unless they are changed as provided in this policy.

Signed for Minnesota Life Insurance Company, a stock company, at St. Paul, Minnesota, on the policy date.

Notice of Your Right to Examine This Policy

It is important to us that you are satisfied with this policy after it is issued. If you are not satisfied with it, you may return the policy to us or to your agent within 30 days after you receive it. If you return the policy, you will receive a full refund of any premiums you have paid within 10 days of the date we receive your notice of cancellation.



President



Secretary

MINNESOTA LIFE

Minnesota Life Insurance Company
400 Robert Street North
St. Paul, MN 55101-2098
651.665.3500

INDEX

If you have questions or complaints about this policy, you may contact your advisor, us, or the insurance department of your state at the following location.

Insurance Department of: []
[Address]
[Address]

Telephone Number []
Toll Free Telephone Number []

Assignment	5
Beneficiary	2
Benefits	3
Conversion Privilege	4
Definitions	2
Grace Period	4
Incontestability	5
Lapse (Premiums)	4
Owner	2
Premiums	4
Reinstatement (Premiums)	4
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Settlement Options	3
Suicide Exclusion	5

Advantage Elite Select Term Policy

An annually renewable, convertible term policy with a guaranteed level premium period

Insured: [JOHN JAMES DOE]
 Issue Age: [35]
 Gender: [Male]
 Policy Number: [1-000-000W]
 Policy Date: [January 1, 2012]
 Risk Class: [Standard Non-Tobacco]
 Face Amount: [\$1,000,000]

Payment Options	Premium	Annual Payment
Annual:	[\$1,375.00]	[\$1,375.00]
Semi-Annual:	[\$715.00]	[\$1,430.00]
Quarterly:	[\$371.25]	[\$1,485.00]
Monthly:	[\$121.00]	[\$1,452.00]

Basic Policy	Annual Premium
Level Term Policy	[\$1,195.00]
Level premium period [20] years	
Effective: [January 1, 2012]	
Premiums payable through [December 31, 2031]	

Renewal Privilege
 See following pages for renewal
 premiums payable through [December 31, 2070]

Conversion Privilege
 Conversion period begins [January 1, 2013] and ends [12/31/2021]

Additional Agreements

Annual Premium

Extended Conversion Agreement	
Extended conversion period begins [January 1, 2022] and ends [December 31, 2031]	
Premiums payable through [December 31, 2031]	[\$40.00]
Waiver of Premium Agreement	[\$140.00]
Effective: [January 1, 2012]	
Premiums payable through [December 31 2031]	
Total Annual Premium on Policy Date -----	[\$1,375.00]

Insured: [JOHN JAMES DOE]

Policy Number: [1-000-000W]

Renewal Premiums Based on Current Experience [with Waiver of Premium Agreement included through [December 31, 2031]].

Renewal Date	Annual	Semi-Annual	Quarterly	Monthly
[January 1]				
[2032	\$10,720.00	\$5,340.40	\$2,772.90	\$903.76
2033	\$11,320.00	\$5,886.40	\$3,056.40	\$996.16
2034	\$12,430.00	\$6,463.60	\$3,356.10	\$1,093.84
2035	\$13,650.00	\$7,098.00	\$3,685.50	\$1,201.20
2036	\$15,010.00	\$7,805.20	\$4,052.70	\$1,320.88
2037	\$11,380.00	\$5,917.60	\$3,072.60	\$1,001.44
2038	\$12,550.00	\$6,526.00	\$3,388.50	\$1,104.40
2039	\$13,880.00	\$7,217.60	\$3,747.60	\$1,221.44
2040	\$15,390.00	\$8,002.80	\$4,155.30	\$1,354.32
2041	\$17,100.00	\$8,892.00	\$4,617.00	\$1,504.80
2042	\$18,990.00	\$9,874.80	\$5,127.30	\$1,671.12
2043	\$21,040.00	\$10,940.80	\$5,680.80	\$1,851.52
2044	\$23,240.00	\$12,084.80	\$6,274.80	\$2,045.12
2045	\$25,610.00	\$13,317.20	\$6,914.70	\$2,253.68
2046	\$28,180.00	\$14,653.60	\$7,608.60	\$2,479.84
2047	\$31,100.00	\$16,172.00	\$8,397.00	\$2,736.80
2048	\$34,930.00	\$18,163.60	\$9,431.10	\$3,073.84
2049	\$38,200.00	\$19,864.00	\$10,314.00	\$3,361.60
2050	\$42,570.00	\$22,136.40	\$11,493.90	\$3,746.16
2051	\$47,480.00	\$24,689.60	\$12,819.60	\$4,178.24
2052	\$52,760.00	\$27,435.20	\$14,245.20	\$4,642.88]

Insured: [JOHN JAMES DOE]

Policy Number: [1-000-000W]

Continued from Page ICC1C

Renewal Premiums Based on Current Experience [with Waiver of Premium Agreement included through [December 31, 2031]].

Renewal Date	Annual	Semi-Annual	Quarterly	Monthly
[January 1]				
[2053	\$58,310.00	\$30,321.20	\$15,743.70	\$5,131.28
2054	\$64,260.00	\$33,415.20	\$17,350.20	\$5,654.88
2055	\$70,390.00	\$36,602.80	\$19,005.30	\$6,194.32
2056	\$76,890.00	\$39,982.80	\$20,760.30	\$6,766.32
2057	\$85,780.00	\$44,605.60	\$23,160.60	\$7,548.64
2058	\$95,810.00	\$49,821.20	\$25,868.70	\$8,431.28
2059	\$107,270.00	\$55,780.40	\$28,962.90	\$9,439.76
2060	\$120,340.00	\$62,576.80	\$32,491.80	\$10,589.92
2061	\$134,890.00	\$70,142.80	\$36,420.30	\$11,870.32
2062	\$150,660.00	\$78,343.20	\$40,678.20	\$13,258.08
2063	\$167,460.00	\$87,079.20	\$45,214.20	\$14,736.48
2064	\$185,190.00	\$96,298.80	\$50,001.30	\$16,296.72
2065	\$203,550.00	\$105,846.00	\$54,958.50	\$17,912.40
2066	\$222,780.00	\$173,752.80	\$90,217.80	\$29,404.32
2067	\$243,100.00	\$189,602.40	\$98,447.40	\$32,086.56
2068	\$264,820.00	\$206,544.00	\$107,244.00	\$34,953.60
2069	\$288,570.00	\$225,069.00	\$116,862.75	\$38,088.60
2070	\$315,250.00	\$245,879.40	\$127,668.15	\$41,610.36]

Insured: [JOHN JAMES DOE]

Policy Number: [1-000-000W]

Guaranteed Renewal Premiums [with Waiver of Premium Agreement included through [December 31, 2031]].

Renewal Date	Annual	Semi-Annual	Quarterly	Monthly
[January 1]				
2032	\$19,760.00	\$10,275.20	\$5,335.20	\$1,738.88
2033	\$22,010.00	\$11,445.20	\$5,942.70	\$1,936.88
2034	\$24,420.00	\$12,698.40	\$6,593.40	\$2,148.96
2035	\$26,570.00	\$13,816.40	\$7,173.90	\$2,338.16
2036	\$29,030.00	\$15,095.60	\$7,838.10	\$2,554.64
2037	\$26,820.00	\$13,946.40	\$7,241.40	\$2,360.16
2038	\$29,820.00	\$15,506.40	\$8,051.40	\$2,624.16
2039	\$33,480.00	\$17,409.60	\$9,039.60	\$2,946.24
2040	\$37,590.00	\$19,546.80	\$10,149.30	\$3,307.92
2041	\$41,910.00	\$21,793.20	\$11,315.70	\$3,688.08
2042	\$46,470.00	\$24,164.40	\$12,546.90	\$4,089.36
2043	\$51,090.00	\$26,566.80	\$13,794.30	\$4,495.92
2044	\$55,770.00	\$29,000.40	\$15,057.90	\$4,907.76
2045	\$60,810.00	\$31,621.20	\$16,418.70	\$5,351.28
2046	\$66,030.00	\$34,335.60	\$17,828.10	\$5,810.64
2047	\$72,360.00	\$37,627.20	\$19,537.20	\$6,367.68
2048	\$79,440.00	\$41,308.80	\$21,448.80	\$6,990.72
2049	\$88,740.00	\$46,144.80	\$23,959.80	\$7,809.12
2050	\$98,550.00	\$51,246.00	\$26,608.50	\$8,672.40
2051	\$108,870.00	\$56,612.40	\$29,394.90	\$9,580.56
2052	\$120,150.00	\$62,478.00	\$32,440.50	\$10,573.20
2053	\$132,450.00	\$68,874.00	\$35,761.50	\$11,655.60
2054	\$146,730.00	\$76,299.60	\$39,617.10	\$12,912.24
2055	\$163,410.00	\$84,973.20	\$44,120.70	\$14,380.08

Insured: [JOHN JAMES DOE]

Policy Number: [1-000-000W]

Continued from Page ICC1E

Guaranteed Renewal Premiums [with Waiver of Premium Agreement included through [December 31, 2035]].

Renewal Date	Annual	Semi-Annual	Quarterly	Monthly
[January 1]				
2056	\$182,670.00	\$94,988.40	\$49,320.90	\$16,074.96
2057	\$203,670.00	\$105,908.40	\$54,990.90	\$17,922.96
2058	\$227,580.00	\$118,341.60	\$61,446.60	\$20,027.04
2059	\$252,480.00	\$131,289.60	\$68,169.60	\$22,218.24
2060	\$279,330.00	\$145,251.60	\$75,419.10	\$24,581.04
2061	\$309,060.00	\$160,711.20	\$83,446.20	\$27,197.28
2062	\$342,270.00	\$177,980.40	\$92,412.90	\$30,119.76
2063	\$379,080.00	\$197,121.60	\$102,351.60	\$33,359.04
2064	\$419,280.00	\$218,025.60	\$113,205.60	\$36,896.64
2065	\$462,360.00	\$240,427.20	\$124,837.20	\$40,687.68
2066	\$507,810.00	\$264,061.20	\$137,108.70	\$44,687.28
2067	\$555,240.00	\$288,724.80	\$149,914.80	\$48,861.12
2068	\$599,850.00	\$311,922.00	\$161,959.50	\$52,786.80
2069	\$646,350.00	\$336,102.00	\$174,514.50	\$56,878.80
2070	\$695,400.00	\$361,608.00	\$187,758.00	\$61,195.20

Death Benefit Alternative Settlement Options

Option 1: Interest Payments

Please refer to the Payment of Death Benefit section of your policy.

Option 2: Payments for a Specified Period

Monthly payments per \$1,000 of death benefit applied under this option are shown below.

Number of Years	Monthly Payments
5	\$17.08
10	8.75
15	5.98
20	4.59
25	3.76

[Option 3: Life Income

Monthly payments per \$1,000 of death benefit based on the Annuity 2000 Table and applied under this option are shown below.

Life Income with Payments Guaranteed for Male

Age	Life	5 Years	10 Years	20 Years
50	\$2.98	\$2.98	\$2.97	\$2.89
55	3.37	3.37	3.34	3.20
60	3.89	3.87	3.82	3.55
65	4.58	4.55	4.43	3.90
70	5.54	5.46	5.20	4.21
75	6.87	6.67	6.08	4.43

Life Income with Payments Guaranteed for Female

Age	Life	5 Years	10 Years	20 Years
50	\$2.75	\$2.74	\$2.74	\$2.70
55	3.08	3.08	3.06	2.99
60	3.52	3.51	3.49	3.34
65	4.11	4.09	4.03	3.72
70	4.93	4.89	4.75	4.09
75	6.12	6.01	5.66	4.37]

[Option 3: Life Income

Monthly payments for each \$1,000 of death benefit based on the Annuity 2000 Table and applied under this option are shown below.

Life Income with Payments Guaranteed for Unisex

Age	Life	5 Years	10 Years	20 Years
50	\$2.79	\$2.79	\$2.78	\$2.74
55	3.14	3.14	3.12	3.04
60	3.59	3.58	3.55	3.38
65	4.20	4.18	4.44	3.76
70	5.05	5.00	4.84	4.12
75	6.26	6.14	5.75	4.38]

Option 4: Payments of a Specified Amount

Please refer to the Payment of Death Benefit section of your policy.

Settlement Option Guaranteed Annual Interest Rate: 1%

Summary of Policy Features

This policy is an annually renewable term life policy with guaranteed level premiums payable for the period shown on the policy data pages. Following the guaranteed premium period, the policy premium will increase on each renewal date as shown on the policy data pages.

Death Benefit

The amount payable to the beneficiary on the death of the insured is the total of the following amounts:

- PLUS** - The face amount (see policy data pages),
- PLUS** - Any additional amounts on the insured's life provided by any additional agreements (see policy data pages),
- PLUS** - Any premium paid beyond the policy month in which death occurs (see page 5),
- MINUS** - Any premium due (see page 5),

Additional Agreements

The additional agreements, if any, listed on the policy data pages are described more fully in those additional agreements.

Definitions

When we use the following words, this is what we mean:

age

The insured's age at nearest birthday.

death benefit

The amount we will pay under the terms of this policy when the insured dies.

face amount

The basic policy amount of insurance initially purchased.

grace period

The period of time measured from the due date of the last premium, during which coverage will remain in force despite non-payment of premium. The grace period is sixty-one days.

guaranteed level period

The length of time your premium for this policy will remain level.

inforce

The insured's life remains insured under the terms of this policy.

insured

The person whose life is insured under this policy as shown on the policy data pages.

issue age

The insured's age at nearest birthday as of the policy date.

lapse

A premium is in default, and the insured's life is no longer insured.

policy anniversary

The same day and month as your policy date for each succeeding year your policy remains in force.

policy date

The date shown on the policy data pages, which is the date from which policy anniversaries, policy years, policy months and premium due dates are determined.

we, our, us

Minnesota Life Insurance Company.

written request

A request in writing signed by you. We also may require that your policy be sent in with your written request.

you, your

The owner of this policy, as shown in the application, unless changed as provided in this policy. The owner may be someone other than the insured.

General Information

What is your agreement with us?

Your policy and any application attached to it contain the entire contract between you and us. This includes the initial application and all subsequent applications to change your policy. Any statements made in the application either by you or by the insured in the initial application or in any application for change will, in the absence of fraud, be considered representations and not warranties. Also, any statement made either by you or by the insured will not be used to void your policy nor defend against a claim under your policy unless the statement is contained in the initial application or any application for change to this policy.

No change or waiver of any of the provisions of this policy will be valid unless made in writing by us, attached to the policy and signed by our president, a vice president, our secretary or an assistant secretary. No agent or other person has the authority to change or waive any provisions of your policy.

Any additional agreement attached to this policy will become a part of this policy and will be subject to all the terms and conditions of this policy unless we state otherwise in the agreement.

When does your policy become effective?

Your policy will become effective on the earlier of the policy date or the date the policy is delivered to you, provided you have paid the first full premium, while the health of the proposed insured remains as stated in the application for this policy.

How do you exercise your rights under the policy?

You can exercise all the rights under this policy during the insured's lifetime by making a written request to us. This includes the right to change the ownership. If your policy is assigned, we will also require the written consent of the assignee. If you have designated an irrevocable beneficiary, the written consent of that beneficiary will also be required.

Beneficiary

To whom will we pay the death benefit?

When we receive proof satisfactory to us of the insured's death, we will pay the death benefit of this policy to the beneficiary or beneficiaries who are named in the application for this policy unless you have changed the beneficiary. In that event, we will pay the death benefit to the beneficiary named in your last change of beneficiary request as provided below.

What happens if one or all of the beneficiaries die before the insured?

If a beneficiary dies before the insured, that beneficiary's interest in the policy ends with that beneficiary's death. Only those beneficiaries who survive the insured will be eligible to share in the death benefit. If no beneficiary survives the insured, we will pay the death benefit of this policy to you, if living, otherwise, to your estate, or your successor if you are a corporation no longer in existence.

Can you change the beneficiary?

If you have reserved the right to change the beneficiary, you can request in writing to change the beneficiary. If you have not reserved the right to change the beneficiary, the written consent of the irrevocable beneficiary will be required.

Your written request will not be effective until we record it in our home office. After we record it, the change will take effect as of the date you signed the request. However, if the insured dies before the request has been so recorded, the request will not be effective as to the death benefit we have paid before we recorded your request.

Payment of Death Benefit

When will the policy death benefit be paid?

The death benefit of this policy will be payable if we receive proof satisfactory to us that the insured died while the policy was in force. Proof of any claim under this policy must be submitted in writing to our home office. The death benefit will be paid at our home office and in a single sum unless a settlement option has been selected.

We will pay interest on single sum death benefit from the date of the insured's death until the date of payment. Interest will be at an annual rate determined by us which will never be less than the settlement option guaranteed interest rate shown on the policy data pages. Settlement will be made within two months after receipt of satisfactory proof of death.

Can the death benefit be paid in other than a single sum?

You may, during the insured's lifetime, request that we pay the death benefit under one of the following settlement options. We may also use any other method of payment that is agreeable to you and us. A settlement option may be selected only if the payments are to be made to a natural person in that person's own right.

The following settlement options are all payable in fixed amounts as described below.

Option 1 -- Interest Payments

Payment of interest on the death benefit at such times and for a period that is agreeable to you and us. Withdrawal of death benefit may be made in amounts of at least \$500. At the end of the period, any remaining

death benefit will be paid in either a single sum or under any other method we approve.

Option 2 -- Payments for a Specified Period

Monthly payments for a specified number of years. The amount of each monthly payment for each \$1,000 of death benefit applied under this option is shown on the policy data pages. The monthly payments for any period not shown will be furnished upon request.

Option 3 -- Life Income

Monthly payments for the life of the person who is to receive the income. We will require satisfactory proof of the person's age and gender. Payments can be guaranteed for 5, 10, or 20 years. The amount of each monthly payment for each \$1,000 of death benefit applied under this option is shown on the policy data pages. The mortality table used for these rates is shown on the policy data pages. The monthly payments for any ages not shown will be furnished upon request.

Option 4 -- Payments of a Specified Amount

Monthly payments of a specified amount until the death benefit and interest are fully paid.

If you request a settlement option, we will prepare an agreement for you to sign, which will state the terms and conditions under which the payments will be made.

Can a beneficiary request payment under a settlement option?

A beneficiary may select a settlement option only after the insured's death. However, you may provide that the beneficiary will not be permitted to change the settlement option you have selected.

Is the death benefit exempt from claims of creditors?

To the extent permitted by law, no payment of death benefit or interest we make will be subject to the claims of any creditors.

Also, if you provide that the option selected cannot be changed after the insured's death, the payments will not be subject to the debts or contracts of the person receiving the payments. If garnishment or any other attachment of the payments is attempted, we will make those payments to a trustee we name. The trustee will apply those payments for the maintenance and support of the person you named to receive the payments.

What guaranteed interest rate will we pay on the policy death benefit?

We will pay interest on single sum death benefit from the date of the insured's death until the date of payment. Interest will be at an annual rate determined by us which will never be less than the settlement option guaranteed interest rate shown on the policy data pages. Additional interest earnings, if any, on deposits under a settlement option will be payable as determined by us.

Premiums

When and where do you pay your premiums?

Your first premium is due as of the policy date and must be paid when your policy is delivered. All premiums after the first premium are payable on or before the date they are due and must be mailed to us at our home office. A premium may not be paid earlier than 20 days before its due date.

How often do you pay premiums?

You may pay your premiums once a year, twice a year, or four times a year. These premiums are shown on the policy data pages as the annual, semi-annual and quarterly premiums.

If you decide to pay premiums once a year, your annual premium will be due on the policy anniversary date of your policy. Should you decide to pay premiums more than once a year, your semi-annual premiums will be due every six months and your quarterly premiums will be due every three months. In each year, one of the premium due dates must fall on the policy anniversary.

Are there other methods of paying premiums?

With the consent of your financial institution, you may request that your premiums be automatically withdrawn on a monthly basis from your account at that institution and paid directly to us. If for any reason your financial institution fails to pay a premium when it is due or if this premium payment arrangement is ended, you must pay an annual, semi-annual or quarterly premium directly to us before the end of the grace period to keep your policy in force.

What are the premiums for your policy?

The premiums due for your policy are level for the period of years shown on the data pages; thereafter they change every year. There are two tables in the policy data pages. The first table shows renewal premiums after the guaranteed level premium period, based on our experience at the time your policy was issued. As long as our experience on policies of this type remains the same, these are the premiums we will bill you. If our experience changes, the premiums we will bill you may be higher or lower. However, we will never bill you for a premium higher than those shown in the second table. These premiums are called "guaranteed" premiums.

Can you pay a premium after the date it is due?

Your policy has a 61-day grace period. This means that if a premium is not paid on or before the date it is due, you may pay that premium during the 61-day period immediately following the due date. Your premium payment, however, must be received in our home office within the 61-day grace period. The insured's life will continue to be insured during this grace period.

If the insured dies during this period, we will deduct a premium for this 61-day grace period from the death

benefit of this policy. This 61-day grace period does not apply to the first premium payment. The first premium must be paid when your policy is delivered.

What happens if a premium is not paid before the end of the grace period?

If a premium is not paid before the end of the 61-day grace period, your policy will lapse and no further premium payments may be made. At any time within three years from the date of lapse, you may ask us to restore your policy to a premium paying basis. We will require:

- (1) your written request to reinstate this policy;
- (2) that you submit to us at our home office during the insured's lifetime evidence satisfactory to us of the insured's insurability so that we may have time to act on the evidence during the insured's lifetime; and
- (3) payment of the premium currently due on your policy.

Is there a premium refund at the insured's death?

We will refund and pay to the beneficiary any part of a paid premium that covers the period from the end of the policy month in which the insured died to the date to which premiums are paid. However, if your policy contains a Waiver of Premium Agreement and the last premium was waived by us under that agreement, we will not refund that premium.

Renewal Privilege

Can this insurance be renewed?

This policy may be renewed, after the initial level guarantee period term period for additional one-year term periods provided:

- (1) the insured's age on the birthday nearest the date of renewal is less than age 95; and
- (2) we receive payment in our home office of the amount shown in the table of Renewal Premiums in the data pages for the date of renewal. The renewal premium must be received in our home office within 61 days from the date the insurance provided by this policy terminates.

Conversion Privilege

Can this insurance be converted to a new policy?

Yes. You may convert this policy during the period shown on the policy data pages upon our receipt of your written request provided:

- (1) all premiums due on this policy have been paid; and
- (2) we are not waiving premiums on this policy under a waiver of premium agreement.

What type of policy will I have after I convert?

The new policy must be single life permanent coverage on the policy forms we are then issuing. Also the new policy must satisfy the current minimum requirements of the product to which you are converting.

What will be the face amount of the new policy after conversion?

The face amount of the new policy may not be:

- (1) greater than the face amount for this policy on the date of conversion; or
- (2) less than the minimum amount we then issue on the new policy you request.

Can you convert less than the face amount?

If you convert less than the face amount and want to retain some of this policy, you may do so as long as the remaining coverage under this policy satisfies the minimum face amount requirements. The premium on the remaining coverage will be based on the face amount and risk classification then in effect.

What will be the risk class for the new policy?

The new policy will be on the same risk class, if available, as shown on the data pages for the original policy. If that original risk class is not available, the new policy will be in the same or equivalent rating class as this policy. The premium rate will be based on the insured's age on the policy date of the new policy.

Will evidence of insurability be required?

Evidence of insurability satisfactory to us will not be required of the insured unless the new policy is to contain an additional agreement. However if this policy contains a waiver of premium agreement, a waiver of premium agreement may be included in the new policy without evidence of insurability. The new policy will not, of course, cover any disability commencing before the date of conversion.

What if we are waiving premiums on this policy?

You cannot convert this policy to a new policy so long as we are waiving premiums on this policy under the waiver of premium agreement.

Who will be the beneficiary of the new policy?

The beneficiary of the new policy will be the same as the beneficiary designated for this policy on the date of conversion, unless you specify otherwise in a written request.

Additional Information

Can you assign your policy?

Your policy may be assigned. The assignment must be in writing and filed with us at our home office. We assume no responsibility for the validity or effect of any assignment of this policy or of any interest in it. Any portion of the death benefit which becomes payable to an assignee will be payable in a single sum. Any claim made by an assignee will be subject to proof of the assignee's interest and the extent of that interest.

What if the insured's age or gender is misstated?

If the insured's age or gender has been misstated, we will adjust the amount of death benefit payable under this policy, or any agreement attached to this policy, to that amount which the premiums paid would have purchased at the insured's correct age and gender.

When does your policy become incontestable?

After this policy has been in force during the insured's lifetime for two years from the policy date, we cannot contest this policy, except for fraud or the nonpayment of premiums. However, if there has been a reinstatement or policy change for which we required evidence of insurability, that reinstatement or policy change will be contestable for two years during the lifetime of the insured, from the effective date of the reinstatement or policy change.

Is there a suicide exclusion?

If the insured, whether sane or insane, dies by suicide, within two years from the policy date, our liability will be limited to an amount equal to the premiums paid for this policy. If there has been a reinstatement or policy change for which we required evidence of insurability, and if the insured dies by suicide within two years from the effective date of the reinstatement or policy change, our liability with respect to the reinstatement or policy change will be limited to an amount equal to the premiums paid for the reinstatement or policy change.

ADVANTAGE ELITE SELECT TERM POLICY

Face Amount payable at death during the term period

Premiums as stated on the Policy Information Page

Conversion and Renewal Privileges

Nonparticipating

Minnesota Life Insurance Company, a stock company, is a subsidiary of Minnesota Mutual Companies, Inc., a mutual holding company. You are a member of the Minnesota Mutual Companies, Inc., which holds its annual meetings on the first Tuesday in March of each year at 3 p.m. local time. The meetings are held at 400 Robert Street North, St. Paul, Minnesota 55101-2098.

MINNESOTA LIFE