

SERFF Tracking Number: JEPL-128341108 State: Arkansas
Filing Company: The Lincoln National Life Insurance Company State Tracking Number:
Company Tracking Number: LFF06312_5-12 ET AL
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: Application filing
Project Name/Number: App filing for MIB change/LFF06312_5-12 et al

Filing at a Glance

Company: The Lincoln National Life Insurance Company

Product Name: Application filing

SERFF Tr Num: JEPL-128341108 State: Arkansas

TOI: L08 Life - Other

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

Sub-TOI: L08.000 Life - Other

Co Tr Num: LFF06312_5-12 ET AL State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Linda Bird

Authors: Ray Fortier, Jane

Disposition Date: 05/14/2012

Neidermyer, Lori Saltmarsh, Randi

Johnson

Date Submitted: 05/10/2012

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: App filing for MIB change

Status of Filing in Domicile: Pending

Project Number: LFF06312_5-12 et al

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Individual Market Type:

Overall Rate Impact:

Filing Status Changed: 05/14/2012

State Status Changed: 05/14/2012

Deemer Date:

Created By: Jane Neidermyer

Submitted By: Jane Neidermyer

Corresponding Filing Tracking Number:

Filing Description:

Re. Individual Life Application Form

LFF06312_5-12 Simplified Issue Application

LFF06321_5-12 Application for Life Insurance

LFF10071-40_5-12 Streamlined Application for Life Insurance

MGF06450_5-12 MoneyGuard Application for Life Insurance

The Lincoln National Life Insurance Company

Group & NAIC #: 020-65676

SERFF Tracking Number: JEPL-128341108 State: Arkansas
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We are submitting the above-referenced forms for your review and approval. The forms have previously been approved and the only change to each form is the MIB required language which must be implemented by January 1, 2013. We have enclosed a copy of the original approved forms with the language that is being changed highlighted. The form numbers in the lower left hand corner of the forms now have a date extension of _5-12. There have been no other changes to the forms.

Application Form #	Original Approval Date	Filing #
LFF06312	12/15/2006	JEPL-125033786
LFF06321	06/16/2008	JEPL-125673253
LFF10071-40	06/16/2010	JEPL-126659396
MGF06450	10/05/2009	LCNC-126293409

The forms appear in final printed format as issued from a laser printer. Upon approval, we reserve the right to change the format of a form without altering the approved language, though it is possible page numbers may change.

We reserve the right to have these applications completed using a telephone application process and also to make these forms available electronically subject to compliance with the Uniform Electronic Transactions Act, and to the extent applicable, the Federal ESIGN Act.

The forms received the following Flesch scores: LFF06312_5-12 Simplified Issue Application received a score of 50, LFF06321_5-12 Application for Life Insurance received a score of 50, LFF10071-40_5-12 Streamlined Application for Life Insurance received a score of 52 and MGF06450_5-12 MoneyGuard Application for Life Insurance received a score of 54.

We have bracketed several items within the form as variable information to allow for flexibility in the content of the form. These items include: the Service Office addresses, MIB contact information, form page number references and the questions relating to desired riders. As we may develop new riders in the future we reserve the right to add approved riders to the appropriate section on the application. It is our understanding that changes to the bracketed items for new issues will not require a new filing of this form. We confirm that the brackets will not actually appear on the form at issue.

This filing has been submitted concurrently to our Home State of Indiana and is pending approval. This submission contains no unusual or possibly controversial items from the standpoint of normal company or industry standards. To the best of our knowledge and belief, these forms comply with all the applicable laws and regulations of your state.

We trust the information provided will be satisfactory and we look forward to your response. Should you require any additional information, please feel free to contact me toll-free at 1-800-258-3648, extension 5627, or via the fax number

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 or e-mail address shown below.

Jane P. Neidermyer
 Senior Analyst, Life Product Compliance & State Filing
 E-mail: Jane.Neidermyer@LFG.com
 Fax: 1-603-226-5128

State Narrative:

Company and Contact

Filing Contact Information

Jane Neidermyer, Senior Compliance Analyst jane.neidermyer@lfg.com
 One Granite Place 800-258-3648 [Phone] 5627 [Ext]
 PO Box 515 603-226-5128 [FAX]
 Concord, NH 03302-0515

Filing Company Information

The Lincoln National Life Insurance Company CoCode: 65676 State of Domicile: Indiana
 350 Church Street Group Code: 20 Company Type: Life Insurance
 Hartford, CT 06103 Group Name: State ID Number:
 (800) 258-3648 ext. [Phone] FEIN Number: 35-0472300

Filing Fees

Fee Required? Yes
 Fee Amount: \$200.00
 Retaliatory? No
 Fee Explanation: AR fee of \$50 per form times 4 forms
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The Lincoln National Life Insurance Company	\$200.00	05/10/2012	59093497

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	05/14/2012	05/14/2012

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Disposition

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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
Form	Simplified Issue Application		Yes
Form	Application for Life Insurance		Yes
Form	Streamlined Application for Life Ins		Yes
Form	MoneyGuard Application for Life Ins		Yes

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Form Schedule

Lead Form Number: LFF06312_5-12

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	LFF06312_5-12	Application/ Enrollment Form	Simplified Issue Application	Other	Other Explanation: MIB wording rev	50.000	LFF06312_5-12 Generic bracket.pdf
	LFF06321_5-12	Application/ Enrollment Form	Application for Life Insurance	Other	Other Explanation: MIB wording rev	50.000	LFF06321_5-12 generic bracket.pdf
	LFF10071-40_5-12	Application/ Enrollment Form	Streamlined Application for Life Ins	Other	Other Explanation: MIB wording rev	52.000	LFF10071-40_5-12 AR filing.pdf
	MGF06450_5-12	Application/ Enrollment Form	MoneyGuard Application for Life Ins	Other	Other Explanation: MIB wording rev	54.000	MGF06450_5-12 Generic bracket.pdf

SIMPLIFIED ISSUE APPLICATION FOR LIFE INSURANCE

PROPOSED INSURED					
1. Name (First) (Middle) (Last)			2. <input type="checkbox"/> Male <input type="checkbox"/> Female	3. Date of Birth (mm/dd/yy)	
4. Place of Birth (State, Country)		5. Social Security Number (xxx-xx-xxxx)		6. Driver License # & State	
7a. Home Address (Street) (City) (State)			7b. Home Address Zip Code		
8. Employer			9. Citizen of (Country)		
10a. Business Address (Street) (City) (State)			10b. Business Address Zip Code		

COVERAGE INFORMATION

11. Plan of Insurance (If VUL also complete Question 17, Premium Allocation and Disclosure Form)

12. Additional Benefits If Available (Please List):

13. Amount of Insurance (Specified Amount, if UL or VUL) \$

14. (i) Death Benefit Option (Complete for Universal Life and Variable Universal Life Product only - not required for Term or Whole Life.)
 Level Increase by Cash Value Increase by Premium Increase by Premium Less Policy Factor
 (ii) Death Benefit Qualification Test - For IRS purposes, premiums will be tested using the Guideline Premium Test unless
 Cash Value Accumulation Test is checked (not available on all products). **Cannot be changed after issue.**

15. Are you considering stopping premium payments, surrendering, replacing, forfeiting, assigning to the insurer or reducing your benefits under an existing policy or annuity, or are you considering using or borrowing funds from your existing policies or annuities to pay premiums due on the new or applied for policy? Yes No
(If "Yes", please complete and sign all required replacement forms and complete Question 16.)

16. What is the total amount of all inforce insurance on your life? (Please list in the box below.) **If none, check this box:**

Company	Face Amount	Policy Number	Issue Date (mm/dd/yy)	Replacement or Change of Policy?	Check here if 1035 Exchange
	\$			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
	\$			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
	\$			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
	\$			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>

17. Complete only if applying for Variable Life Insurance with the Company. Submit Premium Allocation and Disclosure Form for Variable Universal Life with Application:

Suitability	Yes	No
1. Have you, the Proposed Insured(s) and the Owner, if other than the Proposed Insured(s), received a current Prospectus for the policy applied for and have you had sufficient time to review it?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you understand that the amount and duration of the death benefit may increase or decrease depending on the investment performance of funds in the Separate Account?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you understand that the cash values may increase or decrease depending on the investment performance of the funds held in the Separate Account?	<input type="checkbox"/>	<input type="checkbox"/>
4. With this in mind, do you believe that the policy applied for is in accord with your insurance objective and your anticipated financial needs?	<input type="checkbox"/>	<input type="checkbox"/>

CASH VALUES MAY INCREASE OR DECREASE IN ACCORDANCE WITH THE EXPERIENCE OF THE SEPARATE ACCOUNT. THE DEATH BENEFIT MAY BE VARIABLE OR FIXED UNDER SPECIFIED CONDITIONS.

OWNER INFORMATION (If left blank, Proposed Insured(s) will be owner)**► If a Trust, provide Trustee Name(s), Trust Name.**

18. Owner Name (First, Middle, Last)	19. Citizen of (Country)
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20. Owner Address	
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21. Owner Social Security or Tax ID #	22. Relationship to Proposed Insured(s)	23. Trust Date (only if Trust is Owner)
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24. Is the policy being purchased as part of an employer owned life insurance program where the employer is the direct or indirect beneficiary of the policy? Yes No

BENEFICIARY DESIGNATION Beneficiaries share equally unless otherwise indicated.**► If a Trust, provide Trustee Name(s), Trust Name and date of Trust.**

25. Primary Beneficiary(ies):	26. Social Security or Tax ID #:	27. Relationship to Proposed Insured:
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28. Contingent Beneficiary(ies):	29. Social Security or Tax ID #:	30. Relationship to Proposed Insured:
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BILLING INSTRUCTIONS AS AVAILABLE PER PRODUCT

31. Planned Premium: \$ _____	32. Lump Sum: \$ _____ <input type="checkbox"/> 1035 Exchange
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33. Premium Frequency: Annually Semi-Annually Quarterly Monthly (EFT)
 New List Bill Existing List Bill (provide #) _____
 PDF (Complete Transmittal) Other _____

34. Premium Notices To: (check all that apply.) (Please note we cannot bill to your agent.)
 Insured at Residence Insured at Business Owner Other _____

GENERAL RISK INFORMATION

35. Have you ever used tobacco or products containing nicotine? (If "Yes", check all that apply.) Yes No

Type: Cigarettes Cigar Pipe Chew Tobacco Snuff Nicotine Patches/ Gum

Date First Used: (month/year)					
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Date Last Used: (month/year)					
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Amount and Frequency:					
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36. Are you actively at work performing the regular duties of your job in the usual manner and at the usual place of employment or business for at least 30 hours per week? Yes No

36a If you answered "No" to question 36, please give details here:

37. Height _____ft. _____in. Weight _____lbs	Yes	No
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38. What is your regular occupation? _____

39. In the past 10 years have you applied for life, health or disability insurance and been declined, postponed or charged an increased premium?	<input type="checkbox"/>	<input type="checkbox"/>
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40. Within the past two years, have you flown as a pilot, student pilot or crew member, or engaged in skin or scuba diving, racing of any kind, parachuting, sky diving or hang gliding, mountain, rock or technical climbing?	<input type="checkbox"/>	<input type="checkbox"/>
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If "Yes", please complete an Aviation - Avocation Supplement.

41. In the past 10 years have you been treated for high blood pressure, heart disease, chest pain, diabetes, digestive disorder, lung disorder, cancer, kidney disease, liver disorder or nervous disorder?	<input type="checkbox"/>	<input type="checkbox"/>
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42. In the past 5 years have you received treatment for alcohol or drug use?	<input type="checkbox"/>	<input type="checkbox"/>
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- | | Yes | No |
|---|--------------------------|--------------------------|
| 43. In the past 5 years have you been convicted of (i) two or more moving violations, (ii) driving under the influence of alcohol or other drugs (unless prescribed by a doctor), or (iii) had your driver's license suspended or revoked? | <input type="checkbox"/> | <input type="checkbox"/> |
| 44. In the past 10 years have you been diagnosed by a medical professional as having human immune deficiency virus (HIV) infection, Acquired Immunodeficiency Syndrome (AIDS), or have you received treatment from a medical professional for AIDS? | <input type="checkbox"/> | <input type="checkbox"/> |
| 45. In the past 5 years have you been examined or treated by a physician or medical practitioner or been examined or treated in a hospital? If "Yes" provide name and address of personal physician and/or health care facility. | <input type="checkbox"/> | <input type="checkbox"/> |

If you answered "Yes" to question 37-45, please give complete details here including date of last treatment and name/address/phone number of the attending physician (attach an additional sheet of paper if necessary):

46. Special Instructions:

SERVICE OFFICE ENDORSEMENTS (Attach an additional sheet of paper, if necessary)

AGREEMENT AND ACKNOWLEDGEMENT

I, the Owner, declare that my tax identification or social security number as shown is correct. I also certify that I am not subject to backup withholding.

Each of the Undersigned declares that:

1. This Application consists of any amendments to the application(s) attached thereto and any supplements, all of which are required by the Company for the plan, amount and benefits applied for.
2. I/We further agree that (except as provided in the Temporary Life Insurance Agreement if advance payment has been made and acknowledged below and such Agreement issued), insurance will take effect under the Policy only when: 1) the Policy has been delivered to and accepted by me/us; 2) the initial premium has been paid in full during the lifetime of the Proposed Insured(s); and 3) the Proposed Insured(s) remain in the same state of health and insurability as described in each part of the application at the time conditions 1) and 2) are met.
I/We have paid \$ _____ to the Agent/Representative in exchange for the Temporary Life Insurance Agreement, and I/we acknowledge that I/we fully understand and accept its terms.
3. No agent, broker or medical examiner has the authority to make or modify any Company contract or to waive any of the Company's requirements.
4. I HAVE READ, or have had read to me, the completed Simplified Issue Application for Life Insurance before signing below. All statements and answers in this application are correctly recorded, and are full, complete and true.
5. I understand that, in order to informally fund benefit obligations, the Company may need to increase the amount of insurance under existing Policies on my life from time to time. I hereby authorize the Company to effect such an increase or increases without providing any further notice to me.
6. For employer owned life insurance policies, the owner hereby acknowledges its sole responsibility for ensuring that it complies with all legal and regulatory requirements related to life insurance it purchases on its employees, including appropriate disclosure to each employee whose life is insured under such a life insurance policy.
7. Corrections, additions or changes to this application may be made by the Company. Any such changes will be shown under "Service Office Endorsements". Acceptance of a policy issued with such changes will constitute acceptance of the changes. No change will be made in classification (including age at issue), plan, amount, or benefits unless agreed to in writing by the Applicant.

STATE DISCLOSURES

All jurisdictions except AR, AZ, CT, DC, FL, KS, KY, LA, ME, MN, NJ, NM, OH, OK, PA, TX, VA and WA. Any person who, with intent to defraud or knowing that he/she is facilitating fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

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

Washington Only. Any person who knowingly presents a false or fraudulent claim for the payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law.

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

Connecticut and Texas Only. Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud, as determined by a court of competent jurisdiction.

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

TRUST VERIFICATION

I/We hereby certify that the Trustee(s) named in this application are the Trustee(s) for the named Trust, which is in full force and effect. The Company assumes no obligation to inquire into the terms of any trust agreement affecting this policy and shall not be held liable for any party's compliance with the terms thereof. The Company may rely solely upon the signature(s) of the Trustee(s) named in this application to any receipt, release or waiver, or to any transfer or other instrument affecting this policy or any options, privileges or benefits thereunder. Unless otherwise indicated, the signature(s) of all Trustee(s) named, or their successors, will be required to exercise any contractual right under the policy. The Company shall have no obligation to see to the use or application of any funds paid to the Trustee(s) in accordance with the terms of the policy. Any such payment made by the Company to the Trustee(s) shall fully discharge the Company with respect to any amounts so paid.

AUTHORIZATION

Each of the undersigned declares that:

I/We authorize any medical professional, hospital or other medical institution, insurer, MIB, Inc., or any other person or organization that has any records or knowledge of me/us or my/our physical or mental health or insurability to disclose that information to the Company, its reinsurers, or any other party acting on the Company's behalf. I/We authorize the Company or its reinsurer to make a brief report of my protected health information to MIB, Inc. I/We authorize the Company to disclose information related to my insurability to other insurers to whom I/we may apply for coverage.

I/We acknowledge receipt of the Privacy Notice and the Important Notice containing the Investigative Consumer Report and MIB, Inc. information.

The authorization shall be valid for 24 months after it is signed. A photographic copy of this authorization shall be as valid as the original. I/We understand that I/we may revoke this authorization at any time by written notification to the Company; however, any action taken prior to notification will not be affected.

The purpose of this authorization is to allow the Company to determine eligibility for life coverage or a claim for benefits under a life policy.

I elect to be interviewed if an Investigative Consumer Report is prepared.

SIGNATORY SECTION

Signed in _____, this _____ day of _____
(state) (month) (year)

Signature of Proposed Insured
(Parent or Guardian if under 14 years of age)

Signature of Applicant/Owner/Trustee (If other than Proposed Insured)
(Provide Officer's Title if policy is owned by a Corporation)

TO BE COMPLETED BY AGENT ONLY

- (i) Does the applicant have any existing life insurance policies or annuities? Yes No
- (ii) Do you know or have you any reason to believe that replacement of insurance is involved? Yes No
If a replacement is involved, I certify that only company approved sales materials were used in this sale and that copies of all sales materials were left with the applicant.
- (iii) I declare that I asked the Proposed Insured each question on the application. The answers have been recorded by me exactly as stated and I know of nothing affecting the insurability of the Proposed Insured which is not fully recorded in this application.
- (iv) Identify any special compensation instructions or commission schedule or Check here if there is no special commission program:

Signature of Licensed Agent, Broker or Registered Representative

Name of Licensed Agent, Broker or Registered Representative
(Please Print)

APPLICABLE TO VARIABLE LIFE ONLY

I have reviewed the Application, New Account Form and Premium Allocation and Disclosure Form and find the transaction suitable.

Signature of Registered Principal of Broker/Dealer

Name of Registered Principal of Broker/Dealer (Please Print)

IMPORTANT NOTICE

Since you are applying for insurance, we would like you to know more about our underwriting process, and what occurs after you submit your application.

THE UNDERWRITING PROCESS

All forms of insurance are based on the concept of risk-sharing. Underwriters seek to determine the level of risk represented by each applicant, and then assign that person to a group with similar risk characteristics. In this way, the risk potential can be spread among all policyholders within a given risk group, assuring that each assumes his fair share of the insurance cost.

Underwriters collect and review risk factors such as age, occupation, physical condition, medical history and any hazardous avocations. The level of risk and premium for the amount of coverage requested is based on this information.

INVESTIGATIVE CONSUMER REPORT

As a part of our routine procedure for processing your initial application, we may request an investigative consumer report. The agency making the report may keep a copy of the report and disclose its contents to others for whom it performs similar services. The report typically includes information such as identity and residence verification, character, reputation, marital status, estimate of net worth and income, occupation, avocations, medical history, habits, mode of living and other personal characteristics. Additional information is usually obtained from several different sources. Confidential interviews are conducted with neighbors, friends, business associates, and acquaintances. Public records are carefully reviewed.

Past experience shows that information from investigative reports usually does not have an adverse effect on our underwriting decision. If it should, we will notify you in writing and identify the reporting agency. At that point, if you wish to do so, you may discuss the matter with the reporting agency.

You have the right to be interviewed as part of any investigative consumer report that is completed. If you desire such an interview, please indicate this at the time your application is submitted. If you request it, we will supply the name, address and telephone number of the consumer reporting agency so you may obtain a copy of the report.

CONTESTABILITY

We strongly urge you to review the completed application closely for accuracy. During the 2 year incontestability period described in the policy, a claim may be denied if the application contains false statements or misrepresentations or fails to disclose material facts. In such a case, the policy could be void and coverage could be lost.

MIB, INC.

Information you provide regarding your insurability or claims will be treated as confidential except that The Company or its reinsurers, may make a brief report of it to MIB, Inc. This is a nonprofit membership organization of life insurance companies which operates an information exchange on behalf of its members. Upon request by another member insurance company to which you have applied for life or health insurance coverage or submitted a claim, MIB, Inc. will provide the information it may have in its file.

Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB, Inc.'s file, you may contact MIB at: [50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734]. You can reach MIB by phone toll free at [(866) 692-6901]. [(TTY {866} 346-3642)]

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INVESTIGATIVE CONSUMER REPORT

As a part of our routine procedure for processing your initial application, we may request an investigative consumer report. The agency making the report may keep a copy of the report and disclose its contents to others for whom it performs similar services. The report typically includes information such as identity and residence verification, character, reputation, marital status, estimate of net worth and income, occupation, avocations, medical history, habits, mode of living and other personal characteristics. Additional information is usually obtained from several different sources. Confidential interviews are conducted with neighbors, friends, business associates, and acquaintances. Public records are carefully reviewed.

Past experience shows that information from investigative reports usually does not have an adverse effect on our underwriting decision. If it should, we will notify you in writing and identify the reporting agency. At that point, if you wish to do so, you may discuss the matter with the reporting agency.

You have the right to be interviewed as part of any investigative consumer report that is completed. If you desire such an interview, please indicate this at the time your application is submitted. If you request it, we will supply the name, address and telephone number of the consumer reporting agency so you may obtain a copy of the report.

CONTESTABILITY

We strongly urge you to review the completed application closely for accuracy. During the 2 year contestability period described in the policy, a claim may be denied if the application contains false statements or misrepresentations or fails to disclose material facts. In such a case, the policy could be void and coverage could be lost.

MIB, INC.

Information you provide regarding your insurability or claims will be treated as confidential except that The Company or its reinsurers, may make a brief report of it to MIB, Inc. This is a nonprofit membership organization of life insurance companies which operates an information exchange on behalf of its members. Upon request by another member insurance company to which you have applied for life or health insurance coverage or submitted a claim, MIB, Inc. will provide the information it may have in its file.

Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB, Inc.'s file, you may contact MIB at: [50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734]. You can reach MIB by phone toll free at [(866) 692-6901]. [(TTY {866} 346-3642)]

APPLICATION FOR LIFE INSURANCE - PART I

APPLICANT INFORMATION - PROPOSED INSURED A (Required Section)		
1. Proposed Insured A <i>(First, Middle, Last)</i>	2. <input type="checkbox"/> Male <input type="checkbox"/> Female	
3. Date of Birth (If over age [70], please complete Section D) <i>(mm/dd/yy)</i>	4. Soc. Sec. No.	5. Are you a citizen of the United States? <input type="checkbox"/> Y <input type="checkbox"/> N If "No," what country?
6. Place of Birth <i>(State, Country)</i>	7. Driver's License # & State	
8. Home Address <i>(Street, City, State, ZIP)</i>		
9. Occupation/Duties	10. Employer	
11. Business Address <i>(Street, City, State, ZIP)</i>		
12. Annual Earned Income \$	13. Annual Unearned Income \$	14. Net Worth \$
15. In the last 5 years have you filed for bankruptcy? <input type="checkbox"/> Y <input type="checkbox"/> N <i>(If "Yes," please complete the Financial Supplement.)</i>	16. Primary Phone # <input type="checkbox"/> AM <input type="checkbox"/> PM	17. Work Phone # <input type="checkbox"/> AM <input type="checkbox"/> PM

COVERAGE INFORMATION (As available per product)

18. Plan of Insurance _____ 19. Amount of Insurance \$ _____
(Specified Amount, if UL or VUL)

20. (i) Death Benefit Option *(Complete for Universal Life and Variable Universal Life Product only - not required for Term or Whole Life.)*
 Level Increase by Cash Value Increase by Premium Increase by Premium Less Policy Factor

(ii) Death Benefit Qualification Test (DBQT) - For IRS purposes, premiums will be tested using the Guideline Premium Test unless
 Cash Value Accumulation Test is checked (not available on all products or with all riders).
The DBQT cannot be changed after issue unless the terms of the policy require a change.

21. Save Age? Y N *(If not saving age, policy will be current dated.)*

22. Additional Benefits and Riders: <i>(If applicable)</i>	<input type="checkbox"/> Waiver of Premium
<input type="checkbox"/> Supplemental Coverage \$ _____	<input type="checkbox"/> Waiver of Monthly Deductions
<input type="checkbox"/> Term on Spouse/Other Insured Rider \$ _____ <i>(Please complete Section B - Applicant Information - Proposed Insured B)</i>	<input type="checkbox"/> Waiver of Specified Premium \$ _____
<input type="checkbox"/> Accelerated Benefit Rider	<input type="checkbox"/> Children's Term Insurance Rider <i>(Complete Child's Supplement)</i>
<input type="checkbox"/> Other Benefits and Riders <i>(not listed above)</i> . (Please provide full details: e.g. coverage amounts/percentages/etc.):	

BILLING INSTRUCTIONS (As available per product)

23. Premium Mode: Annual Semi-Annual Quarterly Monthly (EFT) Other _____

24. Modal Planned Premium: \$ _____ 25. Lump Sum: \$ _____ 1035 Exchange

26. Special Billing: *(check one, if applicable)* New List Bill Existing List Bill Number: _____

27. Source of Premium: _____ 28. Automatic Premium Loan: Y N
(inheritance, loan, business activity) *(Complete for Whole Life only.)*

29. Premium Notices To: *(check one only.) (Please note we cannot bill to your agent.)*
 Owner in Question 31 Owner in Question 37 Insured at Business Insured at Residence Other *(indicate below)*

30. Special Instructions:

OWNER INFORMATION (If left blank, Proposed Insured(s) will be owner)

31. Owner Name	
32. Owner Address	
33. Relationship to Proposed Insured(s)	34. Owner Soc. Sec. No. / TIN
35. Date of Birth/Trust Date	36. Citizen of (Country)
37. Owner Name	
38. Owner Address	
39. Relationship to Proposed Insured(s)	40. Owner Soc. Sec. No. / TIN
41. Date of Birth/Trust Date	42. Citizen of (Country)
43. Is this policy being purchased as part of an employer owned life insurance program where the employer is the direct or indirect beneficiary of the policy? <input type="checkbox"/> Y <input type="checkbox"/> N	

BENEFICIARY DESIGNATION (Unless otherwise stated below, if multiple beneficiaries are named in a class (Primary, Contingent), the proceeds are to be paid equally to the survivor or survivors, if any, in the class.)

Select Primary (P) or Contingent (C) Beneficiary for each line completed. If Trust, check here .

44. <input type="checkbox"/> P <input type="checkbox"/> C	a. Name/Trust name & Trustees	b. Soc. Sec. No./TIN
		c. Relationship to Proposed Insured
45. <input type="checkbox"/> P <input type="checkbox"/> C	a. Name/Trust name & Trustees	b. Soc. Sec. No./TIN
		c. Relationship to Proposed Insured
46. <input type="checkbox"/> P <input type="checkbox"/> C	a. Name/Trust name & Trustees	b. Soc. Sec. No./TIN
		c. Relationship to Proposed Insured
47. <input type="checkbox"/> P <input type="checkbox"/> C	a. Name/Trust name & Trustees	b. Soc. Sec. No./TIN
		c. Relationship to Proposed Insured
48.	Special Instructions	

APPLICANT INFORMATION - PROPOSED INSURED A

49. Are you considering stopping premium payments, surrendering, replacing, forfeiting, assigning to the insurer or reducing your benefits under an existing policy or annuity, or are you considering using or borrowing funds from your existing policies or annuities to pay premiums due on the new or applied for policy? Y N
(If "Yes", please complete and sign all required replacement forms.)

50. Please list amounts of all inforce life insurance on your life, including any policies that have been sold. *(Please list in the box below.)*

If none, check this box:

Please indicate the Type of coverage: Business (B); Key Person (K); or Personal (P).

Company	Face Amount	Policy Number	Issue Date (mm/dd/yy)	Replacement or Change of Policy?	1035 Exchange	Type
	\$			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
	\$			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
	\$			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
	\$			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	

51. Do you have any applications currently pending or do you plan to apply for new life or disability insurance coverage with any other company? (If "Yes," please provide details in the space provided.) Y N

Company	Amount	Type (Life or Disability)	Reason Policy Applied For
	\$		
	\$		

52. What is the total amount of new life insurance coverage that will be placed in force with all companies including this application? \$ _____

53. Is this policy being funded via a premium financing loan or with funds borrowed, advanced or paid from another person or entity? (If "Yes", please complete the Premium Financing Supplement.) Y N

54. Have you ever applied for life, health or disability insurance and been declined, postponed or charged an increased premium? (If "Yes", provide further information in the "Details" space provided.) Y N

GENERAL RISK INFORMATION - PROPOSED INSURED A

55. Do you now, or do you plan to fly, or have you flown during the past 2 years, as a pilot, student pilot or crew member? (If "Yes", an Aviation Supplement is required; this includes balloon pilots.) Y N

56. Do you plan to participate, or have you participated within the past 2 years; in motor vehicle or boat racing, in hang gliding, sky or scuba diving, or mountain, rock or technical climbing; or in similar sports? (If "Yes", an Avocation Supplement is required.) Y N

57. Do you now, or do you plan to reside or travel outside of the United States or Canada within the next year? (If "Yes", a Foreign Travel or Residence Supplement is required.) Y N

58. In the past 5 years, have you been convicted of two or more moving violations, driving under the influence of alcohol or other drugs, or had your driver's license suspended, restricted or revoked? (If "Yes," please indicate what type and dates in the "Details" space provided.) Y N

59. Have you ever been convicted of or are you awaiting trial for a felony? (If "Yes", please indicate type, date and city/state of felony and if currently on probation or parole, in the "Details" space provided.) Y N

60. Are you a member of, or applied to be a member of, or received a notice of required service in, the armed forces, reserves or National Guard? (If "Yes", please indicate if Retired or active; list branch of service, rank, duties, mobilization category and current duty station; if a notice of deployment has been received, to where and when; in the "Details" space provided.) Y N

61. Have you ever used tobacco or products containing nicotine (including, but not limited to, chew tobacco, snuff, nicotine gum and/or patches)? (If "Yes", list below.) Y N

Type:	Date First Used: (month/year)	Date Last Used: (month/year)	Amount and Frequency:

MEDICAL INFORMATION - PROPOSED INSURED A (Answer this section only when required.)

62. Provide full name/address/phone number of personal physician(s) and any other physicians seen within the past 5 years.

a. Date and reason of last visit:

b. Tests performed & treatment received:

63. Height _____ ft. / _____ in. a. Has your weight changed by more than 10 pounds during the past 12 months? Y N
 Weight _____ lbs. b. If "Yes," by how many pounds? _____ Gain Loss

64.	Age if Living & Health Status	Diabetes, Cancer, Heart Disease? (include age of onset)	Age at Death & Cause
a. Father			
b. Mother			
c. Sibling(s)			

65. **Details:** (List details from questions answered "Yes" and please specify to which question numbers details pertain.)

SECTION A - HEALTH SUMMARY

APPLICANT INFORMATION - PROPOSED INSURED A

(Complete if not submitting a Medical Supplement - Part II of Application or to initiate underwriting process. See Underwriting Guidelines for further details.)

1. Proposed Insured A <i>(First, Middle, Last)</i>	2. Date of Birth <i>(mm/dd/yy)</i>
► If you answer "Yes" to any of the following questions, please provide further information in the "Details" space provided.	
	Yes No
3. Have you had or been advised by a licensed medical professional to have a check-up, EKG, x-ray, blood or urine test or any other diagnostic test or are you now planning to seek medical advice or treatment for any reason?	<input type="checkbox"/> <input type="checkbox"/>
4. Have you been a patient in a hospital, clinic, sanatorium or other medical facility, or been advised by a licensed medical professional to have any hospitalization or surgery which has not been completed?	<input type="checkbox"/> <input type="checkbox"/>
5. Have you ever had any indication of, or been treated by a licensed medical professional for:	
a. Chest pain, palpitations, high blood pressure, heart disease, heart murmur, heart failure or other disorders of the heart or blood vessels?	<input type="checkbox"/> <input type="checkbox"/>
b. Any tumor, cancer, cysts, melanoma, lymphoma or any disorder of the lymph nodes?	<input type="checkbox"/> <input type="checkbox"/>
c. Anemia, leukemia, clotting disorder or any other blood disorder?	<input type="checkbox"/> <input type="checkbox"/>
d. Diabetes, elevated blood sugar, thyroid, or other endocrine or glandular disorder?	<input type="checkbox"/> <input type="checkbox"/>
e. Asthma, emphysema, allergies, sleep apnea, tuberculosis, sarcoidosis, persistent hoarseness or shortness of breath or any other disorder of the respiratory system?	<input type="checkbox"/> <input type="checkbox"/>
f. Seizures, fainting, dizziness, epilepsy, stroke, paralysis or other neurologic or brain disorder?	<input type="checkbox"/> <input type="checkbox"/>
g. Any nervous, mental, or emotional disorder, or received counseling for anxiety, depression, stress or any other emotional condition?	<input type="checkbox"/> <input type="checkbox"/>
h. Ulcers, colitis, jaundice, hepatitis, cirrhosis, gastrointestinal bleeding, or other disorder of the stomach, esophagus, liver, intestines, gallbladder, or pancreas?	<input type="checkbox"/> <input type="checkbox"/>
i. Any complications of pregnancy or disorder of the testicles, prostate, breasts, ovaries, uterus, cervix, kidney or urinary bladder?	<input type="checkbox"/> <input type="checkbox"/>
j. Arthritis, gout, or any disorder of the back, spine, muscles, nerves, bones, joints or skin?	<input type="checkbox"/> <input type="checkbox"/>
k. Any disorder of the eyes, ears, nose or throat?	<input type="checkbox"/> <input type="checkbox"/>
l. Any mental or physical disorder or medically or surgically treated condition not listed above?	<input type="checkbox"/> <input type="checkbox"/>
6. Have you ever been diagnosed as having or been treated by a licensed medical professional for Acquired Immune Deficiency Syndrome or an AIDS related condition?	<input type="checkbox"/> <input type="checkbox"/>
7. Do you use alcoholic beverages? <i>(If "Yes", provide Type, Frequency & Amount.)</i>	<input type="checkbox"/> <input type="checkbox"/>
Type _____ Frequency _____ Amount _____	
8. Have you ever been treated for drug or alcohol abuse or been advised by a licensed medical professional to limit your use of alcohol or any medication, prescribed or not?	<input type="checkbox"/> <input type="checkbox"/>
9. In the past 5 years have you used or experimented with cocaine, marijuana, or other non-prescription stimulants, depressants, or narcotics?	<input type="checkbox"/> <input type="checkbox"/>
10. List all medication and dosages you are currently taking or have taken in the last 30 days, including prescriptions, over the counter drugs, aspirin and herbal supplements.	
11. Details: <i>(List details from questions answered "Yes" and please specify to which question numbers details pertain.)</i>	

SECTION B - ADDITIONAL INSURED

APPLICANT INFORMATION - PROPOSED INSURED B

1. Proposed Insured B <i>(First, Middle, Last)</i>		2. <input type="checkbox"/> Male <input type="checkbox"/> Female	
3. Date of Birth (If over age [70] please complete Section D) <i>(mm/dd/yy)</i>	4. Soc. Sec. No.	5. Are you a citizen of the United States? <input type="checkbox"/> Y <input type="checkbox"/> N If "No," what country?	
6. Place of Birth <i>(State, Country)</i>	7. Driver's License # & State		
8. Home Address <i>(Street, City, State, ZIP)</i>			
9. Occupation/Duties		10. Employer	
11. Business Address <i>(Street, City, State, ZIP)</i>			
12. Annual Earned Income \$		13. Annual Unearned Income \$	
14. Net Worth \$			
15. In the last 5 years have you filed for bankruptcy? <input type="checkbox"/> Y <input type="checkbox"/> N <i>(If "Yes," please complete the Financial Supplement.)</i>	16. Primary Phone # <input type="checkbox"/> AM <input type="checkbox"/> PM	17. Work Phone # <input type="checkbox"/> AM <input type="checkbox"/> PM	

18. Beneficiary for applicable Rider: a. Name		
b. Soc Sec. No./TIN	c. Relationship to Proposed Insured B	

19. Are you considering stopping premium payments, surrendering, replacing, forfeiting, assigning to the insurer or reducing your benefits under an existing policy or annuity, or are you considering using or borrowing funds from your existing policies or annuities to pay premiums due on the new or applied for policy? Y N
(If "Yes", please complete and sign all required replacement forms.)

20. Please list amounts of all inforce life insurance on your life, including any policies that have been sold. *(Please list in the box below.)*
If none, check this box:
 Please indicate the Type of coverage: Business **(B)**; Key Person **(K)**; or Personal **(P)**.

Company	Face Amount	Policy Number	Issue Date <i>(mm/dd/yy)</i>	Replacement or Change of Policy?	1035 Exchange	Type
	\$			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
	\$			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
	\$			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
	\$			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	

21. Do you have any applications currently pending or do you plan to apply for new life or disability insurance coverage with any other company? *(If "Yes," please provide details in the space provided.)* Y N

Company	Amount	Type (Life or Disability)	Reason Policy Applied For
	\$		
	\$		

22. What is the total amount of new life insurance coverage that will be placed inforce with all companies including this application? \$ _____

23. Is this policy being funded via a premium financing loan or with funds borrowed, advanced or paid from another person or entity? *(If "Yes", please complete the Premium Financing Supplement.)* Y N

24. Have you ever applied for life, health or disability insurance and been declined, postponed or charged an increased premium? *(If "Yes", provide further information in the "Details" space provided.)* Y N

GENERAL RISK INFORMATION - PROPOSED INSURED B

25. Do you now, or do you plan to fly, or have you flown during the past 2 years, as a pilot, student pilot or crew member? *(If "Yes", an Aviation Supplement is required; this includes balloon pilots.)* Y N

26. Do you plan to participate, or have you participated within the past 2 years; in motor vehicle or boat racing, in hang gliding, sky or scuba diving, or mountain, rock or technical climbing; or in similar sports? *(If "Yes", an Avocation Supplement is required.)* Y N

27. Do you now, or do you plan to reside or travel outside of the United States or Canada within the next year? *(If "Yes", a Foreign Travel or Residence Supplement is required.)* Y N

28. In the past 5 years, have you been convicted of two or more moving violations, driving under the influence of alcohol or other drugs, or had your driver's license suspended, restricted or revoked? *(If "Yes," please indicate what type and dates in space provided below.)* Y N

29. Have you ever been convicted of or are you awaiting trial for a felony? *(If "Yes", please indicate type, date and city/state of felony and if currently on probation or parole, in space provided below.)* Y N

30. Are you a member of, or applied to be a member of, or received a notice of required service in, the armed forces, reserves or National Guard? *(If "Yes", please indicate if Retired or active; list branch of service, rank, duties, mobilization category and current duty station; if a notice of deployment has been received, to where and when; on the space provided below.)* Y N

31. Have you ever used tobacco or products containing nicotine (including, but not limited to, chew tobacco, snuff, nicotine gum and/or patches)? *(If "Yes", list below.)* Y N

Type	Date First Used: <i>(month/year)</i>	Date Last Used: <i>(month/year)</i>	Amount and Frequency:

MEDICAL INFORMATION - PROPOSED INSURED B *(Answer this section only when required.)*

32. Provide full name/address/phone number of personal physician(s) and any other physicians seen within the past 5 years.

a. Date and reason of last visit:

b. Tests performed & treatment received:

33. Height _____ ft. / _____ in. a. Has your weight changed by more than 10 pounds during the past 12 months? Y N
 Weight _____ lbs. b. If "Yes," by how many pounds? _____ Gain Loss

34.	Age if Living & Health Status	Diabetes, Cancer, Heart Disease? <i>(include age of onset)</i>	Age at Death & Cause
a. Father			
b. Mother			
c. Sibling(s)			

35. **Details:** *(List details from questions answered "Yes" and please specify to which question numbers details pertain.)*

SECTION C - HEALTH SUMMARY

APPLICANT INFORMATION PROPOSED INSURED B

(Complete if not submitting a Medical Supplement - Part II of Application or to initiate underwriting process. See Underwriting Guidelines for further details.)

1. Proposed Insured B <i>(First, Middle, Last):</i>	2. Date of Birth <i>(mm/dd/yy):</i>
► If you answer "Yes" to any of the following questions, please provide further information in the "Details" space provided.	
	Yes No
3. Have you had or been advised by a licensed medical professional to have a check-up, EKG, x-ray, blood or urine test or any other diagnostic test or are you now planning to seek medical advice or treatment for any reason?	<input type="checkbox"/> <input type="checkbox"/>
4. Have you been a patient in a hospital, clinic, sanatorium or other medical facility, or been advised by a licensed medical professional to have any hospitalization or surgery which has not been completed?	<input type="checkbox"/> <input type="checkbox"/>
5. Have you ever had any indication of, or been treated by a licensed medical professional for:	
a. Chest pain, palpitations, high blood pressure, heart disease, heart murmur, heart failure or other disorders of the heart or blood vessels?	<input type="checkbox"/> <input type="checkbox"/>
b. Any tumor, cancer, cysts, melanoma, lymphoma or any disorder of the lymph nodes?	<input type="checkbox"/> <input type="checkbox"/>
c. Anemia, leukemia, clotting disorder or any other blood disorder?	<input type="checkbox"/> <input type="checkbox"/>
d. Diabetes, elevated blood sugar, thyroid, or other endocrine or glandular disorder?	<input type="checkbox"/> <input type="checkbox"/>
e. Asthma, emphysema, allergies, sleep apnea, tuberculosis, sarcoidosis, persistent hoarseness or shortness of breath or any other disorder of the respiratory system?	<input type="checkbox"/> <input type="checkbox"/>
f. Seizures, fainting, dizziness, epilepsy, stroke, paralysis or other neurologic or brain disorder?	<input type="checkbox"/> <input type="checkbox"/>
g. Any nervous, mental, or emotional disorder, or received counseling for anxiety, depression, stress or any other emotional condition?	<input type="checkbox"/> <input type="checkbox"/>
h. Ulcers, colitis, jaundice, hepatitis, cirrhosis, gastrointestinal bleeding, or other disorder of the stomach, esophagus, liver, intestines, gallbladder, or pancreas?	<input type="checkbox"/> <input type="checkbox"/>
i. Any complications of pregnancy or disorder of the testicles, prostate, breasts, ovaries, uterus, cervix, kidney or urinary bladder?	<input type="checkbox"/> <input type="checkbox"/>
j. Arthritis, gout, or any disorder of the back, spine, muscles, nerves, bones, joints or skin?	<input type="checkbox"/> <input type="checkbox"/>
k. Any disorder of the eyes, ears, nose or throat?	<input type="checkbox"/> <input type="checkbox"/>
l. Any mental or physical disorder or medically or surgically treated condition not listed above?	<input type="checkbox"/> <input type="checkbox"/>
6. Have you ever been diagnosed as having or been treated by a licensed medical professional for Acquired Immune Deficiency Syndrome or an AIDS related condition?	<input type="checkbox"/> <input type="checkbox"/>
7. Do you use alcoholic beverages? <i>(If "Yes", provide Type, Frequency & Amount.)</i>	<input type="checkbox"/> <input type="checkbox"/>
Type _____ Frequency _____ Amount _____	
8. Have you ever been treated for drug or alcohol abuse or been advised by a licensed medical professional to limit your use of alcohol or any medication, prescribed or not?	<input type="checkbox"/> <input type="checkbox"/>
9. In the past 5 years have you used or experimented with cocaine, marijuana, or other non-prescription stimulants, depressants, or narcotics?	<input type="checkbox"/> <input type="checkbox"/>
10. List all medication and dosages you are currently taking or have taken in the last 30 days, including prescriptions, over the counter drugs, aspirin and herbal supplements.	
11. Details: <i>(List details from questions answered "Yes" and please specify to which question numbers details pertain.)</i>	

SECTION D - DEFINED AGE QUESTIONNAIRE
(Complete if either Proposed Insured is age [70] or over.)

1. Proposed Insured A *(First, Middle, Last)* _____

2. Proposed Insured B *(First, Middle, Last)* _____

	Proposed Insured A	Proposed Insured B
3. Will you, the proposed insured and/or beneficiary, and/or any entity on your behalf, receive any compensation as an inducement to purchase the policy, whether via the form of cash, property, an agreement to receive money in the future, or otherwise, if this policy is issued?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
4. Have you, the proposed insured, been involved in any discussion about the possible sale or assignment of this policy to an unrelated third party, as an inducement to purchase the life insurance policy? Have you been involved in any discussion about the possible sale or assignment of a beneficial interest in a trust, limited liability company or other entity created or to be created on your behalf which will have an ownership or beneficial interest in this policy?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
5. Have you, the proposed insured, been involved in any discussion about the projected value of this policy in a future sale to an unrelated third party? Do you, the proposed insured, understand that estimated values of policies in the life settlement or other secondary marketplace are not guaranteed and that you may not be able to sell your policy for any amount in excess of the cash surrender value?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
6. Have you, the proposed insured, ever sold a policy to a life settlement, viatical or other secondary market provider, or are you in the process of selling a policy?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
7. Details: <i>(List details from questions answered "Yes" and please specify to which question numbers details pertain.)</i>		

OWNER INFORMATION

	Owner
8. Owner Name _____	
9. Will you, the proposed owner and/or beneficiary, and/or any entity on your behalf, receive any compensation as an inducement to purchase the policy, whether via the form of cash, property, an agreement to receive money in the future, or otherwise, if this policy is issued?	<input type="checkbox"/> Y <input type="checkbox"/> N
10. Have you, the proposed owner, been involved in any discussion about the possible sale or assignment of this policy to an unrelated third party, as an inducement to purchase the life insurance policy? Have you been involved in any discussion about the possible sale or assignment of a beneficial interest in a trust, limited liability company or other entity created or to be created on your behalf?	<input type="checkbox"/> Y <input type="checkbox"/> N
11. Have you, the owner, been involved in any discussion about the projected value of this policy in a future sale to an unrelated third party? Do you, the owner, understand that estimated values of policies in the life settlement or other secondary marketplace are not guaranteed and that you may not be able to sell your policy for any amount in excess of the cash surrender value?	<input type="checkbox"/> Y <input type="checkbox"/> N
12. Is this policy being funded via a premium financing loan or with funds borrowed, advanced or paid from another person or entity? <i>(If "Yes", please complete the Premium Financing Application Supplement.)</i>	<input type="checkbox"/> Y <input type="checkbox"/> N
13. Details: <i>(List details from questions answered "Yes" and please specify to which question numbers details pertain.)</i>	

SERVICE OFFICE ENDORSEMENTS (For Company Use Only. We will attach additional documentation as needed.)

SUITABILITY

Complete only if applying for Variable Life Insurance and submit allocation form(s) with this Application:

1. Have you, the Proposed Insured(s) and the Owner, if other than the Proposed Insured(s), received a current Prospectus for the policy applied for and have you had sufficient time to review it?	<input type="checkbox"/> Y <input type="checkbox"/> N
2. Do you understand that the amount and duration of the death benefit may increase or decrease depending on the investment performance of funds in the Separate Account?	<input type="checkbox"/> Y <input type="checkbox"/> N
3. Do you understand that the cash values may increase or decrease depending on the investment performance of the funds held in the Separate Account?	<input type="checkbox"/> Y <input type="checkbox"/> N
4. With this in mind, do you believe that the policy applied for is in accord with your insurance objective and your anticipated financial needs?	<input type="checkbox"/> Y <input type="checkbox"/> N

CASH VALUES MAY INCREASE OR DECREASE IN ACCORDANCE WITH THE EXPERIENCE OF THE SEPARATE ACCOUNT. THE DEATH BENEFIT MAY BE VARIABLE OR FIXED UNDER SPECIFIED CONDITIONS.

AGREEMENT AND ACKNOWLEDGEMENT

I, the Owner, certify that the tax identification or social security number as provided by me is correct. I also certify that I am not subject to backup withholding.

Each of the Undersigned declares that:

1. This Application consists of: a) Part I (including Sections A-D if needed); b) Part II Medical Application, if required; c) any amendments to the application(s) attached thereto; and d) any supplements, all of which are required by the Company for the plan, amount and benefits applied for. This Application for Life Insurance - Part I shall be complete when it includes Applicant Information - Proposed Insured A, and any or none of the following (please check, as applicable, included Sections A-D):

- Section A- Health Summary -Proposed Insured A, Section B- Applicant Information -Proposed Insured B,
 Section C -Health Summary -Proposed Insured B, and Section D - Defined Age Questionnaire.

2. I/We further agree that (except as provided in the Temporary Life Insurance Agreement if advance payment has been made and acknowledged below and such Agreement issued), insurance will take effect under the Policy only when: 1) the Policy has been delivered to and accepted by me/us; 2) the initial premium has been paid in full during the lifetime of the Proposed Insured(s); and 3) the Proposed Insured(s) remain in the same state of health and insurability as described in each part of the application at the time conditions 1) and 2) are met.

I/We have paid \$ _____ to the Agent/Representative in exchange for the Temporary Life Insurance Agreement, and I/we acknowledge that I/we fully understand and accept its terms. (Please complete Temporary Life Insurance Agreement and submit with application.)

3. No agent, broker or medical examiner has the authority to make or modify any Company contract or to waive any of the Company's requirements.
4. I HAVE READ, or have had read to me, the completed Application for Life Insurance before signing below. All statements and answers in this application are correctly recorded, and are full, complete and true. I confirm that upon receipt of the contract I will review the answers recorded on the application. I will notify the Company immediately if any information in the application is incorrect. Caution: If your answers on this application are incorrect or untrue, the Company may have the right to deny benefits or rescind coverage under the policy and any riders attached to it.
5. For employer owned life insurance policies, the owner hereby acknowledges its sole responsibility for ensuring that it complies with all legal and regulatory requirements related to life insurance it purchases on its employees, including appropriate disclosure to each employee whose life is insured under such a life insurance policy.
6. Corrections, additions or changes to this application may be made by the Company. Any such changes will be shown under "Service Office Endorsements". Acceptance of a policy issued with such changes will constitute acceptance of the changes. No change will be made in classification (including age at issue), plan, amount, or benefits unless agreed to in writing by the Applicant.

STATE DISCLOSURES

All jurisdictions except AR, AZ, CT, DC, FL, KS, KY, LA, ME, MN, NJ, NM, OH, OK, PA, TX, VA and WA. Any person who, with intent to defraud or knowing that he/she is facilitating fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

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

TRUST VERIFICATION

I/We hereby certify that the Trustee(s) named in this application are the Trustee(s) for the named Trust, which is in full force and effect. The Company assumes no obligation to inquire into the terms of any trust agreement affecting this policy and shall not be held liable for any party's compliance with the terms thereof. The Company may rely solely upon the signature(s) of the Trustee(s) named in this application to any receipt, release or waiver, or to any transfer or other instrument affecting this policy or any options, privileges or benefits thereunder. Unless otherwise indicated, the signature(s) of all Trustee(s) named, or their successors, will be required to exercise any contractual right under the policy. The Company shall have no obligation to see to the use or application of any funds paid to the Trustee(s) in accordance with the terms of the policy. Any such payment made by the Company to the Trustee(s) shall fully discharge the Company with respect to any amounts so paid.

AUTHORIZATION

Each of the undersigned declares that:

I/We authorize any medical professional, hospital or other medical institution, insurer, MIB, Inc., or any other person or organization that has any records or knowledge of me/us or my/our physical or mental health or insurability to disclose that information to the Company, its reinsurers, or any other party acting on the Company's behalf. I/We authorize the Company or its reinsurer to make a brief report of my protected health information to MIB, Inc. I/We authorize the Company to disclose information related to my insurability to other insurers to whom I/we may apply for coverage.

I/We acknowledge receipt of the Privacy Notice and the Important Notice containing the Investigative Consumer Report and MIB, Inc. information.

This authorization shall be valid for 24 months after it is signed. A photographic copy of this authorization shall be as valid as the original. I/We understand that I/we may revoke this authorization at any time by written notification to the Company; however, any action taken prior to notification will not be affected.

The purpose of this authorization is to allow the Company to determine eligibility for life coverage or a claim for benefits under a life policy.

I elect to be interviewed if an Investigative Consumer Report is prepared.

SIGNATORY SECTION

Signed in _____, this _____ day of _____ (state) (month) (year)

Signature of Proposed Insured A
(Parent or Guardian if under 14 years of age)

Signature of Proposed Insured B (If coverage applied for)
(Parent or Guardian if under 14 years of age)

Signature of Applicant/Owner/Trustee (If other than Proposed Insured)
(Provide Officer's Title if policy is owned by a Corporation)

Signature of Applicant/Owner/Trustee (If other than Proposed Insured)
(Provide Officer's Title if policy is owned by a Corporation)

TO BE COMPLETED BY AGENT ONLY

(i) Does the applicant have any existing life insurance policies or annuities? Y N

(ii) Do you know or have you any reason to believe that replacement of insurance is involved? Y N

If a replacement is involved, I certify that only company approved sales materials were used in this sale and that copies of all sales materials were left with the applicant.

I declare that I have accurately answered all questions contained in this section.

I declare that I have provided each Proposed Insured and Owner(s) with the Important Notice as well as a copy of the Privacy Practices Notice.

Signature of Licensed Agent, Broker or Registered Representative

Name of Licensed Agent, Broker or Registered Representative
(Please Print)

APPLICABLE TO VARIABLE LIFE ONLY

I have reviewed the Application, Supplements, New Account Form and allocation forms and find the transaction suitable.

Signature of Registered Principal of Broker/Dealer

Name of Registered Principal of Broker/Dealer (Please Print)

IMPORTANT NOTICE

Since you are applying for insurance, we would like you to know more about our underwriting process and what occurs after you submit your application.

(Please give a copy of this notice to the Proposed Insured.)

THE UNDERWRITING PROCESS

All forms of insurance are based on the concept of risk-sharing. Underwriters seek to determine the level of risk represented by each applicant, and then assign that person to a group with similar risk characteristics. In this way, the risk potential can be spread among all policyholders within a given risk group, assuring that each assumes his fair share of the insurance cost.

Underwriters collect and review risk factors such as age, occupation, physical condition, and medical history. The level of risk and premium for the amount of coverage requested is based on this information.

CONTESTABILITY

We strongly urge you to review the completed application closely for accuracy. During the 2 year contestability period described in the policy, a claim may be denied if the application contains false statements or misrepresentations or fails to disclose material facts. In such a case, the policy could be void and coverage could be lost.

MIB, INC.

Information you provide regarding your insurability or claims will be treated as confidential except that The Company or its reinsurers, may make a brief report of it to MIB, Inc. This is a nonprofit membership organization of life insurance companies which operates an information exchange on behalf of its members. Upon request by another member insurance company to which you have applied for life or health insurance coverage or submitted a claim, MIB, Inc. will provide the information it may have in its file.

Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB, Inc.'s file, you may contact MIB at: [50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734]. You can reach MIB by phone toll free at [(866) 692-6901]. [(TTY {866} 346-3642)]

STREAMLINED APPLICATION FOR LIFE INSURANCE

1. Name (First, MI, Last)		2. Date of Birth (mm/dd/yy)	
3. Occupation	4. Soc. Sec. No. (SSN)		5. Are you a citizen of the United States? <input type="checkbox"/> Y <input type="checkbox"/> N If "No," do you have a valid Green Card? <input type="checkbox"/> Y <input type="checkbox"/> N
6. Place of Birth (State, Country)			
7. Home Address (St., City, ST, ZIP)			8. <input type="checkbox"/> Male <input type="checkbox"/> Female

9. Plan of Insurance _____ 10. Specified Amount/Amount of Insurance \$ _____

11. Additional Benefits and Riders: (If applicable) Accelerated Benefits Rider Other Benefits and Riders _____

12. Single Premium: \$ _____ 13. Planned Premium: \$ _____ Frequency _____

14. Lump Sum: \$ _____ 15. Source of Premium: _____ (inheritance, loan, business activity)

16. Owner Name	17. Date of Birth	18. SSN/TIN
19. Relationship	20. Citizen of (Country)	
21. Owner Address (St., City, ST, ZIP)		

22. Indicate Primary (P) or Contingent (C) Beneficiary for each line completed in the first column. **Unless otherwise stated below, if multiple beneficiaries are named in a class (Primary, Contingent), the proceeds are to be paid equally to the survivor or survivors, if any, in the class.**

P/C	Beneficiary Name	Relationship	Date of Birth	SSN/TIN

23. Are you considering stopping premium payments, surrendering, replacing, forfeiting, assigning to the insurer or reducing your benefits under an existing policy or annuity, or are you considering using or borrowing funds from your existing policies or annuities to pay premiums due on the new or applied for policy? Y N (If "Yes", please complete and sign all required replacement forms.)

24. Please list amounts of all inforce life insurance on your life, including any policies that have been sold. (Please list in the box below.)

If none, check this box: <input type="checkbox"/>	Face Amount	Policy Number	Issue Date (mm/dd/yy)	Replacement or Change of Policy?	1035 Exchange
Company	\$			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
	\$			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

25. Have you smoked any cigarettes in the past 12 months? Y N

26. In the past 10 years have you had, been diagnosed with or treated by a licensed medical professional for:

a. Heart disease, heart attack, heart failure or atrial fibrillation? Y N

b. Stroke, transient ischemic attack (TIA or mini-stroke), vascular disease, Alzheimer's disease, dementia, emphysema, chronic lung, kidney or liver disease? Y N

c. Diabetes requiring insulin? Y N

27. In the past 5 years have you been diagnosed with or treated by a licensed medical professional for:

a. Any type of cancer other than non-melanoma skin cancer? Y N

b. Alcohol or drug abuse, or been advised to limit your alcohol intake? Y N

28. Have you ever been diagnosed with or treated by a licensed medical professional for human immune deficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS)? Y N

29. In the past 5 years have you been declined or turned down for life insurance? Y N

30. Provide full details here for any questions answered "Yes" (Include question numbers and if more space is required, use the "Continuation of Details Supplement.):

31. Personal Physician's Name, Address and Telephone Number:

SERVICE OFFICE ENDORSEMENTS (For Company Use Only. We will attach additional documentation as needed.)

Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates.

AGREEMENT AND ACKNOWLEDGEMENT

I, the Owner, certify my TIN or SSN as provided by me is correct. I also certify that I am not subject to backup withholding.

Each of the Undersigned declares that:

1. This Application consists of: a) Application for Life Insurance; b) any amendments to the application(s) attached thereto; and c) any supplements, all of which are required by the Company for the plan, amount and benefits applied for.
2. No agent, broker or medical examiner has the authority to make or modify any Company contract or to waive any of the Company’s requirements.
3. I HAVE READ, or have had read to me, the completed Application for Life Insurance before signing below. All statements and answers in this application are correctly recorded, and are full, complete and true. I confirm that upon receipt of the contract I will review the answers recorded on the application. I will notify the Company immediately if any information in the application is incorrect. Caution: If your answers on this application are incorrect or untrue, the Company may have the right to deny benefits or rescind coverage under the policy and any riders attached to it.
4. For employer owned life insurance policies, the owner hereby acknowledges its sole responsibility for ensuring that it complies with all legal and regulatory requirements related to life insurance it purchases on its employees, including appropriate disclosure to each employee whose life is insured under such a life insurance policy.
5. Corrections, additions or changes to this application may be made by the Company. Any such changes will be shown under “Service Office Endorsements”. Acceptance of a policy issued with such changes will constitute acceptance of the changes. No change will be made in classification (including age at issue), plan, amount, or benefits unless agreed to in writing by the Applicant.

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

AUTHORIZATION - The undersigned declares that:

I authorize any medical professional, hospital or other medical institution, insurer, MIB, Inc., or any other person or organization that has any records or knowledge of me or my physical or mental health or insurability to disclose that information to the Company, its reinsurers, or any other party acting on the Company’s behalf. I authorize the Company or its reinsurer to make a brief report of my protected health information to MIB, Inc. I authorize the Company to disclose information related to my insurability to other insurers to whom I may apply for coverage. I understand that some of these people or entities may not be covered by federal or state privacy regulations and that the information they receive may be redisclosed, however the Company contractually requires them to protect the information we disclose to them. Information may be disclosed as allowed by law or regulation.

I acknowledge receipt of the Privacy Notice and the Important Notice containing the MIB, Inc. information.

This authorization shall be valid for 24 months after it is signed. A photographic copy of this authorization shall be as valid as the original. I understand this consent may be revoked in writing at any time, except to the extent: 1) the Company has taken action in reliance on this Authorization; or 2) the Company is using this Authorization in connection with a contestable claim under my policy with that Company.

Signed in _____, this _____ day of _____
(state) (month) (year)

Signature of Proposed Insured
(Parent or Guardian if under 14 years of age)

Signature of Applicant/Owner/Trustee (If other than Proposed Insured. Provide Officer’s Title if policy is owned by a Corporation)

TO BE COMPLETED BY AGENT ONLY

- (i) Does the applicant have any existing life insurance policies or annuities? Y N
- (ii) Do you know or have you any reason to believe that replacement of insurance is involved? Y N
If a replacement is involved, I certify that only company approved sales materials were used in this sale and that copies of all sales materials were left with the applicant.
- ▶ I declare that I have accurately answered all questions contained in this section. I know of nothing affecting the insurability of the Proposed Insured which is not fully recorded in this application. I declare that I have provided the Proposed Insured and Owner with the Important Notice as well as a copy of the Privacy Practices Notice. I declare that I have verified that all life insurance coverage in force on the Proposed Insured has been disclosed on this application, including any coverage that has been sold or is in the process of being sold to a life settlement, viatical or other secondary market provider.
- ▶ I declare I have not been involved in any recommendation regarding the possible sale or assignment of this policy to a life settlement, viatical or other secondary market provider. If otherwise, please explain: _____

Signature of Licensed Agent or Broker

Print Name of Licensed Agent or Broker

IMPORTANT NOTICE

Since you are applying for insurance, we would like you to know more about our underwriting process and what occurs after you submit your application.

(Please give a copy of this notice to the Proposed Insured.)

THE UNDERWRITING PROCESS

All forms of insurance are based on the concept of risk-sharing. Underwriters seek to determine the level of risk represented by each applicant, and then assign that person to a group with similar risk characteristics. In this way, the risk potential can be spread among all policyholders within a given risk group, assuring that each assumes his fair share of the insurance cost.

Underwriters collect and review risk factors such as age, occupation, physical condition, medical history, cognitive assessment and any hazardous avocations. The level of risk and premium for the amount of coverage requested is based on this information.

INVESTIGATIVE CONSUMER REPORT

As a part of our routine procedure for processing your initial application, we may request an investigative consumer report. The agency making the report may keep a copy of the report and disclose its contents to others for whom it performs similar services. The report typically includes information such as identity and residence verification, character, reputation, marital status, estimate of net worth and income, occupation, avocations, medical history, habits, mode of living and other personal characteristics. Additional information is usually obtained from several different sources. Confidential interviews are conducted with neighbors, friends, business associates, and acquaintances. Public records are carefully reviewed.

Past experience shows that information from investigative reports usually does not have an adverse effect on our underwriting decision. If it should, we will notify you in writing and identify the reporting agency. At that point, if you wish to do so, you may discuss the matter with the reporting agency.

You have the right to be interviewed as part of any investigative consumer report that is completed. If you desire such an interview, please indicate this at the time your application is submitted. If you request it, we will supply the name, address and telephone number of the consumer reporting agency so you may obtain a copy of the report.

CONTESTABILITY

We strongly urge you to review the completed application closely for accuracy. During the 2 year contestability period described in the policy, a claim may be denied if the application contains false statements or misrepresentations or fails to disclose material facts. In such a case, the policy could be void and coverage could be lost.

MIB, INC.

Information you provide regarding your insurability or claims will be treated as confidential except that the Company or its reinsurers, may make a brief report of it to MIB, Inc. This is a nonprofit membership organization of life insurance companies which operates an information exchange on behalf of its members. Upon request by another member insurance company to which you have applied for life or health insurance coverage or submitted a claim, MIB, Inc. will provide the information it may have in its file.

Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB, Inc.'s file, you may contact MIB at: [50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734]. You can reach MIB by phone toll free at [(866) 692-6901]. [(TTY {866} 346-3642)]

MONEYGUARD® APPLICATION FOR LIFE INSURANCE - PART I

PROPOSED INSURED <i>(Please Print in Blue or Black Ink)</i>			
1a. Name <i>(First, Middle Initial, Last)</i>		1b. <input type="checkbox"/> Male <input type="checkbox"/> Female	
1c. Residence Address <i>(No., Street, P.O. Box)</i>			
<i>(City, State, ZIP)</i>			
1d. US Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No		1e. Date of Birth <i>(mm/dd/yy)</i>	1f. Soc. Sec. No.

POLICY INFORMATION

2a. Specified Amount: \$ _____

2b. Convalescent Care Benefits Rider Duration: *(Select One)* 2 Years 3 Years Other (if applicable): _____ years

2c. Extension of Benefits Rider Duration: *(Select One)* None 2 Years 4 Years Other (if applicable): _____ years

2d. Optional Inflation Protection: *(Select One)* Rejected: No Optional Inflation Protection Elected
 Simple Increases 3% Other (if applicable): _____ %
 Compound Increases 3% 5% Other (if applicable): _____ %

2e. Other Benefits/Riders: _____

2f. Other Options/Protections: _____

BILLING INFORMATION

3. Premium Frequency: *(select one)*
 Single Premium amount: \$ _____
 Flexible Premium: *(select one)* Annual Semi-Annual Quarterly Monthly (PAC/EFT)
 Initial premium of \$ _____ and then \$ _____

EXISTING AND PENDING INSURANCE INFORMATION - PROPOSED INSURED

4a. Are you considering stopping premium payments, surrendering, replacing, forfeiting, assigning to the insurer, or reducing your benefits under an existing policy or annuity, or are you considering using or borrowing funds from your existing policies or annuities to pay premiums due on the new or applied for policy? Yes No
(If Yes, please complete and sign all required life insurance and annuity replacement forms and complete Question 4c.)

4b. Will the policy applied for replace any medical, health or long-term care insurance contract currently in force with this or any other company? Yes No
(If Yes, please provide details in question 4c below and please complete and sign all required replacement forms)

4c. Please list in the space below all existing life insurance policies, annuity contracts currently in force with this or any other company. **If none, check this box**

Company	Face Amount	Policy Number	Issue Date <i>(mm/dd/yy)</i>	Replacement or Change of Policy?	Check here if 1035 Exchange
	\$			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
	\$			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
	\$			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
	\$			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

4d. Have you ever applied for life, health or disability insurance and been declined, postponed or charged an increased premium? *(If "Yes", provide further information in the "Details" space provided.)* Yes No

4e. Has any long-term care insurance contract lapsed, been surrendered or otherwise terminated in the past 24 months? Yes No
(If Yes, please provide details in question 4g below.)

4f. Currently, or within the past 12 months have you had any long-term care policies or riders (including healthcare service or health maintenance organization contracts) in force or pending? Yes No

4g. List details from Questions 4e and 4f above.

Company	Issue Date (mm/dd/yy)	Date of Lapse, Surrender or Termination (mm/dd/yy)	Long-Term Care Max Daily Benefit	Replacement or Change of Policy?	In Force	Applied For
				<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/>	<input type="checkbox"/>

4h. Do your long-term care policies or riders include Home Health Care coverage? Yes No

4i. Are you currently covered by Medicaid? Yes No

4j. Provide full name/address/phone number of personal physician(s) and any other physicians seen within the past 5 years.

Physician Name	Address	Phone Number
a. Date and reason of last visit:		
b. Tests performed & treatment received:		

GENERAL RISK - PROPOSED INSURED

(If you answer "Yes" to any of the following questions, please give details and list medications in the Details section provided below.)

- 5a. Are you actively at work performing the regular duties of your job in the usual manner and at the usual place of employment or business for at least 30 hours per week? Yes No
- 5b. Currently, or within the past 10 years, have you received or applied for any disability benefits, including Worker's Compensation, Social Security Disability Insurance or any other form of disability insurance? Yes No
- 5c. Have you ever been told you have, been diagnosed with or been treated by a physician and/or taken medication for:
 - 1. Syncope, vertigo, tremor, or falls? Yes No
 - 2. Angina, congestive heart failure, coronary artery disease, peripheral vascular disease or atrial fibrillation? Yes No
 - 3. Transient ischemic attack (TIA)? Yes No
 - 4. Parkinson's disease, Multiple Sclerosis, ALS, Muscular Dystrophy, Huntington's or Systemic Lupus? Yes No
 - 5. Osteoporosis or Rheumatoid Arthritis? Yes No
 - 6. Alzheimer's disease, dementia or memory loss? Yes No
- 5d. Currently, or within the last 5 years have you had any impairment, whether mental or physical, for which you need or receive assistance or supervision in performing any daily living activities such as bathing, dressing, eating, transferring or ambulation, toileting, or bowel or bladder control? Yes No
- 5e. Do you use a wheelchair, walker or cane, oxygen, catheter, dialysis machine or other mechanical device? Yes No
- 5f. Within the past 5 years have you been confined or recommended admission to a nursing home or received home health care, or are you currently confined to a hospital or nursing facility? Yes No
- 5g. Are you currently living in an Assisted Living facility or Independent Community? Yes No
- 5h. Have you ever used tobacco or products containing nicotine (including, but not limited to, chew tobacco, snuff, nicotine gum and/or patches)? *(If "Yes", list below.)* Yes No

Type:	Date First Used: (month/year)	Date Last Used: (month/year)	Amount and Frequency:

- 5i. Have you had or been advised to have a check-up, EKG, x-ray, blood, or urine test or any other diagnostic test? Yes No
- 5j. Have you been a patient in a hospital, clinic, sanatorium or other medical facility, or been advised to have any hospitalization or surgery which has not been completed? Yes No

5k. Have you ever had any indication of, or been treated for:

- 1. Chest pain, high blood pressure, heart disease, heart murmur or other disorders of the heart or blood vessels? Yes No
- 2. Ulcers, colitis, jaundice, or other diseases of the stomach, liver, intestines, gallbladder, pancreas, kidney or urinary bladder? Yes No
- 3. Seizures, fainting, dizziness, epilepsy, stroke or paralysis? Yes No
- 4. Any nervous, mental, or emotional disorder, or received counseling for anxiety, depression, stress or any other emotional condition? Yes No
- 5. Any tumor, cancer, cysts, skin disorder or any disorder of the lymph nodes? Yes No
- 6. Arthritis, gout, or any disorder of the back, spine, muscles, nerves, bones or joints? Yes No
- 7. Diabetes, thyroid, or other endocrine or glandular disorder? Yes No
- 8. Anemia or any other blood disorder? Yes No
- 9. Asthma, emphysema, shortness of breath, allergies, sleep apnea or any other disorder of the respiratory system? Yes No
- 10. Any disorder of the eyes, ears, nose or throat? Yes No
- 11. Any complication of pregnancy or disorder of the testicles, prostate, breasts, ovaries, uterus or cervix? Yes No
- 12. Any mental or physical disorder not listed above? Yes No

5l. Have you ever been diagnosed as having or been treated by a physician for Acquired Immune Deficiency Syndrome or an AIDS related condition? Yes No

5m. Do you use alcoholic beverages? (If "Yes", provide Type, Frequency & Amount.) Yes No

Type	Frequency	Amount

5n. Have you ever been treated for drug or alcohol abuse or been advised by your doctor to limit your use of alcohol or any medication, prescribed or not? Yes No

5o. Have you ever used hallucinogenic or narcotic drugs not prescribed by a doctor? Yes No

5p. Within the past 5 years have you been consulted, examined or treated by any physician or practitioner for reasons not stated in this application? Yes No

5q. List all medication and dosage you are currently taking, include prescriptions, over the counter drugs, aspirin and herbal supplements.

5r. Details to General Risk Questions: (If more room is needed, use a separate sheet of paper. Make sure you sign and date the form.)

Question #	Date	Details/Reasons	List Medications

OWNER INFORMATION *(If left blank, Proposed Insured will be owner)*

6a. Primary

Full Name	Date of Birth	Soc. Sec. No.	Relationship to Proposed Insured

6b. Contingent

Full Name	Date of Birth	Soc. Sec. No.	Relationship to Proposed Insured

6c. Owner Address

No., Street, P.O. Box
City, State, Zip Code

BENEFICIARY INFORMATION *(Unless otherwise stated below, if multiple beneficiaries are named in a class (Primary, Contingent), the proceeds are to be paid equally to the survivor or survivors, if any, in the class.)*

7a. Primary

Name/Trust name & Trustees	DOB/Trust Date	SSN/Tax ID	Relationship to Proposed Insured

7b. Contingent

Full Name	Date of Birth	Soc. Sec. No.	Relationship to Proposed Insured

PROTECTION AGAINST UNINTENDED LAPSE

I, the Applicant/Owner, understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this insurance policy for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid. I also understand that I will be given the opportunity to change this written designation at any time. My selection is as follows:

- I elect NOT to designate another person to receive notice of lapse or termination.
- I designate the person(s) listed below to receive copies of any notice of lapse or termination.

Third Party Name: _____ Phone Number: _____

Address: _____

AGREEMENT AND ACKNOWLEDGEMENT

I, the Owner, declare that my tax identification or social security number as shown is correct. I also certify that I am not subject to backup withholding.

The Undersigned declares that:

1. This Application consists of: a) Part I Application; b) any amendments to the application(s) attached thereto; and c) any supplements, all of which are required by the Company for the plan, amount and benefits applied for.
2. I further agree that (except as provided in the Temporary Life Insurance Agreement if advance payment has been made and acknowledged below and such Agreement issued), insurance will take effect under the Policy only when: 1) the Policy has been delivered to and accepted by me; 2) the initial premium has been paid in full during the lifetime of the Proposed Insured; and 3) the Proposed Insured remains in the same state of health and insurability as described in each part of the application at the time conditions 1) and 2) are met.

I have paid \$ _____ to the Agent/Representative in exchange for the Temporary Life Insurance Agreement, and I acknowledge that I fully understand and accept its terms.

3. No agent, broker or medical examiner has the authority to make or modify any Company contract or to waive any of the Company's requirements.
4. I HAVE READ, or have had read to me, the completed Application for Life Insurance before signing below. All statements and answers in this application are correctly recorded, and are full, complete and true. **Caution: If your answers on this application are incorrect or untrue, the Company may have the right to deny benefits or rescind coverage under the policy and any riders attached to it.**
5. For employer owned life insurance policies, the owner hereby acknowledges its sole responsibility for ensuring that it complies with all legal and regulatory requirements related to life insurance it purchases on its employees, including appropriate disclosure to each employee whose life is insured under such a life insurance policy.

STATE DISCLOSURES

All jurisdictions except AR, AZ, CT, DC, FL, KS, KY, LA, ME, MN, NJ, NM, OH, OK, PA, TX, VA and WA. Any person who, with intent to defraud or knowing that he/she is facilitating fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

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

Washington Only. Any person who knowingly presents a false or fraudulent claim for the payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law.

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

Connecticut and Texas Only. Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud, as determined by a court of competent jurisdiction.

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

TRUST VERIFICATION

I hereby certify that the Trustee(s) named in this application are the Trustee(s) for the named Trust, which is in full force and effect. The Company assumes no obligation to inquire into the terms of any trust agreement affecting this policy and shall not be held liable for any party's compliance with the terms thereof. The Company may rely solely upon the signature(s) of the Trustee(s) named in this application to any receipt, release or waiver, or to any transfer or other instrument affecting this policy or any options, privileges or benefits thereunder. Unless otherwise indicated, the signature(s) of all Trustee(s) named, or their successors, will be required to exercise any contractual right under the policy. The Company shall have no obligation to see to the use or application of any funds paid to the Trustee(s) in accordance with the terms of the policy. Any such payment made by the Company to the Trustee(s) shall fully discharge the Company with respect to any amounts so paid.

AUTHORIZATION

Each of the undersigned declares that:

The purpose of this authorization is to allow the Company to determine eligibility for life coverage or a claim for benefits under a life policy.

I authorize any medical professional, hospital or other medical institution, insurer, MIB, Inc., or any other person or organization that has any records or knowledge of me or my physical or mental health, employment, finances, transactions or other information relevant to my insurability to disclose that information to the Company, its reinsurers, or any other party acting on the Company's behalf. I authorize the Company or its reinsurer to make a brief report of my protected health information to MIB, Inc. I authorize the Company to disclose information related to my insurability to other insurers to whom I may apply for coverage.

I acknowledge receipt of the Privacy Notice and the Important Notice containing the Investigative Consumer Report and MIB, Inc. information.

The authorization shall be valid for 24 months after it is signed. A photographic copy of this authorization shall be as valid as the original. I understand that I may revoke this authorization at any time by written notification to the Company; however, any action taken prior to notification will not be affected.

INFLATION PROTECTION COVERAGE

I have reviewed the Outline of Coverage and the charts that compare the benefits and premiums of the Convalescent Care Benefits Rider and Extension of Benefits Rider with and without Optional Inflation Protection. I understand and agree that I will be issued a rider or riders with default Compound Increases at 5%, UNLESS I choose another option below:

- I hereby **REJECT** default Compound Increases at 5% and apply for Optional Inflation Protection as shown in the Policy Information section, question 2d, on page 1.
- I hereby **REJECT** all options for Optional Inflation Protection.

SIGNATORY SECTION

Signed in _____, this _____ day of _____ (state) (month) (year)

Signature of Proposed Insured

Signature of Witness

Signature of Applicant/Owner/Trustee (If other than Proposed Insured)
(Provide Officer's Title if policy is owned by a Corporation)

Signature of Witness

TO BE COMPLETED BY AGENT ONLY (All questions are required to be answered.)

- (i) Does the applicant have any existing life insurance policies or annuities? Yes No
- (ii) Do you know or have you any reason to believe that replacement of insurance is involved? Yes No
If a replacement is involved, I certify that only company approved sales materials were used in this sale and that copies of all sales materials were left with the applicant.
- (iii) List all Long-Term Care or Health Insurance that: 1) You have sold to the Proposed Insured that is still in force. 2) You have sold to the Proposed Insured in the last 5 years that is no longer in force.

Company	Policy Number	Year of Issue	
			<input type="checkbox"/> In Force <input type="checkbox"/> No Longer In Force
			<input type="checkbox"/> In Force <input type="checkbox"/> No Longer In Force

I declare that I have accurately answered all questions contained in this section.

I declare that I have provided each Proposed Insured and Owner(s) with the Important Notice as well as a copy of the Privacy Practices Notice.

Signature of Licensed Agent, Broker or Registered Representative

Name of Licensed Agent, Broker or Registered Representative
(Please Print)

SERFF Tracking Number: JEPL-128341108 State: Arkansas
Filing Company: The Lincoln National Life Insurance Company State Tracking Number:
Company Tracking Number: LFF06312_5-12 ET AL
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: Application filing
Project Name/Number: App filing for MIB change/LFF06312_5-12 et al

Supporting Document Schedules

Item Status: **Status**
Date:

Satisfied - Item: Flesch Certification

Comments:

Attachments:

AR Readability_UL_Term.pdf
AR Regulation 19 Certification.pdf

Item Status: **Status**
Date:

Satisfied - Item: Application

Comments:

We have attached copies of the old apps with the hi-lighted sentence to be removed. Then we have attached a copy of the new version with the added sentences hi-lited.

Attachments:

LFF06321 GENERIC.pdf
LFF06321_5-12 generic hi-lited.pdf
LFF10071-40 AR OH filing.pdf
LFF10071-40_5-12 AR filing.pdf
LFF06312 generic.pdf
LFF06312_5-12 Generic hi-lited.pdf
MGF06450.pdf
MGF06450_5-12 Generic hi-lited.pdf

Arkansas

READABILITY CERTIFICATION

The Lincoln National Life Insurance Company

Re: LFF06312_5-12 Simplified Issue Application
LFF06321_5-12 Application for Life Insurance
LFF10071-40_5-12 Streamlined Application for Life Insurance
MGF06450_5-12 *MoneyGuard* Application for Life Insurance

We hereby certify that the attached Form(s) is (are) in compliance with the Rules and Regulation requirements regarding Life, Annuities, and Accident and Sickness Insurance Language Simplification Standards and has (have) achieved a Flesch Reading Ease score of:

<u>Form Number:</u>	<u>Flesch:</u>
LFF06312_5-12	50
LFF06321_5-12	50
LFF10071-40_5-12	52
MGF06450_5-12	54



Raymond Fortier, Assistant Vice President
Product Compliance & State Filing

Date: May 8, 2012

ARKANSAS

CERTIFICATION OF COMPLIANCE

The Lincoln National Life Insurance Company

RE: LFF06312_5-12 Simplified Issue Application
LFF06321_5-12 Application for Life Insurance
LFF10071-40_5-12 Streamlined Application for Life Insurance
MGF06450_5-12 *MoneyGuard* Application for Life Insurance

To the best of my knowledge and belief, the policy form listed above complies with the provisions of Rule and Regulation 19 as well as all applicable requirements of the Arkansas Insurance Department.



Raymond Fortier, Assistant Vice President
Product Compliance & State Filing

Date: May 8, 2012

IMPORTANT NOTICE

Since you are applying for insurance, we would like you to know more about our underwriting process and what occurs after you submit your application.

(Please give a copy of these notices to each Proposed Insured.)

THE UNDERWRITING PROCESS

All forms of insurance are based on the concept of risk-sharing. Underwriters seek to determine the level of risk represented by each applicant, and then assign that person to a group with similar risk characteristics. In this way, the risk potential can be spread among all policyholders within a given risk group, assuring that each assumes his fair share of the insurance cost.

Underwriters collect and review risk factors such as age, occupation, physical condition, medical history and any hazardous avocations. The level of risk and premium for the amount of coverage requested is based on this information.

INVESTIGATIVE CONSUMER REPORT

As a part of our routine procedure for processing your initial application, we may request an investigative consumer report. The agency making the report may keep a copy of the report and disclose its contents to others for whom it performs similar services. The report typically includes information such as identity and residence verification, character, reputation, marital status, estimate of net worth and income, occupation, avocations, medical history, habits, mode of living and other personal characteristics. Additional information is usually obtained from several different sources. Confidential interviews are conducted with neighbors, friends, business associates, and acquaintances. Public records are carefully reviewed.

Past experience shows that information from investigative reports usually does not have an adverse effect on our underwriting decision. If it should, we will notify you in writing and identify the reporting agency. At that point, if you wish to do so, you may discuss the matter with the reporting agency.

You have the right to be interviewed as part of any investigative consumer report that is completed. If you desire such an interview, please indicate this at the time your application is submitted. If you request it, we will supply the name, address and telephone number of the consumer reporting agency so you may obtain a copy of the report.

CONTESTABILITY

We strongly urge you to review the completed application closely for accuracy. During the 2 year contestability period described in the policy, a claim may be denied if the application contains false statements or misrepresentations or fails to disclose material facts. In such a case, the policy could be void and coverage could be lost.

MIB, INC.

Information you provide regarding your insurability or claims will be treated as confidential except that The Company or its reinsurers, may make a brief report of it to MIB, Inc. This is a nonprofit membership organization of life insurance companies which operates an information exchange on behalf of its members. Upon request by another member insurance company to which you have applied for life or health insurance coverage or submitted a claim, MIB, Inc. will provide the information it may have in its file.

Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB, Inc.'s file, you may contact MIB at: Box 105 Essex Station, Boston, MA 02112. You can reach MIB by phone toll free at (866) 692-6901. (TTY {866} 346-3642)

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APPLICATION FOR LIFE INSURANCE - PART I

APPLICANT INFORMATION - PROPOSED INSURED A (Required Section)

1. Proposed Insured A <i>(First, Middle, Last)</i>		2. <input type="checkbox"/> Male <input type="checkbox"/> Female	
3. Date of Birth (If over age 70, please complete Section D.) <i>(mm/dd/yy)</i>	4. Soc. Sec. No.	5. Are you a citizen of the United States? <input type="checkbox"/> Y <input type="checkbox"/> N If "No," what country?	
6. Place of Birth <i>(State, Country)</i>	7. Driver's License # & State		
8. Home Address <i>(Street, City, State, ZIP)</i>			
9. Occupation/Duties	10. Employer		
11. Business Address <i>(Street, City, State, ZIP)</i>			
12. Annual Earned Income \$	13. Annual Unearned Income \$	14. Net Worth \$	
15. In the last 5 years have you filed for bankruptcy? <input type="checkbox"/> Y <input type="checkbox"/> N <i>(If "Yes," please complete the Financial Supplement.)</i>	16. Primary Phone # <input type="checkbox"/> AM <input type="checkbox"/> PM	17. Work Phone # <input type="checkbox"/> AM <input type="checkbox"/> PM	

COVERAGE INFORMATION (As available per product)

18. Plan of Insurance _____ 19. Amount of Insurance \$ _____
(Specified Amount, if UL or VUL)

20. (i) Death Benefit Option *(Complete for Universal Life and Variable Universal Life Product only - not required for Term or Whole Life.)*
 Level Increase by Cash Value Increase by Premium Increase by Premium Less Policy Factor

(ii) Death Benefit Qualification Test (DBQT) - For IRS purposes, premiums will be tested using the Guideline Premium Test unless
 Cash Value Accumulation Test is checked (not available on all products or with all riders).
The DBQT cannot be changed after issue unless the terms of the policy require a change.

21. Save Age? Y N *(If not saving age, policy will be current dated.)*

22. Additional Benefits and Riders: <i>(If applicable)</i>	<input type="checkbox"/> Waiver of Premium
<input type="checkbox"/> Supplemental Coverage \$ _____	<input type="checkbox"/> Waiver of Monthly Deductions
<input type="checkbox"/> Term on Spouse/Other Insured Rider \$ _____ <i>(Please complete Section B - Applicant Information - Proposed Insured B)</i>	<input type="checkbox"/> Waiver of Specified Premium \$ _____
<input type="checkbox"/> Accelerated Benefit Rider	<input type="checkbox"/> Children's Term Insurance Rider <i>(Complete Child's Supplement)</i>

Other Benefits and Riders *(not listed above)*. (Please provide full details: e.g. coverage amounts/percentages/etc.):

BILLING INSTRUCTIONS (As available per product)

23. Premium Mode: Annual Semi-Annual Quarterly Monthly (EFT) Other _____

24. Modal Planned Premium: \$ _____ 25. Lump Sum: \$ _____ 1035 Exchange

26. Special Billing: *(check one, if applicable)* New List Bill Existing List Bill Number: _____

27. Source of Premium: _____ 28. Automatic Premium Loan: Y N
(inheritance, loan, business activity) (Complete for Whole Life only.)

29. Premium Notices To: *(check one only.) (Please note we cannot bill to your agent.)*
 Owner in Question 31 Owner in Question 37 Insured at Business Insured at Residence Other *(indicate below)*

30. Special Instructions:

OWNER INFORMATION (If left blank, Proposed Insured(s) will be owner)

31. Owner Name	
32. Owner Address	
33. Relationship to Proposed Insured(s)	34. Owner Soc. Sec. No. / TIN
35. Date of Birth/Trust Date	36. Citizen of (Country)
37. Owner Name	
38. Owner Address	
39. Relationship to Proposed Insured(s)	40. Owner Soc. Sec. No. / TIN
41. Date of Birth/Trust Date	42. Citizen of (Country)

43. Is this policy being purchased as part of an employer owned life insurance program where the employer is the direct or indirect beneficiary of the policy? Y N

BENEFICIARY DESIGNATION (Unless otherwise stated below, if multiple beneficiaries are named in a class (Primary, Contingent), the proceeds are to be paid equally to the survivor or survivors, if any, in the class.)

Select Primary (P) or Contingent (C) Beneficiary for each line completed. If Trust, check here .

44. <input type="checkbox"/> P <input type="checkbox"/> C	a. Name/Trust name & Trustees	b. Soc. Sec. No./TIN
		c. Relationship to Proposed Insured
45. <input type="checkbox"/> P <input type="checkbox"/> C	a. Name/Trust name & Trustees	b. Soc. Sec. No./TIN
		c. Relationship to Proposed Insured
46. <input type="checkbox"/> P <input type="checkbox"/> C	a. Name/Trust name & Trustees	b. Soc. Sec. No./TIN
		c. Relationship to Proposed Insured
47. <input type="checkbox"/> P <input type="checkbox"/> C	a. Name/Trust name & Trustees	b. Soc. Sec. No./TIN
		c. Relationship to Proposed Insured
48.	Special Instructions	

APPLICANT INFORMATION - PROPOSED INSURED A

49. Are you considering stopping premium payments, surrendering, replacing, forfeiting, assigning to the insurer or reducing your benefits under an existing policy or annuity, or are you considering using or borrowing funds from your existing policies or annuities to pay premiums due on the new or applied for policy? Y N
(If "Yes", please complete and sign all required replacement forms.)

50. Please list amounts of all inforce life insurance on your life, including any policies that have been sold. *(Please list in the box below.)*

If none, check this box:

Please indicate the Type of coverage: Business (**B**); Key Person (**K**); or Personal (**P**).

Company	Face Amount	Policy Number	Issue Date (mm/dd/yy)	Replacement or Change of Policy?	1035 Exchange	Type
	\$			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
	\$			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
	\$			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
	\$			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	

51. Do you have any applications currently pending or do you plan to apply for new life or disability insurance coverage with any other company? (If "Yes," please provide details in the space provided.) Y N

Company	Amount	Type (Life or Disability)	Reason Policy Applied For
	\$		
	\$		

52. What is the total amount of new life insurance coverage that will be placed in force with all companies including this application? \$ _____

53. Is this policy being funded via a premium financing loan or with funds borrowed, advanced or paid from another person or entity? (If "Yes", please complete the Premium Financing Supplement.) Y N

54. Have you ever applied for life, health or disability insurance and been declined, postponed or charged an increased premium? (If "Yes", provide further information in the "Details" space provided.) Y N

GENERAL RISK INFORMATION - PROPOSED INSURED A

55. Do you now, or do you plan to fly, or have you flown during the past 2 years, as a pilot, student pilot or crew member? (If "Yes", an Aviation Supplement is required; this includes balloon pilots.) Y N

56. Do you plan to participate, or have you participated within the past 2 years; in motor vehicle or boat racing, in hang gliding, sky or scuba diving, or mountain, rock or technical climbing; or in similar sports? (If "Yes", an Avocation Supplement is required.) Y N

57. Do you now, or do you plan to reside or travel outside of the United States or Canada within the next year? (If "Yes", a Foreign Travel or Residence Supplement is required.) Y N

58. In the past 5 years, have you been convicted of two or more moving violations, driving under the influence of alcohol or other drugs, or had your driver's license suspended, restricted or revoked? (If "Yes," please indicate what type and dates in the "Details" space provided.) Y N

59. Have you ever been convicted of or are you awaiting trial for a felony? (If "Yes", please indicate type, date and city/state of felony and if currently on probation or parole, in the "Details" space provided.) Y N

60. Are you a member of, or applied to be a member of, or received a notice of required service in, the armed forces, reserves or National Guard? (If "Yes", please indicate if Retired or active; list branch of service, rank, duties, mobilization category and current duty station; if a notice of deployment has been received, to where and when; in the "Details" space provided.) Y N

61. Have you ever used tobacco or products containing nicotine (including, but not limited to, chew tobacco, snuff, nicotine gum and/or patches)? (If "Yes", list below.) Y N

Type:	Date First Used: (month/year)	Date Last Used: (month/year)	Amount and Frequency:

MEDICAL INFORMATION - PROPOSED INSURED A (Answer this section only when required.)

62. Provide full name/address/phone number of personal physician(s) and any other physicians seen within the past 5 years.

a. Date and reason of last visit:

b. Tests performed & treatment received:

63. Height _____ ft. / _____ in. a. Has your weight changed by more than 10 pounds during the past 12 months? Y N
 Weight _____ lbs. b. If "Yes," by how many pounds? _____ Gain Loss

64.	Age if Living & Health Status	Diabetes, Cancer, Heart Disease? (include age of onset)	Age at Death & Cause
a. Father			
b. Mother			
c. Sibling(s)			

65. **Details:** (List details from questions answered "Yes" and please specify to which question numbers details pertain.)

SECTION A - HEALTH SUMMARY

APPLICANT INFORMATION - PROPOSED INSURED A

(Complete if not submitting a Medical Supplement - Part II of Application or to initiate underwriting process. See Underwriting Guidelines for further details.)

1. Proposed Insured A <i>(First, Middle, Last)</i>	2. Date of Birth <i>(mm/dd/yy)</i>
► If you answer "Yes" to any of the following questions, please provide further information in the "Details" space provided.	
	Yes No
3. Have you had or been advised by a licensed medical professional to have a check-up, EKG, x-ray, blood or urine test or any other diagnostic test or are you now planning to seek medical advice or treatment for any reason?	<input type="checkbox"/> <input type="checkbox"/>
4. Have you been a patient in a hospital, clinic, sanatorium or other medical facility, or been advised by a licensed medical professional to have any hospitalization or surgery which has not been completed?	<input type="checkbox"/> <input type="checkbox"/>
5. Have you ever had any indication of, or been treated by a licensed medical professional for:	
a. Chest pain, palpitations, high blood pressure, heart disease, heart murmur, heart failure or other disorders of the heart or blood vessels?	<input type="checkbox"/> <input type="checkbox"/>
b. Any tumor, cancer, cysts, melanoma, lymphoma or any disorder of the lymph nodes?	<input type="checkbox"/> <input type="checkbox"/>
c. Anemia, leukemia, clotting disorder or any other blood disorder?	<input type="checkbox"/> <input type="checkbox"/>
d. Diabetes, elevated blood sugar, thyroid, or other endocrine or glandular disorder?	<input type="checkbox"/> <input type="checkbox"/>
e. Asthma, emphysema, shortness of breath, allergies, sleep apnea, tuberculosis, sarcoidosis, persistent hoarseness or shortness of breath or any other disorder of the respiratory system?	<input type="checkbox"/> <input type="checkbox"/>
f. Seizures, fainting, dizziness, epilepsy, stroke, paralysis or other neurologic or brain disorder?	<input type="checkbox"/> <input type="checkbox"/>
g. Any nervous, mental, or emotional disorder, or received counseling for anxiety, depression, stress or any other emotional condition?	<input type="checkbox"/> <input type="checkbox"/>
h. Ulcers, colitis, jaundice, hepatitis, cirrhosis, gastrointestinal bleeding, or other disorder of the stomach, esophagus, liver, intestines, gallbladder, or pancreas?	<input type="checkbox"/> <input type="checkbox"/>
i. Any complication of pregnancy or disorder of the testicles, prostate, breasts, ovaries, uterus, cervix, kidney or urinary bladder?	<input type="checkbox"/> <input type="checkbox"/>
j. Arthritis, gout, or any disorder of the back, spine, muscles, nerves, bones, joints or skin?	<input type="checkbox"/> <input type="checkbox"/>
k. Any disorder of the eyes, ears, nose or throat?	<input type="checkbox"/> <input type="checkbox"/>
l. Any mental or physical disorder medically or surgically treated condition not listed above?	<input type="checkbox"/> <input type="checkbox"/>
6. Have you ever been diagnosed as having or been treated by a licensed medical professional for Acquired Immune Deficiency Syndrome or an AIDS related condition?	<input type="checkbox"/> <input type="checkbox"/>
7. Do you use alcoholic beverages? <i>(If "Yes", provide Type, Frequency & Amount.)</i>	<input type="checkbox"/> <input type="checkbox"/>
Type _____ Frequency _____ Amount _____	
8. Have you ever been treated for drug or alcohol abuse or been advised by a licensed medical professional to limit your use of alcohol or any medication, prescribed or not?	<input type="checkbox"/> <input type="checkbox"/>
9. In the past 5 years have you used or experimented with cocaine, marijuana, or other non-prescription stimulants, depressants, or narcotics?	<input type="checkbox"/> <input type="checkbox"/>
10. List all medication and dosages you are currently taking or have taken in the last 30 days, including prescriptions, over the counter drugs, aspirin and herbal supplements.	
11. Details: <i>(List details from questions answered "Yes" and please specify to which question numbers details pertain.)</i>	

SECTION B - ADDITIONAL INSURED

APPLICANT INFORMATION - PROPOSED INSURED B

1. Proposed Insured B <i>(First, Middle, Last)</i>		2. <input type="checkbox"/> Male <input type="checkbox"/> Female	
3. Date of Birth (If over age 70 please complete Section D.) <i>(mm/dd/yy)</i>	4. Soc. Sec. No.	5. Are you a citizen of the United States? <input type="checkbox"/> Y <input type="checkbox"/> N If "No," what country?	
6. Place of Birth <i>(State, Country)</i>	7. Driver's License # & State		
8. Home Address <i>(Street, City, State, ZIP)</i>			
9. Occupation/Duties		10. Employer	
11. Business Address <i>(Street, City, State, ZIP)</i>			
12. Annual Earned Income \$		13. Annual Unearned Income \$	
14. Net Worth \$			
15. In the last 5 years have you filed for bankruptcy? <input type="checkbox"/> Y <input type="checkbox"/> N <i>(If "Yes," please complete the Financial Supplement.)</i>	16. Primary Phone # <input type="checkbox"/> AM <input type="checkbox"/> PM	17. Work Phone # <input type="checkbox"/> AM <input type="checkbox"/> PM	

18. Beneficiary for applicable Rider: a. Name		
b. Soc Sec. No./TIN	c. Relationship to Proposed Insured B	

19. Are you considering stopping premium payments, surrendering, replacing, forfeiting, assigning to the insurer or reducing your benefits under an existing policy or annuity, or are you considering using or borrowing funds from your existing policies or annuities to pay premiums due on the new or applied for policy? Y N
(If "Yes", please complete and sign all required replacement forms.)

20. Please list amounts of all inforce life insurance on your life, including any policies that have been sold. *(Please list in the box below.)*
If none, check this box:
 Please indicate the Type of coverage: Business **(B)**; Key Person **(K)**; or Personal **(P)**.

Company	Face Amount	Policy Number	Issue Date <i>(mm/dd/yy)</i>	Replacement or Change of Policy?	1035 Exchange	Type
	\$			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
	\$			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
	\$			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
	\$			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	

21. Do you have any applications currently pending or do you plan to apply for new life or disability insurance coverage with any other company? *(If "Yes," please provide details in the space provided.)* Y N

Company	Amount	Type (Life or Disability)	Reason Policy Applied For
	\$		
	\$		

22. What is the total amount of new life insurance coverage that will be placed inforce with all companies including this application? \$ _____

23. Is this policy being funded via a premium financing loan or with funds borrowed, advanced or paid from another person or entity? *(If "Yes", please complete the Premium Financing Supplement.)* Y N

24. Have you ever applied for life, health or disability insurance and been declined, postponed or charged an increased premium? *(If "Yes", provide further information in the "Details" space provided.)* Y N

GENERAL RISK INFORMATION - PROPOSED INSURED B

25. Do you now, or do you plan to fly, or have you flown during the past 2 years, as a pilot, student pilot or crew member? *(If "Yes", an Aviation Supplement is required; this includes balloon pilots.)* Y N

26. Do you plan to participate, or have you participated within the past 2 years; in motor vehicle or boat racing, in hang gliding, sky or scuba diving, or mountain, rock or technical climbing; or in similar sports? *(If "Yes", an Avocation Supplement is required.)* Y N

27. Do you now, or do you plan to reside or travel outside of the United States or Canada within the next year? *(If "Yes", a Foreign Travel or Residence Supplement is required.)* Y N

28. In the past 5 years, have you been convicted of two or more moving violations, driving under the influence of alcohol or other drugs, or had your driver's license suspended, restricted or revoked? *(If "Yes," please indicate what type and dates in space provided below.)* Y N

29. Have you ever been convicted of or are you awaiting trial for a felony? *(If "Yes", please indicate type, date and city/state of felony and if currently on probation or parole, in space provided below.)* Y N

30. Are you a member of, or applied to be a member of, or received a notice of required service in, the armed forces, reserves or National Guard? *(If "Yes", please indicate if Retired or active; list branch of service, rank, duties, mobilization category and current duty station; if a notice of deployment has been received, to where and when; on the space provided below.)* Y N

31. Have you ever used tobacco or products containing nicotine (including, but not limited to, chew tobacco, snuff, nicotine gum and/or patches)? *(If "Yes", list below.)* Y N

Type	Date First Used: <i>(month/year)</i>	Date Last Used: <i>(month/year)</i>	Amount and Frequency:

MEDICAL INFORMATION - PROPOSED INSURED B *(Answer this section only when required.)*

32. Provide full name/address/phone number of personal physician(s) and any other physicians seen within the past 5 years.

a. Date and reason of last visit:

b. Tests performed & treatment received:

33. Height _____ ft. / _____ in. a. Has your weight changed by more than 10 pounds during the past 12 months? Y N
 Weight _____ lbs. b. If "Yes," by how many pounds? _____ Gain Loss

34.	Age if Living & Health Status	Diabetes, Cancer, Heart Disease? <i>(include age of onset)</i>	Age at Death & Cause
a. Father			
b. Mother			
c. Sibling(s)			

35. **Details:** *(List details from questions answered "Yes" and please specify to which question numbers details pertain.)*

SECTION C - HEALTH SUMMARY

APPLICANT INFORMATION PROPOSED INSURED B

(Complete if not submitting a Medical Supplement - Part II of Application or to initiate underwriting process. See Underwriting Guidelines for further details.)

Proposed Insured B 1. (First, Middle, Last):	Date of Birth 2. (mm/dd/yy):			
<p>► If you answer "Yes" to any of the following questions, please provide further information in the "Details" space provided.</p>				
	<table style="margin-left: auto; margin-right: auto;"> <tr> <td style="width: 100px;"></td> <td style="text-align: center;">Yes</td> <td style="text-align: center;">No</td> </tr> </table>		Yes	No
	Yes	No		
3. Have you had or been advised by a licensed medical professional to have a check-up, EKG, x-ray, blood or urine test or any other diagnostic test or are you now planning to seek medical advice or treatment for any reason?	<table style="margin-left: auto; margin-right: auto;"> <tr> <td style="width: 100px;"></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>		<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>		
4. Have you been a patient in a hospital, clinic, sanatorium or other medical facility, or been advised by a licensed medical professional to have any hospitalization or surgery which has not been completed?	<table style="margin-left: auto; margin-right: auto;"> <tr> <td style="width: 100px;"></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>		<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>		
5. Have you ever had any indication of, or been treated by a licensed medical professional for:				
a. Chest pain, palpitations, high blood pressure, heart disease, heart murmur, heart failure or other disorders of the heart or blood vessels?	<table style="margin-left: auto; margin-right: auto;"> <tr> <td style="width: 100px;"></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>		<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>		
b. Any tumor, cancer, cysts, melanoma, lymphoma or any disorder of the lymph nodes?	<table style="margin-left: auto; margin-right: auto;"> <tr> <td style="width: 100px;"></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>		<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>		
c. Anemia, leukemia, clotting disorder or any other blood disorder?	<table style="margin-left: auto; margin-right: auto;"> <tr> <td style="width: 100px;"></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>		<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>		
d. Diabetes, elevated blood sugar, thyroid, or other endocrine or glandular disorder?	<table style="margin-left: auto; margin-right: auto;"> <tr> <td style="width: 100px;"></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>		<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>		
e. Asthma, emphysema, shortness of breath, allergies, sleep apnea, tuberculosis, sarcoidosis, persistent hoarseness or shortness of breath or any other disorder of the respiratory system?	<table style="margin-left: auto; margin-right: auto;"> <tr> <td style="width: 100px;"></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>		<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>		
f. Seizures, fainting, dizziness, epilepsy, stroke, paralysis or other neurologic or brain disorder?	<table style="margin-left: auto; margin-right: auto;"> <tr> <td style="width: 100px;"></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>		<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>		
g. Any nervous, mental, or emotional disorder, or received counseling for anxiety, depression, stress or any other emotional condition?	<table style="margin-left: auto; margin-right: auto;"> <tr> <td style="width: 100px;"></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>		<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>		
h. Ulcers, colitis, jaundice, hepatitis, cirrhosis, gastrointestinal bleeding, or other disorder of the stomach, esophagus, liver, intestines, gallbladder, or pancreas?	<table style="margin-left: auto; margin-right: auto;"> <tr> <td style="width: 100px;"></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>		<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>		
i. Any complication of pregnancy or disorder of the testicles, prostate, breasts, ovaries, uterus, cervix, kidney or urinary bladder?	<table style="margin-left: auto; margin-right: auto;"> <tr> <td style="width: 100px;"></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>		<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>		
j. Arthritis, gout, or any disorder of the back, spine, muscles, nerves, bones, joints or skin?	<table style="margin-left: auto; margin-right: auto;"> <tr> <td style="width: 100px;"></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>		<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>		
k. Any disorder of the eyes, ears, nose or throat?	<table style="margin-left: auto; margin-right: auto;"> <tr> <td style="width: 100px;"></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>		<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>		
l. Any mental or physical disorder medically or surgically treated condition not listed above?	<table style="margin-left: auto; margin-right: auto;"> <tr> <td style="width: 100px;"></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>		<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>		
6. Have you ever been diagnosed as having or been treated by a licensed medical professional for Acquired Immune Deficiency Syndrome or an AIDS related condition?	<table style="margin-left: auto; margin-right: auto;"> <tr> <td style="width: 100px;"></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>		<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>		
7. Do you use alcoholic beverages? (If "Yes", provide Type, Frequency & Amount.) Type _____ Frequency _____ Amount _____	<table style="margin-left: auto; margin-right: auto;"> <tr> <td style="width: 100px;"></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>		<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>		
8. Have you ever been treated for drug or alcohol abuse or been advised by a licensed medical professional to limit your use of alcohol or any medication, prescribed or not?	<table style="margin-left: auto; margin-right: auto;"> <tr> <td style="width: 100px;"></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>		<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>		
9. In the past 5 years have you used or experimented with cocaine, marijuana, or other non-prescription stimulants, depressants, or narcotics?	<table style="margin-left: auto; margin-right: auto;"> <tr> <td style="width: 100px;"></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>		<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>		
10. List all medication and dosages you are currently taking or have taken in the last 30 days, including prescriptions, over the counter drugs, aspirin and herbal supplements.				
11. Details: (List details from questions answered "Yes" and please specify to which question numbers details pertain.)				

SECTION D - DEFINED AGE QUESTIONNAIRE
(Complete if either Proposed Insured is age 70 or over.)

1. Proposed Insured A *(First, Middle, Last)* _____

2. Proposed Insured B *(First, Middle, Last)* _____

	Proposed Insured A	Proposed Insured B
3. Will you, the proposed insured and/or beneficiary, and/or any entity on your behalf, receive any compensation as an inducement to purchase the policy, whether via the form of cash, property, an agreement to receive money in the future, or otherwise, if this policy is issued?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
4. Have you, the proposed insured, been involved in any discussion about the possible sale or assignment of this policy to an unrelated third party, as an inducement to purchase the life insurance policy? Have you been involved in any discussion about the possible sale or assignment of a beneficial interest in a trust, limited liability company or other entity created or to be created on your behalf which will have an ownership or beneficial interest in this policy?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
5. Have you, the proposed insured, been involved in any discussion about the projected value of this policy in a future sale to an unrelated third party? Do you, the proposed insured, understand that estimated values of policies in the life settlement or other secondary marketplace are not guaranteed and that you may not be able to sell your policy for any amount in excess of the cash surrender value?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
6. Have you, the proposed insured, ever sold a policy to a life settlement, viatical or other secondary market provider, or are you in the process of selling a policy?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
7. Details: <i>(List details from questions answered "Yes" and please specify to which question numbers details pertain.)</i>		

OWNER INFORMATION

	Owner
8. Owner Name _____	
9. Will you, the proposed owner and/or beneficiary, and/or any entity on your behalf, receive any compensation as an inducement to purchase the policy, whether via the form of cash, property, an agreement to receive money in the future, or otherwise, if this policy is issued?	<input type="checkbox"/> Y <input type="checkbox"/> N
10. Have you, the proposed owner, been involved in any discussion about the possible sale or assignment of this policy to an unrelated third party, as an inducement to purchase the life insurance policy? Have you been involved in any discussion about the possible sale or assignment of a beneficial interest in a trust, limited liability company or other entity created or to be created on your behalf?	<input type="checkbox"/> Y <input type="checkbox"/> N
11. Have you, the owner, been involved in any discussion about the projected value of this policy in a future sale to an unrelated third party? Do you, the owner, understand that estimated values of policies in the life settlement or other secondary marketplace are not guaranteed and that you may not be able to sell your policy for any amount in excess of the cash surrender value?	<input type="checkbox"/> Y <input type="checkbox"/> N
12. Is this policy being funded via a premium financing loan or with funds borrowed, advanced or paid from another person or entity? <i>(If "Yes", please complete the Premium Financing Application Supplement.)</i>	<input type="checkbox"/> Y <input type="checkbox"/> N
13. Details: <i>(List details from questions answered "Yes" and please specify to which question numbers details pertain.)</i>	

SERVICE OFFICE ENDORSEMENTS (For Company Use Only. We will attach additional documentation as needed.)

SUITABILITY

Complete only if applying for Variable Life Insurance and submit allocation form(s) with this Application:

1. Have you, the Proposed Insured(s) and the Owner, if other than the Proposed Insured(s), received a current Prospectus for the policy applied for and have you had sufficient time to review it?	<input type="checkbox"/> Y <input type="checkbox"/> N
2. Do you understand that the amount and duration of the death benefit may increase or decrease depending on the investment performance of funds in the Separate Account?	<input type="checkbox"/> Y <input type="checkbox"/> N
3. Do you understand that the cash values may increase or decrease depending on the investment performance of the funds held in the Separate Account?	<input type="checkbox"/> Y <input type="checkbox"/> N
4. With this in mind, do you believe that the policy applied for is in accord with your insurance objective and your anticipated financial needs?	<input type="checkbox"/> Y <input type="checkbox"/> N

CASH VALUES MAY INCREASE OR DECREASE IN ACCORDANCE WITH THE EXPERIENCE OF THE SEPARATE ACCOUNT. THE DEATH BENEFIT MAY BE VARIABLE OR FIXED UNDER SPECIFIED CONDITIONS.

AGREEMENT AND ACKNOWLEDGEMENT

I, the Owner, certify that the tax identification or social security number as provided by me is correct. I also certify that I am not subject to backup withholding.

Each of the Undersigned declares that:

1. This Application consists of: a) Part I (including Sections A-D if needed); b) Part II Medical Application, if required; c) any amendments to the application(s) attached thereto; and d) any supplements, all of which are required by the Company for the plan, amount and benefits applied for. This Application for Life Insurance - Part I shall be complete when it includes Application Information - Proposed Insured A, and any or none of the following (please check, as applicable, included Sections A-D):

- Section A- Health Summary -Proposed Insured A, Section B- Applicant Information -Proposed Insured B,
 Section C -Health Summary -Proposed Insured B, and Section D - Defined Age Questionnaire.

2. I/We further agree that (except as provided in the Temporary Life Insurance Agreement if advance payment has been made and acknowledged below and such Agreement issued), insurance will take effect under the Policy only when: 1) the Policy has been delivered to and accepted by me/us; 2) the initial premium has been paid in full during the lifetime of the Proposed Insured(s); and 3) the Proposed Insured(s) remain in the same state of health and insurability as described in each part of the application at the time conditions 1) and 2) are met.

I/We have paid \$ _____ to the Agent/Representative in exchange for the Temporary Life Insurance Agreement, and I/we acknowledge that I/we fully understand and accept its terms. (Please complete Temporary Life Insurance Agreement and submit with application.)

3. No agent, broker or medical examiner has the authority to make or modify any Company contract or to waive any of the Company's requirements.
4. I HAVE READ, or have had read to me, the completed Application for Life Insurance before signing below. All statements and answers in this application are correctly recorded, and are full, complete and true. I confirm that upon receipt of the contract I will review the answers recorded on the application. I will notify the Company immediately if any information in the application is incorrect. Caution: If your answers on this application are incorrect or untrue, the Company may have the right to deny benefits or rescind coverage under the policy and any riders attached to it.
5. For employer owned life insurance policies, the owner hereby acknowledges its sole responsibility for ensuring that it complies with all legal and regulatory requirements related to life insurance it purchases on its employees, including appropriate disclosure to each employee whose life is insured under such a life insurance policy.
6. Corrections, additions or changes to this application may be made by the Company. Any such changes will be shown under "Service Office Endorsements". Acceptance of a policy issued with such changes will constitute acceptance of the changes. No change will be made in classification (including age at issue), plan, amount, or benefits unless agreed to in writing by the Applicant.

STATE DISCLOSURES

All jurisdictions except AR, AZ, CT, DC, FL, KS, KY, LA, ME, MN, NJ, NM, OH, OK, PA, TX, VA and WA. Any person who, with intent to defraud or knowing that he/she is facilitating fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

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

TRUST VERIFICATION

I/WE hereby certify that the Trustee(s) named in this application are the Trustee(s) for the named Trust, which is in full force and effect. The Company assumes no obligation to inquire into the terms of any trust agreement affecting this policy and shall not be held liable for any party's compliance with the terms thereof. The Company may rely solely upon the signature(s) of the Trustee(s) named in this application to any receipt, release or waiver, or to any transfer or other instrument affecting this policy or any options, privileges or benefits thereunder. Unless otherwise indicated, the signature(s) of all Trustee(s) named, or their successors, will be required to exercise any contractual right under the policy. The Company shall have no obligation to see to the use or application of any funds paid to the Trustee(s) in accordance with the terms of the policy. Any such payment made by the Company to the Trustee(s) shall fully discharge the Company with respect to any amounts so paid.

AUTHORIZATION

Each of the undersigned declares that:

I/We authorize any medical professional, hospital or other medical institution, insurer, MIB, Inc., or any other person or organization that has any records or knowledge of me/us or my/our physical or mental health or insurability to disclose that information to the Company, its reinsurers, or any other party acting on the Company's behalf. I/We authorize the Company to disclose information related to my insurability to MIB, Inc., and to other insurers to whom I/we may apply for coverage.

I/We acknowledge receipt of the Privacy Notice and the Important Notice containing the Investigative Consumer Report and MIB, Inc. information.

This authorization shall be valid for 24 months after it is signed. A photographic copy of this authorization shall be as valid as the original. I/We understand that I/we may revoke this authorization at any time by written notification to the Company; however, any action taken prior to notification will not be affected.

The purpose of this authorization is to allow the Company to determine eligibility for life coverage or a claim for benefits under a life policy.

I elect to be interviewed if an Investigative Consumer Report is prepared.

SIGNATORY SECTION

Signed in _____, this _____ day of _____ (state) (month) (year)

Signature of Proposed Insured A
(Parent or Guardian if under 14 years of age)

Signature of Proposed Insured B (If coverage applied for)
(Parent or Guardian if under 14 years of age)

Signature of Applicant/Owner/Trustee (If other than Proposed Insured)
(Provide Officer's Title if policy is owned by a Corporation)

Signature of Applicant/Owner/Trustee (If other than Proposed Insured)
(Provide Officer's Title if policy is owned by a Corporation)

TO BE COMPLETED BY AGENT ONLY

(i) Does the applicant have any existing life insurance policies or annuities? Y N

(ii) Do you know or have you any reason to believe that replacement of insurance is involved? Y N

If a replacement is involved, I certify that only company approved sales materials were used in this sale and that copies of all sales materials were left with the applicant.

I declare that I have accurately answered all questions contained in this section.

I declare that I have provided each Proposed Insured and Owner(s) with the Important Notice as well as a copy of the Privacy Practices Notice.

Signature of Licensed Agent, Broker or Registered Representative

Name of Licensed Agent, Broker or Registered Representative
(Please Print)

APPLICABLE TO VARIABLE LIFE ONLY

I have reviewed the Application, Supplements, New Account Form and allocation forms and find the transaction suitable.

Signature of Registered Principal of Broker/Dealer

Name of Registered Principal of Broker/Dealer (Please Print)

IMPORTANT NOTICE

Since you are applying for insurance, we would like you to know more about our underwriting process and what occurs after you submit your application.

(Please give a copy of these notices to each Proposed Insured.)

THE UNDERWRITING PROCESS

All forms of insurance are based on the concept of risk-sharing. Underwriters seek to determine the level of risk represented by each applicant, and then assign that person to a group with similar risk characteristics. In this way, the risk potential can be spread among all policyholders within a given risk group, assuring that each assumes his fair share of the insurance cost.

Underwriters collect and review risk factors such as age, occupation, physical condition, medical history and any hazardous avocations. The level of risk and premium for the amount of coverage requested is based on this information.

INVESTIGATIVE CONSUMER REPORT

As a part of our routine procedure for processing your initial application, we may request an investigative consumer report. The agency making the report may keep a copy of the report and disclose its contents to others for whom it performs similar services. The report typically includes information such as identity and residence verification, character, reputation, marital status, estimate of net worth and income, occupation, avocations, medical history, habits, mode of living and other personal characteristics. Additional information is usually obtained from several different sources. Confidential interviews are conducted with neighbors, friends, business associates, and acquaintances. Public records are carefully reviewed.

Past experience shows that information from investigative reports usually does not have an adverse effect on our underwriting decision. If it should, we will notify you in writing and identify the reporting agency. At that point, if you wish to do so, you may discuss the matter with the reporting agency.

You have the right to be interviewed as part of any investigative consumer report that is completed. If you desire such an interview, please indicate this at the time your application is submitted. If you request it, we will supply the name, address and telephone number of the consumer reporting agency so you may obtain a copy of the report.

CONTESTABILITY

We strongly urge you to review the completed application closely for accuracy. During the 2 year contestability period described in the policy, a claim may be denied if the application contains false statements or misrepresentations or fails to disclose material facts. In such a case, the policy could be void and coverage could be lost.

MIB, INC.

Information you provide regarding your insurability or claims will be treated as confidential except that The Company or its reinsurers, may make a brief report of it to MIB, Inc. This is a nonprofit membership organization of life insurance companies which operates an information exchange on behalf of its members. Upon request by another member insurance company to which you have applied for life or health insurance coverage or submitted a claim, MIB, Inc. will provide the information it may have in its file.

Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB, Inc.'s file, you may contact MIB at: 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734. You can reach MIB by phone toll free at (866) 692-6901. (TTY {866} 346-3642)

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APPLICATION FOR LIFE INSURANCE - PART I

APPLICANT INFORMATION - PROPOSED INSURED A (Required Section)		
1. Proposed Insured A <i>(First, Middle, Last)</i>	2. <input type="checkbox"/> Male <input type="checkbox"/> Female	
3. Date of Birth (If over age 70, please complete Section D.) <i>(mm/dd/yy)</i>	4. Soc. Sec. No.	5. Are you a citizen of the United States? <input type="checkbox"/> Y <input type="checkbox"/> N If "No," what country?
6. Place of Birth <i>(State, Country)</i>	7. Driver's License # & State	
8. Home Address <i>(Street, City, State, ZIP)</i>		
9. Occupation/Duties	10. Employer	
11. Business Address <i>(Street, City, State, ZIP)</i>		
12. Annual Earned Income \$	13. Annual Unearned Income \$	14. Net Worth \$
15. In the last 5 years have you filed for bankruptcy? <input type="checkbox"/> Y <input type="checkbox"/> N <i>(If "Yes," please complete the Financial Supplement.)</i>	16. Primary Phone # <input type="checkbox"/> AM <input type="checkbox"/> PM	17. Work Phone # <input type="checkbox"/> AM <input type="checkbox"/> PM

COVERAGE INFORMATION (As available per product)

18. Plan of Insurance _____ 19. Amount of Insurance \$ _____
(Specified Amount, if UL or VUL)

20. (i) Death Benefit Option *(Complete for Universal Life and Variable Universal Life Product only - not required for Term or Whole Life.)*
 Level Increase by Cash Value Increase by Premium Increase by Premium Less Policy Factor

(ii) Death Benefit Qualification Test (DBQT) - For IRS purposes, premiums will be tested using the Guideline Premium Test unless
 Cash Value Accumulation Test is checked (not available on all products or with all riders).
The DBQT cannot be changed after issue unless the terms of the policy require a change.

21. Save Age? Y N *(If not saving age, policy will be current dated.)*

22. Additional Benefits and Riders: <i>(If applicable)</i>	<input type="checkbox"/> Waiver of Premium
<input type="checkbox"/> Supplemental Coverage \$ _____	<input type="checkbox"/> Waiver of Monthly Deductions
<input type="checkbox"/> Term on Spouse/Other Insured Rider \$ _____ <i>(Please complete Section B - Applicant Information - Proposed Insured B)</i>	<input type="checkbox"/> Waiver of Specified Premium \$ _____
<input type="checkbox"/> Accelerated Benefit Rider	<input type="checkbox"/> Children's Term Insurance Rider <i>(Complete Child's Supplement)</i>
<input type="checkbox"/> Other Benefits and Riders <i>(not listed above)</i> . (Please provide full details: e.g. coverage amounts/percentages/etc.):	

BILLING INSTRUCTIONS (As available per product)

23. Premium Mode: Annual Semi-Annual Quarterly Monthly (EFT) Other _____

24. Modal Planned Premium: \$ _____ 25. Lump Sum: \$ _____ 1035 Exchange

26. Special Billing: *(check one, if applicable)* New List Bill Existing List Bill Number: _____

27. Source of Premium: _____ 28. Automatic Premium Loan: Y N
(inheritance, loan, business activity) (Complete for Whole Life only.)

29. Premium Notices To: *(check one only.) (Please note we cannot bill to your agent.)*
 Owner in Question 31 Owner in Question 37 Insured at Business Insured at Residence Other *(indicate below)*

30. Special Instructions:

OWNER INFORMATION (If left blank, Proposed Insured(s) will be owner)

31. Owner Name	
32. Owner Address	
33. Relationship to Proposed Insured(s)	34. Owner Soc. Sec. No. / TIN
35. Date of Birth/Trust Date	36. Citizen of (Country)
37. Owner Name	
38. Owner Address	
39. Relationship to Proposed Insured(s)	40. Owner Soc. Sec. No. / TIN
41. Date of Birth/Trust Date	42. Citizen of (Country)

43. Is this policy being purchased as part of an employer owned life insurance program where the employer is the direct or indirect beneficiary of the policy? Y N

BENEFICIARY DESIGNATION (Unless otherwise stated below, if multiple beneficiaries are named in a class (Primary, Contingent), the proceeds are to be paid equally to the survivor or survivors, if any, in the class.)

Select Primary (P) or Contingent (C) Beneficiary for each line completed. If Trust, check here .

44. <input type="checkbox"/> P <input type="checkbox"/> C	a. Name/Trust name & Trustees	b. Soc. Sec. No./TIN
		c. Relationship to Proposed Insured
45. <input type="checkbox"/> P <input type="checkbox"/> C	a. Name/Trust name & Trustees	b. Soc. Sec. No./TIN
		c. Relationship to Proposed Insured
46. <input type="checkbox"/> P <input type="checkbox"/> C	a. Name/Trust name & Trustees	b. Soc. Sec. No./TIN
		c. Relationship to Proposed Insured
47. <input type="checkbox"/> P <input type="checkbox"/> C	a. Name/Trust name & Trustees	b. Soc. Sec. No./TIN
		c. Relationship to Proposed Insured
48.	Special Instructions	

APPLICANT INFORMATION - PROPOSED INSURED A

49. Are you considering stopping premium payments, surrendering, replacing, forfeiting, assigning to the insurer or reducing your benefits under an existing policy or annuity, or are you considering using or borrowing funds from your existing policies or annuities to pay premiums due on the new or applied for policy? Y N
(If "Yes", please complete and sign all required replacement forms.)

50. Please list amounts of all inforce life insurance on your life, including any policies that have been sold. *(Please list in the box below.)*

If none, check this box:

Please indicate the Type of coverage: Business (B); Key Person (K); or Personal (P).

Company	Face Amount	Policy Number	Issue Date (mm/dd/yy)	Replacement or Change of Policy?	1035 Exchange	Type
	\$			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
	\$			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
	\$			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
	\$			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	

51. Do you have any applications currently pending or do you plan to apply for new life or disability insurance coverage with any other company? (If "Yes," please provide details in the space provided.) Y N

Company	Amount	Type (Life or Disability)	Reason Policy Applied For
	\$		
	\$		

52. What is the total amount of new life insurance coverage that will be placed in force with all companies including this application? \$ _____

53. Is this policy being funded via a premium financing loan or with funds borrowed, advanced or paid from another person or entity? (If "Yes", please complete the Premium Financing Supplement.) Y N

54. Have you ever applied for life, health or disability insurance and been declined, postponed or charged an increased premium? (If "Yes", provide further information in the "Details" space provided.) Y N

GENERAL RISK INFORMATION - PROPOSED INSURED A

55. Do you now, or do you plan to fly, or have you flown during the past 2 years, as a pilot, student pilot or crew member? (If "Yes", an Aviation Supplement is required; this includes balloon pilots.) Y N

56. Do you plan to participate, or have you participated within the past 2 years; in motor vehicle or boat racing, in hang gliding, sky or scuba diving, or mountain, rock or technical climbing; or in similar sports? (If "Yes", an Avocation Supplement is required.) Y N

57. Do you now, or do you plan to reside or travel outside of the United States or Canada within the next year? (If "Yes", a Foreign Travel or Residence Supplement is required.) Y N

58. In the past 5 years, have you been convicted of two or more moving violations, driving under the influence of alcohol or other drugs, or had your driver's license suspended, restricted or revoked? (If "Yes," please indicate what type and dates in the "Details" space provided.) Y N

59. Have you ever been convicted of or are you awaiting trial for a felony? (If "Yes", please indicate type, date and city/state of felony and if currently on probation or parole, in the "Details" space provided.) Y N

60. Are you a member of, or applied to be a member of, or received a notice of required service in, the armed forces, reserves or National Guard? (If "Yes", please indicate if Retired or active; list branch of service, rank, duties, mobilization category and current duty station; if a notice of deployment has been received, to where and when; in the "Details" space provided.) Y N

61. Have you ever used tobacco or products containing nicotine (including, but not limited to, chew tobacco, snuff, nicotine gum and/or patches)? (If "Yes", list below.) Y N

Type:	Date First Used: (month/year)	Date Last Used: (month/year)	Amount and Frequency:

MEDICAL INFORMATION - PROPOSED INSURED A (Answer this section only when required.)

62. Provide full name/address/phone number of personal physician(s) and any other physicians seen within the past 5 years.

a. Date and reason of last visit:

b. Tests performed & treatment received:

63. Height _____ ft. / _____ in. a. Has your weight changed by more than 10 pounds during the past 12 months? Y N
 Weight _____ lbs. b. If "Yes," by how many pounds? _____ Gain Loss

64.	Age if Living & Health Status	Diabetes, Cancer, Heart Disease? (include age of onset)	Age at Death & Cause
a. Father			
b. Mother			
c. Sibling(s)			

65. **Details:** (List details from questions answered "Yes" and please specify to which question numbers details pertain.)

SECTION A - HEALTH SUMMARY

APPLICANT INFORMATION - PROPOSED INSURED A

(Complete if not submitting a Medical Supplement - Part II of Application or to initiate underwriting process. See Underwriting Guidelines for further details.)

1. Proposed Insured A <i>(First, Middle, Last)</i>	2. Date of Birth <i>(mm/dd/yy)</i>
► If you answer "Yes" to any of the following questions, please provide further information in the "Details" space provided.	
	Yes No
3. Have you had or been advised by a licensed medical professional to have a check-up, EKG, x-ray, blood or urine test or any other diagnostic test or are you now planning to seek medical advice or treatment for any reason?	<input type="checkbox"/> <input type="checkbox"/>
4. Have you been a patient in a hospital, clinic, sanatorium or other medical facility, or been advised by a licensed medical professional to have any hospitalization or surgery which has not been completed?	<input type="checkbox"/> <input type="checkbox"/>
5. Have you ever had any indication of, or been treated by a licensed medical professional for:	
a. Chest pain, palpitations, high blood pressure, heart disease, heart murmur, heart failure or other disorders of the heart or blood vessels?	<input type="checkbox"/> <input type="checkbox"/>
b. Any tumor, cancer, cysts, melanoma, lymphoma or any disorder of the lymph nodes?	<input type="checkbox"/> <input type="checkbox"/>
c. Anemia, leukemia, clotting disorder or any other blood disorder?	<input type="checkbox"/> <input type="checkbox"/>
d. Diabetes, elevated blood sugar, thyroid, or other endocrine or glandular disorder?	<input type="checkbox"/> <input type="checkbox"/>
e. Asthma, emphysema, allergies, sleep apnea, tuberculosis, sarcoidosis, persistent hoarseness or shortness of breath or any other disorder of the respiratory system?	<input type="checkbox"/> <input type="checkbox"/>
f. Seizures, fainting, dizziness, epilepsy, stroke, paralysis or other neurologic or brain disorder?	<input type="checkbox"/> <input type="checkbox"/>
g. Any nervous, mental, or emotional disorder, or received counseling for anxiety, depression, stress or any other emotional condition?	<input type="checkbox"/> <input type="checkbox"/>
h. Ulcers, colitis, jaundice, hepatitis, cirrhosis, gastrointestinal bleeding, or other disorder of the stomach, esophagus, liver, intestines, gallbladder, or pancreas?	<input type="checkbox"/> <input type="checkbox"/>
i. Any complications of pregnancy or disorder of the testicles, prostate, breasts, ovaries, uterus, cervix, kidney or urinary bladder?	<input type="checkbox"/> <input type="checkbox"/>
j. Arthritis, gout, or any disorder of the back, spine, muscles, nerves, bones, joints or skin?	<input type="checkbox"/> <input type="checkbox"/>
k. Any disorder of the eyes, ears, nose or throat?	<input type="checkbox"/> <input type="checkbox"/>
l. Any mental or physical disorder or medically or surgically treated condition not listed above?	<input type="checkbox"/> <input type="checkbox"/>
6. Have you ever been diagnosed as having or been treated by a licensed medical professional for Acquired Immune Deficiency Syndrome or an AIDS related condition?	<input type="checkbox"/> <input type="checkbox"/>
7. Do you use alcoholic beverages? <i>(If "Yes", provide Type, Frequency & Amount.)</i>	<input type="checkbox"/> <input type="checkbox"/>
Type _____ Frequency _____ Amount _____	
8. Have you ever been treated for drug or alcohol abuse or been advised by a licensed medical professional to limit your use of alcohol or any medication, prescribed or not?	<input type="checkbox"/> <input type="checkbox"/>
9. In the past 5 years have you used or experimented with cocaine, marijuana, or other non-prescription stimulants, depressants, or narcotics?	<input type="checkbox"/> <input type="checkbox"/>
10. List all medication and dosages you are currently taking or have taken in the last 30 days, including prescriptions, over the counter drugs, aspirin and herbal supplements.	
11. Details: <i>(List details from questions answered "Yes" and please specify to which question numbers details pertain.)</i>	

SECTION B - ADDITIONAL INSURED

APPLICANT INFORMATION - PROPOSED INSURED B

1. Proposed Insured B <i>(First, Middle, Last)</i>		2. <input type="checkbox"/> Male <input type="checkbox"/> Female	
3. Date of Birth (If over age 70 please complete Section D.) <i>(mm/dd/yy)</i>	4. Soc. Sec. No.	5. Are you a citizen of the United States? <input type="checkbox"/> Y <input type="checkbox"/> N If "No," what country?	
6. Place of Birth <i>(State, Country)</i>	7. Driver's License # & State		
8. Home Address <i>(Street, City, State, ZIP)</i>			
9. Occupation/Duties		10. Employer	
11. Business Address <i>(Street, City, State, ZIP)</i>			
12. Annual Earned Income \$	13. Annual Unearned Income \$	14. Net Worth \$	
15. In the last 5 years have you filed for bankruptcy? <input type="checkbox"/> Y <input type="checkbox"/> N <i>(If "Yes," please complete the Financial Supplement.)</i>	16. Primary Phone # <input type="checkbox"/> AM <input type="checkbox"/> PM	17. Work Phone # <input type="checkbox"/> AM <input type="checkbox"/> PM	

18. Beneficiary for applicable Rider: a. Name		
b. Soc Sec. No./TIN	c. Relationship to Proposed Insured B	

19. Are you considering stopping premium payments, surrendering, replacing, forfeiting, assigning to the insurer or reducing your benefits under an existing policy or annuity, or are you considering using or borrowing funds from your existing policies or annuities to pay premiums due on the new or applied for policy? Y N
(If "Yes", please complete and sign all required replacement forms.)

20. Please list amounts of all inforce life insurance on your life, including any policies that have been sold. *(Please list in the box below.)*
If none, check this box:
 Please indicate the Type of coverage: Business **(B)**; Key Person **(K)**; or Personal **(P)**.

Company	Face Amount	Policy Number	Issue Date <i>(mm/dd/yy)</i>	Replacement or Change of Policy?	1035 Exchange	Type
	\$			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
	\$			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
	\$			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
	\$			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	

21. Do you have any applications currently pending or do you plan to apply for new life or disability insurance coverage with any other company? *(If "Yes," please provide details in the space provided.)* Y N

Company	Amount	Type (Life or Disability)	Reason Policy Applied For
	\$		
	\$		

22. What is the total amount of new life insurance coverage that will be placed inforce with all companies including this application? \$ _____

23. Is this policy being funded via a premium financing loan or with funds borrowed, advanced or paid from another person or entity? *(If "Yes", please complete the Premium Financing Supplement.)* Y N

24. Have you ever applied for life, health or disability insurance and been declined, postponed or charged an increased premium? *(If "Yes", provide further information in the "Details" space provided.)* Y N

GENERAL RISK INFORMATION - PROPOSED INSURED B

25. Do you now, or do you plan to fly, or have you flown during the past 2 years, as a pilot, student pilot or crew member? *(If "Yes", an Aviation Supplement is required; this includes balloon pilots.)* Y N

26. Do you plan to participate, or have you participated within the past 2 years; in motor vehicle or boat racing, in hang gliding, sky or scuba diving, or mountain, rock or technical climbing; or in similar sports? *(If "Yes", an Avocation Supplement is required.)* Y N

27. Do you now, or do you plan to reside or travel outside of the United States or Canada within the next year? *(If "Yes", a Foreign Travel or Residence Supplement is required.)* Y N

28. In the past 5 years, have you been convicted of two or more moving violations, driving under the influence of alcohol or other drugs, or had your driver's license suspended, restricted or revoked? *(If "Yes," please indicate what type and dates in space provided below.)* Y N

29. Have you ever been convicted of or are you awaiting trial for a felony? *(If "Yes", please indicate type, date and city/state of felony and if currently on probation or parole, in space provided below.)* Y N

30. Are you a member of, or applied to be a member of, or received a notice of required service in, the armed forces, reserves or National Guard? *(If "Yes", please indicate if Retired or active; list branch of service, rank, duties, mobilization category and current duty station; if a notice of deployment has been received, to where and when; on the space provided below.)* Y N

31. Have you ever used tobacco or products containing nicotine (including, but not limited to, chew tobacco, snuff, nicotine gum and/or patches)? *(If "Yes", list below.)* Y N

Type	Date First Used: <i>(month/year)</i>	Date Last Used: <i>(month/year)</i>	Amount and Frequency:

MEDICAL INFORMATION - PROPOSED INSURED B *(Answer this section only when required.)*

32. Provide full name/address/phone number of personal physician(s) and any other physicians seen within the past 5 years.

a. Date and reason of last visit:

b. Tests performed & treatment received:

33. Height _____ ft. / _____ in. a. Has your weight changed by more than 10 pounds during the past 12 months? Y N
 Weight _____ lbs. b. If "Yes," by how many pounds? _____ Gain Loss

34.	Age if Living & Health Status	Diabetes, Cancer, Heart Disease? <i>(include age of onset)</i>	Age at Death & Cause
a. Father			
b. Mother			
c. Sibling(s)			

35. **Details:** *(List details from questions answered "Yes" and please specify to which question numbers details pertain.)*

SECTION C - HEALTH SUMMARY

APPLICANT INFORMATION PROPOSED INSURED B

(Complete if not submitting a Medical Supplement - Part II of Application or to initiate underwriting process. See Underwriting Guidelines for further details.)

1. Proposed Insured B <i>(First, Middle, Last):</i>	2. Date of Birth <i>(mm/dd/yy):</i>
► If you answer "Yes" to any of the following questions, please provide further information in the "Details" space provided.	
	Yes No
3. Have you had or been advised by a licensed medical professional to have a check-up, EKG, x-ray, blood or urine test or any other diagnostic test or are you now planning to seek medical advice or treatment for any reason?	<input type="checkbox"/> <input type="checkbox"/>
4. Have you been a patient in a hospital, clinic, sanatorium or other medical facility, or been advised by a licensed medical professional to have any hospitalization or surgery which has not been completed?	<input type="checkbox"/> <input type="checkbox"/>
5. Have you ever had any indication of, or been treated by a licensed medical professional for:	
a. Chest pain, palpitations, high blood pressure, heart disease, heart murmur, heart failure or other disorders of the heart or blood vessels?	<input type="checkbox"/> <input type="checkbox"/>
b. Any tumor, cancer, cysts, melanoma, lymphoma or any disorder of the lymph nodes?	<input type="checkbox"/> <input type="checkbox"/>
c. Anemia, leukemia, clotting disorder or any other blood disorder?	<input type="checkbox"/> <input type="checkbox"/>
d. Diabetes, elevated blood sugar, thyroid, or other endocrine or glandular disorder?	<input type="checkbox"/> <input type="checkbox"/>
e. Asthma, emphysema, allergies, sleep apnea, tuberculosis, sarcoidosis, persistent hoarseness or shortness of breath or any other disorder of the respiratory system?	<input type="checkbox"/> <input type="checkbox"/>
f. Seizures, fainting, dizziness, epilepsy, stroke, paralysis or other neurologic or brain disorder?	<input type="checkbox"/> <input type="checkbox"/>
g. Any nervous, mental, or emotional disorder, or received counseling for anxiety, depression, stress or any other emotional condition?	<input type="checkbox"/> <input type="checkbox"/>
h. Ulcers, colitis, jaundice, hepatitis, cirrhosis, gastrointestinal bleeding, or other disorder of the stomach, esophagus, liver, intestines, gallbladder, or pancreas?	<input type="checkbox"/> <input type="checkbox"/>
i. Any complications of pregnancy or disorder of the testicles, prostate, breasts, ovaries, uterus, cervix, kidney or urinary bladder?	<input type="checkbox"/> <input type="checkbox"/>
j. Arthritis, gout, or any disorder of the back, spine, muscles, nerves, bones, joints or skin?	<input type="checkbox"/> <input type="checkbox"/>
k. Any disorder of the eyes, ears, nose or throat?	<input type="checkbox"/> <input type="checkbox"/>
l. Any mental or physical disorder or medically or surgically treated condition not listed above?	<input type="checkbox"/> <input type="checkbox"/>
6. Have you ever been diagnosed as having or been treated by a licensed medical professional for Acquired Immune Deficiency Syndrome or an AIDS related condition?	<input type="checkbox"/> <input type="checkbox"/>
7. Do you use alcoholic beverages? <i>(If "Yes", provide Type, Frequency & Amount.)</i>	<input type="checkbox"/> <input type="checkbox"/>
Type _____ Frequency _____ Amount _____	
8. Have you ever been treated for drug or alcohol abuse or been advised by a licensed medical professional to limit your use of alcohol or any medication, prescribed or not?	<input type="checkbox"/> <input type="checkbox"/>
9. In the past 5 years have you used or experimented with cocaine, marijuana, or other non-prescription stimulants, depressants, or narcotics?	<input type="checkbox"/> <input type="checkbox"/>
10. List all medication and dosages you are currently taking or have taken in the last 30 days, including prescriptions, over the counter drugs, aspirin and herbal supplements.	
11. Details: <i>(List details from questions answered "Yes" and please specify to which question numbers details pertain.)</i>	

SECTION D - DEFINED AGE QUESTIONNAIRE
(Complete if either Proposed Insured is age 70 or over.)

1. Proposed Insured A (First, Middle, Last) _____

2. Proposed Insured B (First, Middle, Last) _____

	Proposed Insured A	Proposed Insured B
3. Will you, the proposed insured and/or beneficiary, and/or any entity on your behalf, receive any compensation as an inducement to purchase the policy, whether via the form of cash, property, an agreement to receive money in the future, or otherwise, if this policy is issued?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
4. Have you, the proposed insured, been involved in any discussion about the possible sale or assignment of this policy to an unrelated third party, as an inducement to purchase the life insurance policy? Have you been involved in any discussion about the possible sale or assignment of a beneficial interest in a trust, limited liability company or other entity created or to be created on your behalf which will have an ownership or beneficial interest in this policy?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
5. Have you, the proposed insured, been involved in any discussion about the projected value of this policy in a future sale to an unrelated third party? Do you, the proposed insured, understand that estimated values of policies in the life settlement or other secondary marketplace are not guaranteed and that you may not be able to sell your policy for any amount in excess of the cash surrender value?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
6. Have you, the proposed insured, ever sold a policy to a life settlement, viatical or other secondary market provider, or are you in the process of selling a policy?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
7. Details: (List details from questions answered "Yes" and please specify to which question numbers details pertain.)		

OWNER INFORMATION

8. Owner Name _____	Owner
9. Will you, the proposed owner and/or beneficiary, and/or any entity on your behalf, receive any compensation as an inducement to purchase the policy, whether via the form of cash, property, an agreement to receive money in the future, or otherwise, if this policy is issued?	<input type="checkbox"/> Y <input type="checkbox"/> N
10. Have you, the proposed owner, been involved in any discussion about the possible sale or assignment of this policy to an unrelated third party, as an inducement to purchase the life insurance policy? Have you been involved in any discussion about the possible sale or assignment of a beneficial interest in a trust, limited liability company or other entity created or to be created on your behalf?	<input type="checkbox"/> Y <input type="checkbox"/> N
11. Have you, the owner, been involved in any discussion about the projected value of this policy in a future sale to an unrelated third party? Do you, the owner, understand that estimated values of policies in the life settlement or other secondary marketplace are not guaranteed and that you may not be able to sell your policy for any amount in excess of the cash surrender value?	<input type="checkbox"/> Y <input type="checkbox"/> N
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", please complete the Premium Financing Application Supplement.)	<input type="checkbox"/> Y <input type="checkbox"/> N
13. Details: (List details from questions answered "Yes" and please specify to which question numbers details pertain.)	

SERVICE OFFICE ENDORSEMENTS (For Company Use Only. We will attach additional documentation as needed.)

SUITABILITY

Complete only if applying for Variable Life Insurance and submit allocation form(s) with this Application:

1. Have you, the Proposed Insured(s) and the Owner, if other than the Proposed Insured(s), received a current Prospectus for the policy applied for and have you had sufficient time to review it?	<input type="checkbox"/> Y <input type="checkbox"/> N
2. Do you understand that the amount and duration of the death benefit may increase or decrease depending on the investment performance of funds in the Separate Account?	<input type="checkbox"/> Y <input type="checkbox"/> N
3. Do you understand that the cash values may increase or decrease depending on the investment performance of the funds held in the Separate Account?	<input type="checkbox"/> Y <input type="checkbox"/> N
4. With this in mind, do you believe that the policy applied for is in accord with your insurance objective and your anticipated financial needs?	<input type="checkbox"/> Y <input type="checkbox"/> N

CASH VALUES MAY INCREASE OR DECREASE IN ACCORDANCE WITH THE EXPERIENCE OF THE SEPARATE ACCOUNT. THE DEATH BENEFIT MAY BE VARIABLE OR FIXED UNDER SPECIFIED CONDITIONS.

AGREEMENT AND ACKNOWLEDGEMENT

I, the Owner, certify that the tax identification or social security number as provided by me is correct. I also certify that I am not subject to backup withholding.

Each of the Undersigned declares that:

1. This Application consists of: a) Part I (including Sections A-D if needed); b) Part II Medical Application, if required; c) any amendments to the application(s) attached thereto; and d) any supplements, all of which are required by the Company for the plan, amount and benefits applied for. This Application for Life Insurance - Part I shall be complete when it includes Applicant Information - Proposed Insured A, and any or none of the following (please check, as applicable, included Sections A-D):

- Section A- Health Summary -Proposed Insured A, Section B- Applicant Information -Proposed Insured B,
 Section C -Health Summary -Proposed Insured B, and Section D - Defined Age Questionnaire.

2. I/We further agree that (except as provided in the Temporary Life Insurance Agreement if advance payment has been made and acknowledged below and such Agreement issued), insurance will take effect under the Policy only when: 1) the Policy has been delivered to and accepted by me/us; 2) the initial premium has been paid in full during the lifetime of the Proposed Insured(s); and 3) the Proposed Insured(s) remain in the same state of health and insurability as described in each part of the application at the time conditions 1) and 2) are met.

I/We have paid \$ _____ to the Agent/Representative in exchange for the Temporary Life Insurance Agreement, and I/we acknowledge that I/we fully understand and accept its terms. (Please complete Temporary Life Insurance Agreement and submit with application.)

3. No agent, broker or medical examiner has the authority to make or modify any Company contract or to waive any of the Company's requirements.
4. I HAVE READ, or have had read to me, the completed Application for Life Insurance before signing below. All statements and answers in this application are correctly recorded, and are full, complete and true. I confirm that upon receipt of the contract I will review the answers recorded on the application. I will notify the Company immediately if any information in the application is incorrect. Caution: If your answers on this application are incorrect or untrue, the Company may have the right to deny benefits or rescind coverage under the policy and any riders attached to it.
5. For employer owned life insurance policies, the owner hereby acknowledges its sole responsibility for ensuring that it complies with all legal and regulatory requirements related to life insurance it purchases on its employees, including appropriate disclosure to each employee whose life is insured under such a life insurance policy.
6. Corrections, additions or changes to this application may be made by the Company. Any such changes will be shown under "Service Office Endorsements". Acceptance of a policy issued with such changes will constitute acceptance of the changes. No change will be made in classification (including age at issue), plan, amount, or benefits unless agreed to in writing by the Applicant.

STATE DISCLOSURES

All jurisdictions except AR, AZ, CT, DC, FL, KS, KY, LA, ME, MN, NJ, NM, OH, OK, PA, TX, VA and WA. Any person who, with intent to defraud or knowing that he/she is facilitating fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

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

TRUST VERIFICATION

I/We hereby certify that the Trustee(s) named in this application are the Trustee(s) for the named Trust, which is in full force and effect. The Company assumes no obligation to inquire into the terms of any trust agreement affecting this policy and shall not be held liable for any party's compliance with the terms thereof. The Company may rely solely upon the signature(s) of the Trustee(s) named in this application to any receipt, release or waiver, or to any transfer or other instrument affecting this policy or any options, privileges or benefits thereunder. Unless otherwise indicated, the signature(s) of all Trustee(s) named, or their successors, will be required to exercise any contractual right under the policy. The Company shall have no obligation to see to the use or application of any funds paid to the Trustee(s) in accordance with the terms of the policy. Any such payment made by the Company to the Trustee(s) shall fully discharge the Company with respect to any amounts so paid.

AUTHORIZATION

Each of the undersigned declares that:

I/We authorize any medical professional, hospital or other medical institution, insurer, MIB, Inc., or any other person or organization that has any records or knowledge of me/us or my/our physical or mental health or insurability to disclose that information to the Company, its reinsurers, or any other party acting on the Company's behalf. I/We authorize the Company or its reinsurer to make a brief report of my protected health information to MIB, Inc. I/We authorize the Company to disclose information related to my insurability to other insurers to whom I/we may apply for coverage.

I/We acknowledge receipt of the Privacy Notice and the Important Notice containing the Investigative Consumer Report and MIB, Inc. information.

This authorization shall be valid for 24 months after it is signed. A photographic copy of this authorization shall be as valid as the original. I/We understand that I/we may revoke this authorization at any time by written notification to the Company; however, any action taken prior to notification will not be affected.

The purpose of this authorization is to allow the Company to determine eligibility for life coverage or a claim for benefits under a life policy.

I elect to be interviewed if an Investigative Consumer Report is prepared.

SIGNATORY SECTION

Signed in _____, this _____ day of _____ (state) (month) (year)

Signature of Proposed Insured A
(Parent or Guardian if under 14 years of age)

Signature of Proposed Insured B (If coverage applied for)
(Parent or Guardian if under 14 years of age)

Signature of Applicant/Owner/Trustee (If other than Proposed Insured)
(Provide Officer's Title if policy is owned by a Corporation)

Signature of Applicant/Owner/Trustee (If other than Proposed Insured)
(Provide Officer's Title if policy is owned by a Corporation)

TO BE COMPLETED BY AGENT ONLY

(i) Does the applicant have any existing life insurance policies or annuities? Y N

(ii) Do you know or have you any reason to believe that replacement of insurance is involved? Y N

If a replacement is involved, I certify that only company approved sales materials were used in this sale and that copies of all sales materials were left with the applicant.

I declare that I have accurately answered all questions contained in this section.

I declare that I have provided each Proposed Insured and Owner(s) with the Important Notice as well as a copy of the Privacy Practices Notice.

Signature of Licensed Agent, Broker or Registered Representative

Name of Licensed Agent, Broker or Registered Representative
(Please Print)

APPLICABLE TO VARIABLE LIFE ONLY

I have reviewed the Application, Supplements, New Account Form and allocation forms and find the transaction suitable.

Signature of Registered Principal of Broker/Dealer

Name of Registered Principal of Broker/Dealer (Please Print)

IMPORTANT NOTICE

Since you are applying for insurance, we would like you to know more about our underwriting process and what occurs after you submit your application.

(Please give a copy of this notice to the Proposed Insured.)

THE UNDERWRITING PROCESS

All forms of insurance are based on the concept of risk-sharing. Underwriters seek to determine the level of risk represented by each applicant, and then assign that person to a group with similar risk characteristics. In this way, the risk potential can be spread among all policyholders within a given risk group, assuring that each assumes his fair share of the insurance cost.

Underwriters collect and review risk factors such as age, occupation, physical condition, and medical history. The level of risk and premium for the amount of coverage requested is based on this information.

CONTESTABILITY

We strongly urge you to review the completed application closely for accuracy. During the 2 year contestability period described in the policy, a claim may be denied if the application contains false statements or misrepresentations or fails to disclose material facts. In such a case, the policy could be void and coverage could be lost.

MIB, INC.

Information you provide regarding your insurability or claims will be treated as confidential except that The Company or its reinsurers, may make a brief report of it to MIB, Inc. This is a nonprofit membership organization of life insurance companies which operates an information exchange on behalf of its members. Upon request by another member insurance company to which you have applied for life or health insurance coverage or submitted a claim, MIB, Inc. will provide the information it may have in its file.

Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB, Inc.'s file, you may contact MIB at: [50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734]. You can reach MIB by phone toll free at [(866) 692-6901]. [(TTY {866} 346-3642)]

STREAMLINED APPLICATION FOR LIFE INSURANCE

1. Name (First, MI, Last)		2. Date of Birth (mm/dd/yy)	
3. Occupation	4. Soc. Sec. No. (SSN)		5. Are you a citizen of the United States? <input type="checkbox"/> Y <input type="checkbox"/> N If "No," do you have a valid Green Card? <input type="checkbox"/> Y <input type="checkbox"/> N
6. Place of Birth (State, Country)			
7. Home Address (St., City, ST, ZIP)			8. <input type="checkbox"/> Male <input type="checkbox"/> Female

9. Plan of Insurance _____ 10. Specified Amount/Amount of Insurance \$ _____
 11. Additional Benefits and Riders: (If applicable) Accelerated Benefits Rider Other Benefits and Riders _____
 12. Single Premium: \$ _____ 13. Planned Premium: \$ _____ Frequency _____
 14. Lump Sum: \$ _____ 15. Source of Premium: _____ (inheritance, loan, business activity)

16. Owner Name	17. Date of Birth	18. SSN/TIN
19. Relationship	20. Citizen of (Country)	
21. Owner Address (St., City, ST, ZIP)		

22. Indicate Primary (P) or Contingent (C) Beneficiary for each line completed in the first column. **Unless otherwise stated below, if multiple beneficiaries are named in a class (Primary, Contingent), the proceeds are to be paid equally to the survivor or survivors, if any, in the class.**

P/C	Beneficiary Name	Relationship	Date of Birth	SSN/TIN

23. Are you considering stopping premium payments, surrendering, replacing, forfeiting, assigning to the insurer or reducing your benefits under an existing policy or annuity, or are you considering using or borrowing funds from your existing policies or annuities to pay premiums due on the new or applied for policy? Y N (If "Yes", please complete and sign all required replacement forms.)

24. Please list amounts of all inforce life insurance on your life, including any policies that have been sold. (Please list in the box below.)

If none, check this box: <input type="checkbox"/>	Face Amount	Policy Number	Issue Date (mm/dd/yy)	Replacement or Change of Policy?	1035 Exchange
Company	\$			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
	\$			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

25. Have you smoked any cigarettes in the past 12 months? Y N

26. In the past 10 years have you had, been diagnosed with or treated by a licensed medical professional for:
 a. Heart disease, heart attack, heart failure or atrial fibrillation? Y N
 b. Stroke, transient ischemic attack (TIA or mini-stroke), vascular disease, Alzheimer's disease, dementia, emphysema, chronic lung, kidney or liver disease? Y N
 c. Diabetes requiring insulin? Y N

27. In the past 5 years have you been diagnosed with or treated by a licensed medical professional for:
 a. Any type of cancer other than non-melanoma skin cancer? Y N
 b. Alcohol or drug abuse, or been advised to limit your alcohol intake? Y N

28. Have you ever been diagnosed with or treated by a licensed medical professional for human immune deficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS)? Y N

29. In the past 5 years have you been declined or turned down for life insurance? Y N

30. Provide full details here for any questions answered "Yes" (Include question numbers and if more space is required, use the "Continuation of Details Supplement.):

31. Personal Physician's Name, Address and Telephone Number:

SERVICE OFFICE ENDORSEMENTS (For Company Use Only. We will attach additional documentation as needed.)

AGREEMENT AND ACKNOWLEDGEMENT

I, the Owner, certify my TIN or SSN as provided by me is correct. I also certify that I am not subject to backup withholding.

Each of the Undersigned declares that:

- 1. This Application consists of: a) Application for Life Insurance; b) any amendments to the application(s) attached thereto; and c) any supplements, all of which are required by the Company for the plan, amount and benefits applied for.
- 2. No agent, broker or medical examiner has the authority to make or modify any Company contract or to waive any of the Company’s requirements.
- 3. I HAVE READ, or have had read to me, the completed Application for Life Insurance before signing below. All statements and answers in this application are correctly recorded, and are full, complete and true. I confirm that upon receipt of the contract I will review the answers recorded on the application. I will notify the Company immediately if any information in the application is incorrect. Caution: If your answers on this application are incorrect or untrue, the Company may have the right to deny benefits or rescind coverage under the policy and any riders attached to it.
- 4. For employer owned life insurance policies, the owner hereby acknowledges its sole responsibility for ensuring that it complies with all legal and regulatory requirements related to life insurance it purchases on its employees, including appropriate disclosure to each employee whose life is insured under such a life insurance policy.
- 5. Corrections, additions or changes to this application may be made by the Company. Any such changes will be shown under “Service Office Endorsements”. Acceptance of a policy issued with such changes will constitute acceptance of the changes. No change will be made in classification (including age at issue), plan, amount, or benefits unless agreed to in writing by the Applicant.

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

AUTHORIZATION - The undersigned declares that:

I authorize any medical professional, hospital or other medical institution, insurer, MIB, Inc., or any other person or organization that has any records or knowledge of me or my physical or mental health or insurability to disclose that information to the Company, its reinsurers, or any other party acting on the Company’s behalf. **I authorize the Company to disclose information related to my insurability to MIB, Inc., and to other insurers to whom I may apply for coverage.** I understand that some of these people or entities may not be covered by federal or state privacy regulations and that the information they receive may be redisclosed, however the Company contractually requires them to protect the information we disclose to them. Information may be disclosed as allowed by law or regulation.

I acknowledge receipt of the Privacy Notice and the Important Notice containing the MIB, Inc. information.

This authorization shall be valid for 24 months after it is signed. A photographic copy of this authorization shall be as valid as the original. I understand this consent may be revoked in writing at any time, except to the extent: 1) the Company has taken action in reliance on this Authorization; or 2) the Company is using this Authorization in connection with a contestable claim under my policy with that Company.

Signed in _____, this _____ day of _____ (state) (month) (year)

Signature of Proposed Insured
(Parent or Guardian if under 14 years of age)

Signature of Applicant/Owner/Trustee (If other than Proposed Insured. Provide Officer’s Title if policy is owned by a Corporation)

TO BE COMPLETED BY AGENT ONLY

- (i) Does the applicant have any existing life insurance policies or annuities? Y N
- (ii) Do you know or have you any reason to believe that replacement of insurance is involved? Y N
If a replacement is involved, I certify that only company approved sales materials were used in this sale and that copies of all sales materials were left with the applicant.
- ▶ I declare that I have accurately answered all questions contained in this section. I know of nothing affecting the insurability of the Proposed Insured which is not fully recorded in this application. I declare that I have provided the Proposed Insured and Owner with the Important Notice as well as a copy of the Privacy Practices Notice. I declare that I have verified that all life insurance coverage in force on the Proposed Insured has been disclosed on this application, including any coverage that has been sold or is in the process of being sold to a life settlement, viatical or other secondary market provider.
- ▶ I declare I have not been involved in any recommendation regarding the possible sale or assignment of this policy to a life settlement, viatical or other secondary market provider. If otherwise, please explain: _____

Signature of Licensed Agent or Broker

Print Name of Licensed Agent or Broker

IMPORTANT NOTICE

Since you are applying for insurance, we would like you to know more about our underwriting process and what occurs after you submit your application.

(Please give a copy of this notice to the Proposed Insured.)

THE UNDERWRITING PROCESS

All forms of insurance are based on the concept of risk-sharing. Underwriters seek to determine the level of risk represented by each applicant, and then assign that person to a group with similar risk characteristics. In this way, the risk potential can be spread among all policyholders within a given risk group, assuring that each assumes his fair share of the insurance cost.

Underwriters collect and review risk factors such as age, occupation, physical condition, and medical history. The level of risk and premium for the amount of coverage requested is based on this information.

CONTESTABILITY

We strongly urge you to review the completed application closely for accuracy. During the 2 year contestability period described in the policy, a claim may be denied if the application contains false statements or misrepresentations or fails to disclose material facts. In such a case, the policy could be void and coverage could be lost.

MIB, INC.

Information you provide regarding your insurability or claims will be treated as confidential except that The Company or its reinsurers, may make a brief report of it to MIB, Inc. This is a nonprofit membership organization of life insurance companies which operates an information exchange on behalf of its members. Upon request by another member insurance company to which you have applied for life or health insurance coverage or submitted a claim, MIB, Inc. will provide the information it may have in its file.

Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB, Inc.'s file, you may contact MIB at: [50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734]. You can reach MIB by phone toll free at [(866) 692-6901]. [(TTY {866} 346-3642)]

STREAMLINED APPLICATION FOR LIFE INSURANCE

1. Name (<i>First, MI, Last</i>)		2. Date of Birth (<i>mm/dd/yy</i>)	
3. Occupation	4. Soc. Sec. No. (SSN)		5. Are you a citizen of the United States? <input type="checkbox"/> Y <input type="checkbox"/> N If "No," do you have a valid Green Card? <input type="checkbox"/> Y <input type="checkbox"/> N
6. Place of Birth (<i>State, Country</i>)			
7. Home Address (<i>St., City, ST, ZIP</i>)			8. <input type="checkbox"/> Male <input type="checkbox"/> Female

9. Plan of Insurance _____ 10. Specified Amount/Amount of Insurance \$ _____

11. Additional Benefits and Riders: (*If applicable*) Accelerated Benefits Rider Other Benefits and Riders _____

12. Single Premium: \$ _____ 13. Planned Premium: \$ _____ Frequency _____

14. Lump Sum: \$ _____ 15. Source of Premium: _____ (*inheritance, loan, business activity*)

16. Owner Name	17. Date of Birth	18. SSN/TIN
19. Relationship	20. Citizen of (Country)	
21. Owner Address (<i>St., City, ST, ZIP</i>)		

22. Indicate Primary (P) or Contingent (C) Beneficiary for each line completed in the first column. ***Unless otherwise stated below, if multiple beneficiaries are named in a class (Primary, Contingent), the proceeds are to be paid equally to the survivor or survivors, if any, in the class.***

P/C	Beneficiary Name	Relationship	Date of Birth	SSN/TIN

23. Are you considering stopping premium payments, surrendering, replacing, forfeiting, assigning to the insurer or reducing your benefits under an existing policy or annuity, or are you considering using or borrowing funds from your existing policies or annuities to pay premiums due on the new or applied for policy? Y N (*If "Yes", please complete and sign all required replacement forms.*)

24. Please list amounts of all inforce life insurance on your life, including any policies that have been sold. (*Please list in the box below.*)

If none, check this box: <input type="checkbox"/>	Face Amount	Policy Number	Issue Date (<i>mm/dd/yy</i>)	Replacement or Change of Policy?	1035 Exchange
Company	\$			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
	\$			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

25. Have you smoked any cigarettes in the past 12 months? Y N

26. In the past 10 years have you had, been diagnosed with or treated by a licensed medical professional for:

a. Heart disease, heart attack, heart failure or atrial fibrillation? Y N

b. Stroke, transient ischemic attack (TIA or mini-stroke), vascular disease, Alzheimer's disease, dementia, emphysema, chronic lung, kidney or liver disease? Y N

c. Diabetes requiring insulin? Y N

27. In the past 5 years have you been diagnosed with or treated by a licensed medical professional for:

a. Any type of cancer other than non-melanoma skin cancer? Y N

b. Alcohol or drug abuse, or been advised to limit your alcohol intake? Y N

28. Have you ever been diagnosed with or treated by a licensed medical professional for human immune deficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS)? Y N

29. In the past 5 years have you been declined or turned down for life insurance? Y N

30. Provide full details here for any questions answered "Yes" (*Include question numbers and if more space is required, use the "Continuation of Details Supplement."*):

31. Personal Physician's Name, Address and Telephone Number:

SERVICE OFFICE ENDORSEMENTS (For Company Use Only. We will attach additional documentation as needed.)

AGREEMENT AND ACKNOWLEDGEMENT

I, the Owner, certify my TIN or SSN as provided by me is correct. I also certify that I am not subject to backup withholding.

Each of the Undersigned declares that:

1. This Application consists of: a) Application for Life Insurance; b) any amendments to the application(s) attached thereto; and c) any supplements, all of which are required by the Company for the plan, amount and benefits applied for.
2. No agent, broker or medical examiner has the authority to make or modify any Company contract or to waive any of the Company’s requirements.
3. I HAVE READ, or have had read to me, the completed Application for Life Insurance before signing below. All statements and answers in this application are correctly recorded, and are full, complete and true. I confirm that upon receipt of the contract I will review the answers recorded on the application. I will notify the Company immediately if any information in the application is incorrect. Caution: If your answers on this application are incorrect or untrue, the Company may have the right to deny benefits or rescind coverage under the policy and any riders attached to it.
4. For employer owned life insurance policies, the owner hereby acknowledges its sole responsibility for ensuring that it complies with all legal and regulatory requirements related to life insurance it purchases on its employees, including appropriate disclosure to each employee whose life is insured under such a life insurance policy.
5. Corrections, additions or changes to this application may be made by the Company. Any such changes will be shown under “Service Office Endorsements”. Acceptance of a policy issued with such changes will constitute acceptance of the changes. No change will be made in classification (including age at issue), plan, amount, or benefits unless agreed to in writing by the Applicant.

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

AUTHORIZATION - The undersigned declares that:

I authorize any medical professional, hospital or other medical institution, insurer, MIB, Inc., or any other person or organization that has any records or knowledge of me or my physical or mental health or insurability to disclose that information to the Company, its reinsurers, or any other party acting on the Company’s behalf. I authorize the Company or its reinsurer to make a brief report of my protected health information to MIB, Inc. I authorize the Company to disclose information related to my insurability to other insurers to whom I may apply for coverage. I understand that some of these people or entities may not be covered by federal or state privacy regulations and that the information they receive may be redisclosed, however the Company contractually requires them to protect the information we disclose to them. Information may be disclosed as allowed by law or regulation.

I acknowledge receipt of the Privacy Notice and the Important Notice containing the MIB, Inc. information.

This authorization shall be valid for 24 months after it is signed. A photographic copy of this authorization shall be as valid as the original. I understand this consent may be revoked in writing at any time, except to the extent: 1) the Company has taken action in reliance on this Authorization; or 2) the Company is using this Authorization in connection with a contestable claim under my policy with that Company.

Signed in _____, this _____ day of _____
(state) (month) (year)

Signature of Proposed Insured
(Parent or Guardian if under 14 years of age)

Signature of Applicant/Owner/Trustee (If other than Proposed Insured. Provide Officer’s Title if policy is owned by a Corporation)

TO BE COMPLETED BY AGENT ONLY

- (i) Does the applicant have any existing life insurance policies or annuities? Y N
- (ii) Do you know or have you any reason to believe that replacement of insurance is involved? Y N
If a replacement is involved, I certify that only company approved sales materials were used in this sale and that copies of all sales materials were left with the applicant.
- ▶ I declare that I have accurately answered all questions contained in this section. I know of nothing affecting the insurability of the Proposed Insured which is not fully recorded in this application. I declare that I have provided the Proposed Insured and Owner with the Important Notice as well as a copy of the Privacy Practices Notice. I declare that I have verified that all life insurance coverage in force on the Proposed Insured has been disclosed on this application, including any coverage that has been sold or is in the process of being sold to a life settlement, viatical or other secondary market provider.
- ▶ I declare I have not been involved in any recommendation regarding the possible sale or assignment of this policy to a life settlement, viatical or other secondary market provider. If otherwise, please explain: _____

Signature of Licensed Agent or Broker

Print Name of Licensed Agent or Broker

SIMPLIFIED ISSUE APPLICATION FOR LIFE INSURANCE

PROPOSED INSURED					
1. Name (First) (Middle) (Last)	2. <input type="checkbox"/> Male <input type="checkbox"/> Female	3. Date of Birth (mm/dd/yy)			
4. Place of Birth (State, Country)	5. Social Security Number (xxx-xx-xxxx)		6. Driver License # & State		
7a. Home Address (Street) (City) (State)			7b. Home Address Zip Code		
8. Employer			9. Citizen of (Country)		
10a. Business Address (Street) (City) (State)			10b. Business Address Zip Code		

COVERAGE INFORMATION

11. Plan of Insurance (If VUL also complete Question 17, Premium Allocation and Disclosure Form)

12. Additional Benefits If Available (Please List):

13. Amount of Insurance (Specified Amount, if UL or VUL) \$

14. (i) Death Benefit Option (Complete for Universal Life and Variable Universal Life Product only - not required for Term or Whole Life.)
 Level Increase by Cash Value Increase by Premium Increase by Premium Less Policy Factor

(ii) Death Benefit Qualification Test - For IRS purposes, premiums will be tested using the Guideline Premium Test unless
 Cash Value Accumulation Test is checked (not available on all products). **Cannot be changed after issue.**

15. Are you considering stopping premium payments, surrendering, replacing, forfeiting, assigning to the insurer or reducing your benefits under an existing policy or annuity, or are you considering using or borrowing funds from your existing policies or annuities to pay premiums due on the new or applied for policy? Yes No
(If "Yes", please complete and sign all required replacement forms and complete Question 16.)

16. What is the total amount of all inforce insurance on your life? (Please list in the box below.) **If none, check this box:**

Company	Face Amount	Policy Number	Issue Date (mm/dd/yy)	Replacement or Change of Policy?	Check here if 1035Exchange
	\$			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
	\$			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
	\$			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
	\$			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>

17. Complete only if applying for Variable Life Insurance with the Company. Submit Premium Allocation and Disclosure Form for Variable Universal Life with Application:

Suitability	Yes	No
1. Have you, the Proposed Insured(s) and the Owner, if other than the Proposed Insured(s), received a current Prospectus for the policy applied for and have you had sufficient time to review it?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you understand that the amount and duration of the death benefit may increase or decrease depending on the investment performance of funds in the Separate Account?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you understand that the cash values may increase or decrease depending on the investment performance of the funds held in the Separate Account?	<input type="checkbox"/>	<input type="checkbox"/>
4. With this in mind, do you believe that the policy applied for is in accord with your insurance objective and your anticipated financial needs?	<input type="checkbox"/>	<input type="checkbox"/>

CASH VALUES MAY INCREASE OR DECREASE IN ACCORDANCE WITH THE EXPERIENCE OF THE SEPARATE ACCOUNT. THE DEATH BENEFIT MAY BE VARIABLE OR FIXED UNDER SPECIFIED CONDITIONS.

OWNER INFORMATION (If left blank, Proposed Insured(s) will be owner)

► **If a Trust, provide Trustee Name(s), Trust Name.**

18. Owner Name (First, Middle, Last) _____ 19. Citizen of (Country) _____

20. Owner Address _____

21. Owner Social Security or Tax ID # _____ 22. Relationship to Proposed Insured(s) _____ 23. Trust Date (only if Trust is Owner) _____

24. Is the policy being purchased as part of an employer owned life insurance program where the employer is the direct or indirect beneficiary of the policy? Yes No

BENEFICIARY DESIGNATION Beneficiaries share equally unless otherwise indicated.

► **If a Trust, provide Trustee Name(s), Trust Name and date of Trust.**

25. Primary Beneficiary(ies): _____ 26. Social Security or Tax ID #: _____ 27. Relationship to Proposed Insured: _____
28. Contingent Beneficiary(ies): _____ 29. Social Security or Tax ID #: _____ 30. Relationship to Proposed Insured: _____

BILLING INSTRUCTIONS AS AVAILABLE PER PRODUCT

31. Planned Premium: \$ _____ 32. Lump Sum: \$ _____ 1035 Exchange
33. Premium Frequency: Annually Semi-Annually Quarterly Monthly (EFT)
 New List Bill Existing List Bill (provide #) _____
 PDF (Complete Transmittal) Other _____

34. Premium Notices To: (check all that apply.) (Please note we cannot bill to your agent.)
 Insured at Residence Insured at Business Owner Other _____

GENERAL RISK INFORMATION

35. Have you ever used tobacco or products containing nicotine? (If "Yes", check all that apply.) Yes No
Type: Cigarettes Cigar Pipe Chew Tobacco Snuff Nicotine Patches/ Gum
Date First Used: (month/year) _____
Date Last Used: (month/year) _____
Amount and Frequency: _____

36. Are you actively at work performing the regular duties of your job in the usual manner and at the usual place of employment or business for at least 30 hours per week? Yes No

36a If you answered "No" to question 36, please give details here:

37. Height _____ft. _____in. Weight _____lbs **Yes No**
38. What is your regular occupation? _____
39. In the past 10 years have you applied for life, health or disability insurance and been declined, postponed or charged an increased premium?
40. Within the past two years, have you flown as a pilot, student pilot or crew member, or engaged in skin or scuba diving, racing of any kind, parachuting, sky diving or hang gliding, mountain, rock or technical climbing?
If "Yes", please complete an Aviation - Avocation Supplement.
41. In the past 10 years have you been treated for high blood pressure, heart disease, chest pain, diabetes, digestive disorder, lung disorder, cancer, kidney disease, liver disorder or nervous disorder?
42. In the past 5 years have you received treatment for alcohol or drug use?

- | | Yes | No |
|---|--------------------------|--------------------------|
| 43. In the past 5 years have you been convicted of (i) two or more moving violations, (ii) driving under the influence of alcohol or other drugs (unless prescribed by a doctor), or (iii) had your driver's license suspended or revoked? | <input type="checkbox"/> | <input type="checkbox"/> |
| 44. In the past 10 years have you been diagnosed by a medical professional as having human immune deficiency virus (HIV) infection, Acquired Immunodeficiency Syndrome (AIDS), or have you received treatment from a medical professional for AIDS? | <input type="checkbox"/> | <input type="checkbox"/> |
| 45. In the past 5 years have you been examined or treated by a physician or medical practitioner or been examined or treated in a hospital? If "Yes" provide name and address of personal physician and/or health care facility. | <input type="checkbox"/> | <input type="checkbox"/> |
- If you answered "Yes" to question 37-45, please give complete details here including date of last treatment and name/address/phone number of the attending physician (attach an additional sheet of paper if necessary):

46. Special Instructions:

SERVICE OFFICE ENDORSEMENTS (Attach an additional sheet of paper, if necessary)

AGREEMENT AND ACKNOWLEDGEMENT

I, the Owner, declare that my tax identification or social security number as shown is correct. I also certify that I am not subject to backup withholding.

Each of the Undersigned declares that:

1. This Application consists of any amendments to the application(s) attached thereto and any supplements, all of which are required by the Company for the plan, amount and benefits applied for.
2. I/We further agree that (except as provided in the Temporary Life Insurance Agreement if advance payment has been made and acknowledged below and such Agreement issued), insurance will take effect under the Policy only when: 1) the Policy has been delivered to and accepted by me/us; 2) the initial premium has been paid in full during the lifetime of the Proposed Insured(s); and 3) the Proposed Insured(s) remain in the same state of health and insurability as described in each part of the application at the time conditions 1) and 2) are met.
I/We have paid \$_____ to the Agent/Representative in exchange for the Temporary Life Insurance Agreement, and I/we acknowledge that I/we fully understand and accept its terms.
3. No agent, broker or medical examiner has the authority to make or modify any Company contract or to waive any of the Company's requirements.
4. I HAVE READ, or have had read to me, the completed Simplified Issue Application for Life Insurance before signing below. All statements and answers in this application are correctly recorded, and are full, complete and true.
5. I understand that, in order to informally fund benefit obligations, the Company may need to increase the amount of insurance under existing Policies on my life from time to time. I hereby authorize the Company to effect such an increase or increases without providing any further notice to me.
6. For employer owned life insurance policies, the owner hereby acknowledges its sole responsibility for ensuring that it complies with all legal and regulatory requirements related to life insurance it purchases on its employees, including appropriate disclosure to each employee whose life is insured under such a life insurance policy.
7. Corrections, additions or changes to this application may be made by the Company. Any such changes will be shown under "Service Office Endorsements". Acceptance of a policy issued with such changes will constitute acceptance of the changes. No change will be made in classification (including age at issue), plan, amount, or benefits unless agreed to in writing by the Applicant.

STATE DISCLOSURES

All jurisdictions except AR, AZ, CT, DC, FL, KS, KY, LA, ME, MN, NJ, NM, OH, OK, PA, TX, VA and WA. Any person who, with intent to defraud or knowing that he/she is facilitating fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

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

Washington Only. Any person who knowingly presents a false or fraudulent claim for the payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law.

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

Connecticut and Texas Only. Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud, as determined by a court of competent jurisdiction.

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

TRUST VERIFICATION

I/WE hereby certify that the Trustee(s) named in this application are the Trustee(s) for the named Trust, which is in full force and effect. The Company assumes no obligation to inquire into the terms of any trust agreement affecting this policy and shall not be held liable for any party's compliance with the terms thereof. The Company may rely solely upon the signature(s) of the Trustee(s) named in this application to any receipt, release or waiver, or to any transfer or other instrument affecting this policy or any options, privileges or benefits thereunder. Unless otherwise indicated, the signature(s) of all Trustee(s) named, or their successors, will be required to exercise any contractual right under the policy. The Company shall have no obligation to see to the use or application of any funds paid to the Trustee(s) in accordance with the terms of the policy. Any such payment made by the Company to the Trustee(s) shall fully discharge the Company with respect to any amounts so paid.

AUTHORIZATION

Each of the undersigned declares that:

I/We authorize any medical professional, hospital or other medical institution, insurer, MIB, Inc., or any other person or organization that has any records or knowledge of me/us or my/our physical or mental health or insurability to disclose that information to the Company, its reinsurers, or any other party acting on the Company's behalf. I/We authorize the Company to disclose medical information to MIB, Inc., and to other insurers to whom I/we may apply for coverage.

I/We acknowledge receipt of the Privacy Notice and the Important Notice containing the Investigative Consumer Report and MIB, Inc. information.

The authorization shall be valid for 24 months after it is signed. A photographic copy of this authorization shall be as valid as the original. I/We understand that I/we may revoke this authorization at any time by written notification to the Company; however, any action taken prior to notification will not be affected.

The purpose of this authorization is to allow the Company to determine eligibility for life coverage or a claim for benefits under a life policy.

I elect to be interviewed if an Investigative Consumer Report is prepared.

SIGNATORY SECTION

Signed in _____, this _____ day of _____ (year)
(state) (month)

Signature of Proposed Insured
(Parent or Guardian if under 14 years of age)

Signature of Applicant/Owner/Trustee (If other than Proposed Insured)
(Provide Officer's Title if policy is owned by a Corporation)

TO BE COMPLETED BY AGENT ONLY

- (i) Does the applicant have any existing life insurance policies or annuities? Yes No
- (ii) Do you know or have you any reason to believe that replacement of insurance is involved? Yes No
If a replacement is involved, I certify that only company approved sales materials were used in this sale and that copies of all sales materials were left with the applicant.
- (iii) I declare that I asked the Proposed Insured each question on the application. The answers have been recorded by me exactly as stated and I know of nothing affecting the insurability of the Proposed Insured which is not fully recorded in this application.
- (iv) Identify any special compensation instructions or commission schedule or Check here if there is no special commission program:

Signature of Licensed Agent, Broker or Registered Representative

Name of Licensed Agent, Broker or Registered Representative
(Please Print)

APPLICABLE TO VARIABLE LIFE ONLY

I have reviewed the Application, New Account Form and Premium Allocation and Disclosure Form and find the transaction suitable.

Signature of Registered Principal of Broker/Dealer

Name of Registered Principal of Broker/Dealer (Please Print)

IMPORTANT NOTICE

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Underwriters collect and review risk factors such as age, occupation, physical condition, medical history and any hazardous avocations. The level of risk and premium for the amount of coverage requested is based on this information.

INVESTIGATIVE CONSUMER REPORT

As a part of our routine procedure for processing your initial application, we may request an investigative consumer report. The agency making the report may keep a copy of the report and disclose its contents to others for whom it performs similar services. The report typically includes information such as identity and residence verification, character, reputation, marital status, estimate of net worth and income, occupation, avocations, medical history, habits, mode of living and other personal characteristics. Additional information is usually obtained from several different sources. Confidential interviews are conducted with neighbors, friends, business associates, and acquaintances. Public records are carefully reviewed.

Past experience shows that information from investigative reports usually does not have an adverse effect on our underwriting decision. If it should, we will notify you in writing and identify the reporting agency. At that point, if you wish to do so, you may discuss the matter with the reporting agency.

You have the right to be interviewed as part of any investigative consumer report that is completed. If you desire such an interview, please indicate this at the time your application is submitted. If you request it, we will supply the name, address and telephone number of the consumer reporting agency so you may obtain a copy of the report.

CONTESTABILITY

We strongly urge you to review the completed application closely for accuracy. During the 2 year incontestability period described in the policy, a claim may be denied if the application contains false statements or misrepresentations or fails to disclose material facts. In such a case, the policy could be void and coverage could be lost.

MIB, INC.

Information you provide regarding your insurability or claims will be treated as confidential except that The Company or its reinsurers, may make a brief report of it to MIB, Inc. This is a nonprofit membership organization of life insurance companies which operates an information exchange on behalf of its members. Upon request by another member insurance company to which you have applied for life or health insurance coverage or submitted a claim, MIB, Inc. will provide the information it may have in its file.

Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB, Inc.'s file, you may contact MIB at: 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734. You can reach MIB by phone toll free at (866) 692-6901. (TTY {866} 346-3642)

SIMPLIFIED ISSUE APPLICATION FOR LIFE INSURANCE

PROPOSED INSURED					
1. Name (First) (Middle) (Last)			2. <input type="checkbox"/> Male <input type="checkbox"/> Female	3. Date of Birth (mm/dd/yy)	
4. Place of Birth (State, Country)		5. Social Security Number (xxx-xx-xxxx)		6. Driver License # & State	
7a. Home Address (Street) (City) (State)			7b. Home Address Zip Code		
8. Employer			9. Citizen of (Country)		
10a. Business Address (Street) (City) (State)			10b. Business Address Zip Code		

COVERAGE INFORMATION

11. Plan of Insurance (If VUL also complete Question 17, Premium Allocation and Disclosure Form)

12. Additional Benefits If Available (Please List):

13. Amount of Insurance (Specified Amount, if UL or VUL) \$

14. (i) Death Benefit Option (Complete for Universal Life and Variable Universal Life Product only - not required for Term or Whole Life.)
 Level Increase by Cash Value Increase by Premium Increase by Premium Less Policy Factor
 (ii) Death Benefit Qualification Test - For IRS purposes, premiums will be tested using the Guideline Premium Test unless
 Cash Value Accumulation Test is checked (not available on all products). **Cannot be changed after issue.**

15. Are you considering stopping premium payments, surrendering, replacing, forfeiting, assigning to the insurer or reducing your benefits under an existing policy or annuity, or are you considering using or borrowing funds from your existing policies or annuities to pay premiums due on the new or applied for policy? Yes No
(If "Yes", please complete and sign all required replacement forms and complete Question 16.)

16. What is the total amount of all inforce insurance on your life? (Please list in the box below.) **If none, check this box:**

Company	Face Amount	Policy Number	Issue Date (mm/dd/yy)	Replacement or Change of Policy?	Check here if 1035 Exchange
	\$			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
	\$			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
	\$			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
	\$			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>

17. Complete only if applying for Variable Life Insurance with the Company. Submit Premium Allocation and Disclosure Form for Variable Universal Life with Application:

Suitability	Yes	No
1. Have you, the Proposed Insured(s) and the Owner, if other than the Proposed Insured(s), received a current Prospectus for the policy applied for and have you had sufficient time to review it?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you understand that the amount and duration of the death benefit may increase or decrease depending on the investment performance of funds in the Separate Account?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you understand that the cash values may increase or decrease depending on the investment performance of the funds held in the Separate Account?	<input type="checkbox"/>	<input type="checkbox"/>
4. With this in mind, do you believe that the policy applied for is in accord with your insurance objective and your anticipated financial needs?	<input type="checkbox"/>	<input type="checkbox"/>

CASH VALUES MAY INCREASE OR DECREASE IN ACCORDANCE WITH THE EXPERIENCE OF THE SEPARATE ACCOUNT. THE DEATH BENEFIT MAY BE VARIABLE OR FIXED UNDER SPECIFIED CONDITIONS.

OWNER INFORMATION (If left blank, Proposed Insured(s) will be owner)

► If a Trust, provide Trustee Name(s), Trust Name.

18. Owner Name (First, Middle, Last) _____ 19. Citizen of (Country) _____

20. Owner Address _____

21. Owner Social Security or Tax ID # _____ 22. Relationship to Proposed Insured(s) _____ 23. Trust Date (only if Trust is Owner) _____

24. Is the policy being purchased as part of an employer owned life insurance program where the employer is the direct or indirect beneficiary of the policy? Yes No

BENEFICIARY DESIGNATION Beneficiaries share equally unless otherwise indicated.

► If a Trust, provide Trustee Name(s), Trust Name and date of Trust.

25. Primary Beneficiary(ies): _____ 26. Social Security or Tax ID #: _____ 27. Relationship to Proposed Insured: _____

28. Contingent Beneficiary(ies): _____ 29. Social Security or Tax ID #: _____ 30. Relationship to Proposed Insured: _____

BILLING INSTRUCTIONS AS AVAILABLE PER PRODUCT

31. Planned Premium: \$ _____ 32. Lump Sum: \$ _____ 1035 Exchange

33. Premium Frequency: Annually Semi-Annually Quarterly Monthly (EFT)
 New List Bill Existing List Bill (provide #) _____
 PDF (Complete Transmittal) Other _____

34. Premium Notices To: (check all that apply.) (Please note we cannot bill to your agent.)
 Insured at Residence Insured at Business Owner Other _____

GENERAL RISK INFORMATION

35. Have you ever used tobacco or products containing nicotine? (If "Yes", check all that apply.) Yes No

Type: Cigarettes Cigar Pipe Chew Tobacco Snuff Nicotine Patches/ Gum

Date First Used: (month/year) _____

Date Last Used: (month/year) _____

Amount and Frequency: _____

36. Are you actively at work performing the regular duties of your job in the usual manner and at the usual place of employment or business for at least 30 hours per week? Yes No

36a If you answered "No" to question 36, please give details here:

37. Height _____ ft. _____ in. Weight _____ lbs **Yes** **No**

38. What is your regular occupation? _____

39. In the past 10 years have you applied for life, health or disability insurance and been declined, postponed or charged an increased premium?

40. Within the past two years, have you flown as a pilot, student pilot or crew member, or engaged in skin or scuba diving, racing of any kind, parachuting, sky diving or hang gliding, mountain, rock or technical climbing?

If "Yes", please complete an Aviation - Avocation Supplement.

41. In the past 10 years have you been treated for high blood pressure, heart disease, chest pain, diabetes, digestive disorder, lung disorder, cancer, kidney disease, liver disorder or nervous disorder?

42. In the past 5 years have you received treatment for alcohol or drug use?

- | | Yes | No |
|---|--------------------------|--------------------------|
| 43. In the past 5 years have you been convicted of (i) two or more moving violations, (ii) driving under the influence of alcohol or other drugs (unless prescribed by a doctor), or (iii) had your driver's license suspended or revoked? | <input type="checkbox"/> | <input type="checkbox"/> |
| 44. In the past 10 years have you been diagnosed by a medical professional as having human immune deficiency virus (HIV) infection, Acquired Immunodeficiency Syndrome (AIDS), or have you received treatment from a medical professional for AIDS? | <input type="checkbox"/> | <input type="checkbox"/> |
| 45. In the past 5 years have you been examined or treated by a physician or medical practitioner or been examined or treated in a hospital? If "Yes" provide name and address of personal physician and/or health care facility. | <input type="checkbox"/> | <input type="checkbox"/> |

If you answered "Yes" to question 37-45, please give complete details here including date of last treatment and name/address/phone number of the attending physician (attach an additional sheet of paper if necessary):

46. Special Instructions:

SERVICE OFFICE ENDORSEMENTS (Attach an additional sheet of paper, if necessary)

AGREEMENT AND ACKNOWLEDGEMENT

I, the Owner, declare that my tax identification or social security number as shown is correct. I also certify that I am not subject to backup withholding.

Each of the Undersigned declares that:

1. This Application consists of any amendments to the application(s) attached thereto and any supplements, all of which are required by the Company for the plan, amount and benefits applied for.
2. I/We further agree that (except as provided in the Temporary Life Insurance Agreement if advance payment has been made and acknowledged below and such Agreement issued), insurance will take effect under the Policy only when: 1) the Policy has been delivered to and accepted by me/us; 2) the initial premium has been paid in full during the lifetime of the Proposed Insured(s); and 3) the Proposed Insured(s) remain in the same state of health and insurability as described in each part of the application at the time conditions 1) and 2) are met.
I/We have paid \$ _____ to the Agent/Representative in exchange for the Temporary Life Insurance Agreement, and I/we acknowledge that I/we fully understand and accept its terms.
3. No agent, broker or medical examiner has the authority to make or modify any Company contract or to waive any of the Company's requirements.
4. I HAVE READ, or have had read to me, the completed Simplified Issue Application for Life Insurance before signing below. All statements and answers in this application are correctly recorded, and are full, complete and true.
5. I understand that, in order to informally fund benefit obligations, the Company may need to increase the amount of insurance under existing Policies on my life from time to time. I hereby authorize the Company to effect such an increase or increases without providing any further notice to me.
6. For employer owned life insurance policies, the owner hereby acknowledges its sole responsibility for ensuring that it complies with all legal and regulatory requirements related to life insurance it purchases on its employees, including appropriate disclosure to each employee whose life is insured under such a life insurance policy.
7. Corrections, additions or changes to this application may be made by the Company. Any such changes will be shown under "Service Office Endorsements". Acceptance of a policy issued with such changes will constitute acceptance of the changes. No change will be made in classification (including age at issue), plan, amount, or benefits unless agreed to in writing by the Applicant.

STATE DISCLOSURES

All jurisdictions except AR, AZ, CT, DC, FL, KS, KY, LA, ME, MN, NJ, NM, OH, OK, PA, TX, VA and WA. Any person who, with intent to defraud or knowing that he/she is facilitating fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

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TRUST VERIFICATION

I/We hereby certify that the Trustee(s) named in this application are the Trustee(s) for the named Trust, which is in full force and effect. The Company assumes no obligation to inquire into the terms of any trust agreement affecting this policy and shall not be held liable for any party's compliance with the terms thereof. The Company may rely solely upon the signature(s) of the Trustee(s) named in this application to any receipt, release or waiver, or to any transfer or other instrument affecting this policy or any options, privileges or benefits thereunder. Unless otherwise indicated, the signature(s) of all Trustee(s) named, or their successors, will be required to exercise any contractual right under the policy. The Company shall have no obligation to see to the use or application of any funds paid to the Trustee(s) in accordance with the terms of the policy. Any such payment made by the Company to the Trustee(s) shall fully discharge the Company with respect to any amounts so paid.

AUTHORIZATION

Each of the undersigned declares that:

I/We authorize any medical professional, hospital or other medical institution, insurer, MIB, Inc., or any other person or organization that has any records or knowledge of me/us or my/our physical or mental health or insurability to disclose that information to the Company, its reinsurers, or any other party acting on the Company's behalf. I/We authorize the Company or its reinsurer to make a brief report of my protected health information to MIB, Inc. I/We authorize the Company to disclose information related to my insurability to other insurers to whom I/we may apply for coverage.

I/We acknowledge receipt of the Privacy Notice and the Important Notice containing the Investigative Consumer Report and MIB, Inc. information.

The authorization shall be valid for 24 months after it is signed. A photographic copy of this authorization shall be as valid as the original. I/We understand that I/we may revoke this authorization at any time by written notification to the Company; however, any action taken prior to notification will not be affected.

The purpose of this authorization is to allow the Company to determine eligibility for life coverage or a claim for benefits under a life policy.

I elect to be interviewed if an Investigative Consumer Report is prepared.

SIGNATORY SECTION

Signed in _____, this _____ day of _____
(state) (month) (year)

Signature of Proposed Insured
(Parent or Guardian if under 14 years of age)

Signature of Applicant/Owner/Trustee (If other than Proposed Insured)
(Provide Officer's Title if policy is owned by a Corporation)

TO BE COMPLETED BY AGENT ONLY

- (i) Does the applicant have any existing life insurance policies or annuities? Yes No
- (ii) Do you know or have you any reason to believe that replacement of insurance is involved? Yes No
If a replacement is involved, I certify that only company approved sales materials were used in this sale and that copies of all sales materials were left with the applicant.
- (iii) I declare that I asked the Proposed Insured each question on the application. The answers have been recorded by me exactly as stated and I know of nothing affecting the insurability of the Proposed Insured which is not fully recorded in this application.
- (iv) Identify any special compensation instructions or commission schedule or Check here if there is no special commission program:

Signature of Licensed Agent, Broker or Registered Representative

Name of Licensed Agent, Broker or Registered Representative
(Please Print)

APPLICABLE TO VARIABLE LIFE ONLY

I have reviewed the Application, New Account Form and Premium Allocation and Disclosure Form and find the transaction suitable.

Signature of Registered Principal of Broker/Dealer

Name of Registered Principal of Broker/Dealer (Please Print)

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(Please give a copy of this notice to the Proposed Insured.)

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MONEYGUARD® APPLICATION FOR LIFE INSURANCE - PART I

PROPOSED INSURED <i>(Please Print in Blue or Black Ink)</i>			
1a. Name <i>(First, Middle Initial, Last)</i>		1b. <input type="checkbox"/> Male <input type="checkbox"/> Female	
1c. Residence Address <i>(No., Street, P.O. Box)</i>			
<i>(City, State, ZIP)</i>			
1d. US Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," what country?		1e. Date of Birth <i>(mm/dd/yy)</i>	1f. Soc. Sec. No.

POLICY INFORMATION

2a. Specified Amount: \$ _____

2b. Convalescent Care Benefits Rider Duration: *(Select One)* 2 Years 3 Years Other (if applicable): _____ years

2c. Extension of Benefits Rider Duration: *(Select One)* None 2 Years 4 Years Other (if applicable): _____ years

2d. Optional Inflation Protection: *(Select One)* Rejected: No Optional Inflation Protection Elected
 Simple Increases 3% Other (if applicable): _____ %
 Compound Increases 3% 5% Other (if applicable): _____ %

2e. Other Benefits/Riders: _____

2f. Other Options/Protections: _____

BILLING INFORMATION

3. Premium Frequency: *(select one)*
 Single Premium amount: \$ _____
 Flexible Premium: *(select one)* Annual Semi-Annual Quarterly Monthly (PAC/EFT)
 Initial premium of \$ _____ and then \$ _____

EXISTING AND PENDING INSURANCE INFORMATION - PROPOSED INSURED

4a. Are you considering stopping premium payments, surrendering, replacing, forfeiting, assigning to the insurer, or reducing your benefits under an existing policy or annuity, or are you considering using or borrowing funds from your existing policies or annuities to pay premiums due on the new or applied for policy? Yes No
(If Yes, please complete and sign all required life insurance and annuity replacement forms and complete Question 4c.)

4b. Will the policy applied for replace any medical, health or long-term care insurance contract currently in force with this or any other company? Yes No
(If Yes, please provide details in question 4c below and please complete and sign all required replacement forms)

4c. Please list in the space below all existing life insurance policies, annuity contracts currently in force with this or any other company. **If none, check this box**

Company	Face Amount	Policy Number	Issue Date (mm/dd/yy)	Replacement or Change of Policy?	Check here if 1035 Exchange
	\$			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
	\$			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
	\$			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
	\$			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

4d. Have you ever applied for life, health or disability insurance and been declined, postponed or charged an increased premium? *(If "Yes", provide further information in the "Details" space provided.)* Yes No

4e. Has any long-term care insurance contract lapsed, been surrendered or otherwise terminated in the past 24 months? *(If Yes, please provide details in question 4g below.)* Yes No

4f. Currently, or within the past 12 months have you had any long-term care policies or riders (including healthcare service or health maintenance organization contracts) in force or pending? Yes No

4g. List details from Questions 4e and 4f above.

Company	Issue Date (mm/dd/yy)	Date of Lapse, Surrender or Termination (mm/dd/yy)	Long-Term Care Max Daily Benefit	Replacement or Change of Policy?	In Force	Applied For
				<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/>	<input type="checkbox"/>

4h. Do your long-term care policies or riders include Home Health Care coverage? Yes No

4i. Are you currently covered by Medicaid? Yes No

4j. Provide full name/address/phone number of personal physician(s) and any other physicians seen within the past 5 years.

Physician Name	Address	Phone Number
a. Date and reason of last visit:		
b. Tests performed & treatment received:		

GENERAL RISK - PROPOSED INSURED

(If you answer "Yes" to any of the following questions, please give details and list medications in the Details section provided below.)

- 5a. Are you actively at work performing the regular duties of your job in the usual manner and at the usual place of employment or business for at least 30 hours per week? Yes No
- 5b. Currently, or within the past 10 years, have you received or applied for any disability benefits, including Worker's Compensation, Social Security Disability Insurance or any other form of disability insurance? Yes No
- 5c. Have you ever been told you have, been diagnosed with or been treated by a physician and/or taken medication for:
 - 1. Syncope, vertigo, tremor, or falls? Yes No
 - 2. Angina, congestive heart failure, coronary artery disease, peripheral vascular disease or atrial fibrillation? Yes No
 - 3. Transient ischemic attack (TIA)? Yes No
 - 4. Parkinson's disease, Multiple Sclerosis, ALS, Muscular Dystrophy, Huntington's or Systemic Lupus? Yes No
 - 5. Osteoporosis or Rheumatoid Arthritis? Yes No
 - 6. Alzheimer's disease, dementia or memory loss? Yes No
- 5d. Currently, or within the last 5 years have you had any impairment, whether mental or physical, for which you need or receive assistance or supervision in performing any daily living activities such as bathing, dressing, eating, transferring or ambulation, toileting, or bowel or bladder control? Yes No
- 5e. Do you use a wheelchair, walker or cane, oxygen, catheter, dialysis machine or other mechanical device? Yes No
- 5f. Within the past 5 years have you been confined or recommended admission to a nursing home or received home health care, or are you currently confined to a hospital or nursing facility? Yes No
- 5g. Are you currently living in an Assisted Living facility or Independent Community? Yes No
- 5h. Have you ever used tobacco or products containing nicotine (including, but not limited to, chew tobacco, snuff, nicotine gum and/or patches)? *(If "Yes", list below.)* Yes No

Type:	Date First Used: (month/year)	Date Last Used: (month/year)	Amount and Frequency:

- 5i. Have you had or been advised to have a check-up, EKG, x-ray, blood, or urine test or any other diagnostic test? Yes No
- 5j. Have you been a patient in a hospital, clinic, sanatorium or other medical facility, or been advised to have any hospitalization or surgery which has not been completed? Yes No

5k. Have you ever had any indication of, or been treated for:

- 1. Chest pain, high blood pressure, heart disease, heart murmur or other disorders of the heart or blood vessels? Yes No
- 2. Ulcers, colitis, jaundice, or other diseases of the stomach, liver, intestines, gallbladder, pancreas, kidney or urinary bladder? Yes No
- 3. Seizures, fainting, dizziness, epilepsy, stroke or paralysis? Yes No
- 4. Any nervous, mental, or emotional disorder, or received counseling for anxiety, depression, stress or any other emotional condition? Yes No
- 5. Any tumor, cancer, cysts, skin disorder or any disorder of the lymph nodes? Yes No
- 6. Arthritis, gout, or any disorder of the back, spine, muscles, nerves, bones or joints? Yes No
- 7. Diabetes, thyroid, or other endocrine or glandular disorder? Yes No
- 8. Anemia or any other blood disorder? Yes No
- 9. Asthma, emphysema, shortness of breath, allergies, sleep apnea or any other disorder of the respiratory system? Yes No
- 10. Any disorder of the eyes, ears, nose or throat? Yes No
- 11. Any complication of pregnancy or disorder of the testicles, prostate, breasts, ovaries, uterus or cervix? Yes No
- 12. Any mental or physical disorder not listed above? Yes No

5l. Have you ever been diagnosed as having or been treated by a physician for Acquired Immune Deficiency Syndrome or an AIDS related condition? Yes No

5m. Do you use alcoholic beverages? (If "Yes", provide Type, Frequency & Amount.) Yes No

Type	Frequency	Amount

5n. Have you ever been treated for drug or alcohol abuse or been advised by your doctor to limit your use of alcohol or any medication, prescribed or not? Yes No

5o. Have you ever used hallucinogenic or narcotic drugs not prescribed by a doctor? Yes No

5p. Within the past 5 years have you been consulted, examined or treated by any physician or practitioner for reasons not stated in this application? Yes No

5q. List all medication and dosage you are currently taking, include prescriptions, over the counter drugs, aspirin and herbal supplements.

5r. Details to General Risk Questions: (If more room is needed, use a separate sheet of paper. Make sure you sign and date the form.)

Question #	Date	Details/Reasons	List Medications

OWNER INFORMATION (If left blank, Proposed Insured will be owner)

6a. Primary

Full Name	Date of Birth	Soc. Sec. No.	Relationship to Proposed Insured

6b. Contingent

Full Name	Date of Birth	Soc. Sec. No.	Relationship to Proposed Insured

6c. Owner Address

No., Street, P.O. Box
City, State, Zip Code

BENEFICIARY INFORMATION (Unless otherwise stated below, if multiple beneficiaries are named in a class (Primary, Contingent), the proceeds are to be paid equally to the survivor or survivors, if any, in the class.)

6a. Primary

Name/Trust name & Trustees	DOB/Trust Date	SSN/Tax ID	Relationship to Proposed Insured

6b. Contingent

Full Name	Date of Birth	Soc. Sec. No.	Relationship to Proposed Insured

PROTECTION AGAINST UNINTENDED LAPSE

I, the Applicant/Owner, understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this insurance policy for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid. I also understand that I will be given the opportunity to change this written designation at any time. My selection is as follows:

- I elect NOT to designate another person to receive notice of lapse or termination.
- I designate the person(s) listed below to receive copies of any notice of lapse or termination.

Third Party Name: _____ Phone Number: _____

Address: _____

AGREEMENT AND ACKNOWLEDGEMENT

I, the Owner, declare that my tax identification or social security number as shown is correct. I also certify that I am not subject to backup withholding.

The Undersigned declares that:

1. This Application consists of: a) Part I Application; b) any amendments to the application(s) attached thereto; and c) any supplements, all of which are required by the Company for the plan, amount and benefits applied for.
2. I further agree that (except as provided in the Temporary Life Insurance Agreement if advance payment has been made and acknowledged below and such Agreement issued), insurance will take effect under the Policy only when: 1) the Policy has been delivered to and accepted by me; 2) the initial premium has been paid in full during the lifetime of the Proposed Insured; and 3) the Proposed Insured remains in the same state of health and insurability as described in each part of the application at the time conditions 1) and 2) are met.

I have paid \$ _____ to the Agent/Representative in exchange for the Temporary Life Insurance Agreement, and I acknowledge that I fully understand and accept its terms.

3. No agent, broker or medical examiner has the authority to make or modify any Company contract or to waive any of the Company's requirements.
4. I HAVE READ, or have had read to me, the completed Application for Life Insurance before signing below. All statements and answers in this application are correctly recorded, and are full, complete and true. **Caution: If your answers on this application are incorrect or untrue, the Company may have the right to deny benefits or rescind coverage under the policy and any riders attached to it.**
5. For employer owned life insurance policies, the owner hereby acknowledges its sole responsibility for ensuring that it complies with all legal and regulatory requirements related to life insurance it purchases on its employees, including appropriate disclosure to each employee whose life is insured under such a life insurance policy.

STATE DISCLOSURES

All jurisdictions except AR, AZ, CT, DC, FL, KS, KY, LA, ME, MN, NJ, NM, OH, OK, PA, TX, VA and WA. Any person who, with intent to defraud or knowing that he/she is facilitating fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

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

Washington Only. Any person who knowingly presents a false or fraudulent claim for the payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law.

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

Connecticut and Texas Only. Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud, as determined by a court of competent jurisdiction.

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

TRUST VERIFICATION

I hereby certify that the Trustee(s) named in this application are the Trustee(s) for the named Trust, which is in full force and effect. The Company assumes no obligation to inquire into the terms of any trust agreement affecting this policy and shall not be held liable for any party's compliance with the terms thereof. The Company may rely solely upon the signature(s) of the Trustee(s) named in this application to any receipt, release or waiver, or to any transfer or other instrument affecting this policy or any options, privileges or benefits thereunder. Unless otherwise indicated, the signature(s) of all Trustee(s) named, or their successors, will be required to exercise any contractual right under the policy. The Company shall have no obligation to see to the use or application of any funds paid to the Trustee(s) in accordance with the terms of the policy. Any such payment made by the Company to the Trustee(s) shall fully discharge the Company with respect to any amounts so paid.

AUTHORIZATION

Each of the undersigned declares that:

The purpose of this authorization is to allow the Company to determine eligibility for life coverage or a claim for benefits under a life policy.

I authorize any medical professional, hospital or other medical institution, insurer, MIB, Inc., or any other person or organization that has any records or knowledge of me or my physical or mental health, employment, finances, transactions or other information relevant to my insurability to disclose that information to the Company, its reinsurers, or any other party acting on the Company's behalf. **I authorize the Company to disclose medical information to MIB, Inc., and to other insurers to whom I may apply for coverage.**

I acknowledge receipt of the Privacy Notice and the Important Notice containing the Investigative Consumer Report and MIB, Inc. information.

The authorization shall be valid for 24 months after it is signed. A photographic copy of this authorization shall be as valid as the original. I understand that I may revoke this authorization at any time by written notification to the Company; however, any action taken prior to notification will not be affected.

INFLATION PROTECTION COVERAGE

I have reviewed the Outline of Coverage and the charts that compare the benefits and premiums of the Convalescent Care Benefits Rider and Extension of Benefits Rider with and without Optional Inflation Protection. I understand and agree that I will be issued a rider or riders with default Compound Increases at 5%, **UNLESS I choose another option below:**

- I hereby **REJECT** default Compound Increases at 5% and apply for Optional Inflation Protection as shown in the Policy Information section, question 2d, on page 1.
- I hereby **REJECT** all options for Optional Inflation Protection.

SIGNATORY SECTION

Signed in _____, this _____ day of _____ (state) (month) (year)

Signature of Proposed Insured

Signature of Witness

Signature of Applicant/Owner/Trustee (If other than Proposed Insured)
(Provide Officer's Title if policy is owned by a Corporation)

Signature of Witness

TO BE COMPLETED BY AGENT ONLY (All questions are required to be answered.)

- (i) Does the applicant have any existing life insurance policies or annuities? Yes No
- (ii) Do you know or have you any reason to believe that replacement of insurance is involved? Yes No
If a replacement is involved, I certify that only company approved sales materials were used in this sale and that copies of all sales materials were left with the applicant.
- (iii) List all Long-Term Care or Health Insurance that: 1) You have sold to the Proposed Insured that is still in force. 2) You have sold to the Proposed Insured in the last 5 years that is no longer in force.

Company	Policy Number	Year of Issue	
			<input type="checkbox"/> In Force <input type="checkbox"/> No Longer In Force
			<input type="checkbox"/> In Force <input type="checkbox"/> No Longer In Force

I declare that I have accurately answered all questions contained in this section.

I declare that I have provided each Proposed Insured and Owner(s) with the Important Notice as well as a copy of the Privacy Practices Notice.

Signature of Licensed Agent, Broker or Registered Representative

Name of Licensed Agent, Broker or Registered Representative
(Please Print)

IMPORTANT NOTICE

Since you are applying for insurance, we would like you to know more about our underwriting process and what occurs after you submit your application.

(Please give a copy of this notice to the Proposed Insured.)

THE UNDERWRITING PROCESS

All forms of insurance are based on the concept of risk-sharing. Underwriters seek to determine the level of risk represented by each applicant, and then assign that person to a group with similar risk characteristics. In this way, the risk potential can be spread among all policyholders within a given risk group, assuring that each assumes his fair share of the insurance cost.

Underwriters collect and review risk factors such as age, occupation, physical condition, medical history, cognitive assessment and any hazardous avocations. The level of risk and premium for the amount of coverage requested is based on this information.

INVESTIGATIVE CONSUMER REPORT

As a part of our routine procedure for processing your initial application, we may request an investigative consumer report. The agency making the report may keep a copy of the report and disclose its contents to others for whom it performs similar services. The report typically includes information such as identity and residence verification, character, reputation, marital status, estimate of net worth and income, occupation, avocations, medical history, habits, mode of living and other personal characteristics. Additional information is usually obtained from several different sources. Confidential interviews are conducted with neighbors, friends, business associates, and acquaintances. Public records are carefully reviewed.

Past experience shows that information from investigative reports usually does not have an adverse effect on our underwriting decision. If it should, we will notify you in writing and identify the reporting agency. At that point, if you wish to do so, you may discuss the matter with the reporting agency.

You have the right to be interviewed as part of any investigative consumer report that is completed. If you desire such an interview, please indicate this at the time your application is submitted. If you request it, we will supply the name, address and telephone number of the consumer reporting agency so you may obtain a copy of the report.

CONTESTABILITY

We strongly urge you to review the completed application closely for accuracy. During the 2 year contestability period described in the policy, a claim may be denied if the application contains false statements or misrepresentations or fails to disclose material facts. In such a case, the policy could be void and coverage could be lost.

MIB, INC.

Information you provide regarding your insurability or claims will be treated as confidential except that the Company or its reinsurers, may make a brief report of it to MIB, Inc. This is a nonprofit membership organization of life insurance companies which operates an information exchange on behalf of its members. Upon request by another member insurance company to which you have applied for life or health insurance coverage or submitted a claim, MIB, Inc. will provide the information it may have in its file.

Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB, Inc.'s file, you may contact MIB at: 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734. You can reach MIB by phone toll free at (866) 692-6901. (TTY {866} 346-3642)

MONEYGUARD® APPLICATION FOR LIFE INSURANCE - PART I

PROPOSED INSURED <i>(Please Print in Blue or Black Ink)</i>			
1a. Name <i>(First, Middle Initial, Last)</i>		1b. <input type="checkbox"/> Male <input type="checkbox"/> Female	
1c. Residence Address <i>(No., Street, P.O. Box)</i>			
<i>(City, State, ZIP)</i>			
1d. US Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No		If "No," what country?	1e. Date of Birth <i>(mm/dd/yy)</i>
			1f. Soc. Sec. No.

POLICY INFORMATION

2a. Specified Amount: \$ _____

2b. Convalescent Care Benefits Rider Duration: *(Select One)* 2 Years 3 Years Other (if applicable): _____ years

2c. Extension of Benefits Rider Duration: *(Select One)* None 2 Years 4 Years Other (if applicable): _____ years

2d. Optional Inflation Protection: *(Select One)* Rejected: No Optional Inflation Protection Elected
 Simple Increases 3% Other (if applicable): _____ %
 Compound Increases 3% 5% Other (if applicable): _____ %

2e. Other Benefits/Riders: _____

2f. Other Options/Protections: _____

BILLING INFORMATION

3. Premium Frequency: *(select one)*
 Single Premium amount: \$ _____
 Flexible Premium: *(select one)* Annual Semi-Annual Quarterly Monthly (PAC/EFT)
 Initial premium of \$ _____ and then \$ _____

EXISTING AND PENDING INSURANCE INFORMATION - PROPOSED INSURED

4a. Are you considering stopping premium payments, surrendering, replacing, forfeiting, assigning to the insurer, or reducing your benefits under an existing policy or annuity, or are you considering using or borrowing funds from your existing policies or annuities to pay premiums due on the new or applied for policy? Yes No
(If Yes, please complete and sign all required life insurance and annuity replacement forms and complete Question 4c.)

4b. Will the policy applied for replace any medical, health or long-term care insurance contract currently in force with this or any other company? Yes No
(If Yes, please provide details in question 4c below and please complete and sign all required replacement forms)

4c. Please list in the space below all existing life insurance policies, annuity contracts currently in force with this or any other company. **If none, check this box**

Company	Face Amount	Policy Number	Issue Date <i>(mm/dd/yy)</i>	Replacement or Change of Policy?	Check here if 1035 Exchange
	\$			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
	\$			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
	\$			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
	\$			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

4d. Have you ever applied for life, health or disability insurance and been declined, postponed or charged an increased premium? *(If "Yes", provide further information in the "Details" space provided.)* Yes No

4e. Has any long-term care insurance contract lapsed, been surrendered or otherwise terminated in the past 24 months? Yes No
(If Yes, please provide details in question 4g below.)

4f. Currently, or within the past 12 months have you had any long-term care policies or riders (including healthcare service or health maintenance organization contracts) in force or pending? Yes No

4g. List details from Questions 4e and 4f above.

Company	Issue Date (mm/dd/yy)	Date of Lapse, Surrender or Termination (mm/dd/yy)	Long-Term Care Max Daily Benefit	Replacement or Change of Policy?	In Force	Applied For
				<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/>	<input type="checkbox"/>

4h. Do your long-term care policies or riders include Home Health Care coverage? Yes No

4i. Are you currently covered by Medicaid? Yes No

4j. Provide full name/address/phone number of personal physician(s) and any other physicians seen within the past 5 years.

Physician Name	Address	Phone Number
a. Date and reason of last visit:		
b. Tests performed & treatment received:		

GENERAL RISK - PROPOSED INSURED

(If you answer "Yes" to any of the following questions, please give details and list medications in the Details section provided below.)

- 5a. Are you actively at work performing the regular duties of your job in the usual manner and at the usual place of employment or business for at least 30 hours per week? Yes No
- 5b. Currently, or within the past 10 years, have you received or applied for any disability benefits, including Worker's Compensation, Social Security Disability Insurance or any other form of disability insurance? Yes No
- 5c. Have you ever been told you have, been diagnosed with or been treated by a physician and/or taken medication for:
 - 1. Syncope, vertigo, tremor, or falls? Yes No
 - 2. Angina, congestive heart failure, coronary artery disease, peripheral vascular disease or atrial fibrillation? Yes No
 - 3. Transient ischemic attack (TIA)? Yes No
 - 4. Parkinson's disease, Multiple Sclerosis, ALS, Muscular Dystrophy, Huntington's or Systemic Lupus? Yes No
 - 5. Osteoporosis or Rheumatoid Arthritis? Yes No
 - 6. Alzheimer's disease, dementia or memory loss? Yes No
- 5d. Currently, or within the last 5 years have you had any impairment, whether mental or physical, for which you need or receive assistance or supervision in performing any daily living activities such as bathing, dressing, eating, transferring or ambulation, toileting, or bowel or bladder control? Yes No
- 5e. Do you use a wheelchair, walker or cane, oxygen, catheter, dialysis machine or other mechanical device? Yes No
- 5f. Within the past 5 years have you been confined or recommended admission to a nursing home or received home health care, or are you currently confined to a hospital or nursing facility? Yes No
- 5g. Are you currently living in an Assisted Living facility or Independent Community? Yes No
- 5h. Have you ever used tobacco or products containing nicotine (including, but not limited to, chew tobacco, snuff, nicotine gum and/or patches)? *(If "Yes", list below.)* Yes No

Type:	Date First Used: (month/year)	Date Last Used: (month/year)	Amount and Frequency:

- 5i. Have you had or been advised to have a check-up, EKG, x-ray, blood, or urine test or any other diagnostic test? Yes No
- 5j. Have you been a patient in a hospital, clinic, sanatorium or other medical facility, or been advised to have any hospitalization or surgery which has not been completed? Yes No

5k. Have you ever had any indication of, or been treated for:

- 1. Chest pain, high blood pressure, heart disease, heart murmur or other disorders of the heart or blood vessels? Yes No
- 2. Ulcers, colitis, jaundice, or other diseases of the stomach, liver, intestines, gallbladder, pancreas, kidney or urinary bladder? Yes No
- 3. Seizures, fainting, dizziness, epilepsy, stroke or paralysis? Yes No
- 4. Any nervous, mental, or emotional disorder, or received counseling for anxiety, depression, stress or any other emotional condition? Yes No
- 5. Any tumor, cancer, cysts, skin disorder or any disorder of the lymph nodes? Yes No
- 6. Arthritis, gout, or any disorder of the back, spine, muscles, nerves, bones or joints? Yes No
- 7. Diabetes, thyroid, or other endocrine or glandular disorder? Yes No
- 8. Anemia or any other blood disorder? Yes No
- 9. Asthma, emphysema, shortness of breath, allergies, sleep apnea or any other disorder of the respiratory system? Yes No
- 10. Any disorder of the eyes, ears, nose or throat? Yes No
- 11. Any complication of pregnancy or disorder of the testicles, prostate, breasts, ovaries, uterus or cervix? Yes No
- 12. Any mental or physical disorder not listed above? Yes No

5l. Have you ever been diagnosed as having or been treated by a physician for Acquired Immune Deficiency Syndrome or an AIDS related condition? Yes No

5m. Do you use alcoholic beverages? (If "Yes", provide Type, Frequency & Amount.) Yes No

Type	Frequency	Amount

5n. Have you ever been treated for drug or alcohol abuse or been advised by your doctor to limit your use of alcohol or any medication, prescribed or not? Yes No

5o. Have you ever used hallucinogenic or narcotic drugs not prescribed by a doctor? Yes No

5p. Within the past 5 years have you been consulted, examined or treated by any physician or practitioner for reasons not stated in this application? Yes No

5q. List all medication and dosage you are currently taking, include prescriptions, over the counter drugs, aspirin and herbal supplements.

5r. Details to General Risk Questions: (If more room is needed, use a separate sheet of paper. Make sure you sign and date the form.)

Question #	Date	Details/Reasons	List Medications

OWNER INFORMATION (If left blank, Proposed Insured will be owner)

6a. Primary

Full Name	Date of Birth	Soc. Sec. No.	Relationship to Proposed Insured

6b. Contingent

Full Name	Date of Birth	Soc. Sec. No.	Relationship to Proposed Insured

6c. Owner Address

No., Street, P.O. Box
City, State, Zip Code

BENEFICIARY INFORMATION (Unless otherwise stated below, if multiple beneficiaries are named in a class (Primary, Contingent), the proceeds are to be paid equally to the survivor or survivors, if any, in the class.)

7a. Primary

Name/Trust name & Trustees	DOB/Trust Date	SSN/Tax ID	Relationship to Proposed Insured

7b. Contingent

Full Name	Date of Birth	Soc. Sec. No.	Relationship to Proposed Insured

PROTECTION AGAINST UNINTENDED LAPSE

I, the Applicant/Owner, understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this insurance policy for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid. I also understand that I will be given the opportunity to change this written designation at any time. My selection is as follows:

- I elect NOT to designate another person to receive notice of lapse or termination.
- I designate the person(s) listed below to receive copies of any notice of lapse or termination.

Third Party Name: _____ Phone Number: _____

Address: _____

AGREEMENT AND ACKNOWLEDGEMENT

I, the Owner, declare that my tax identification or social security number as shown is correct. I also certify that I am not subject to backup withholding.

The Undersigned declares that:

1. This Application consists of: a) Part I Application; b) any amendments to the application(s) attached thereto; and c) any supplements, all of which are required by the Company for the plan, amount and benefits applied for.
2. I further agree that (except as provided in the Temporary Life Insurance Agreement if advance payment has been made and acknowledged below and such Agreement issued), insurance will take effect under the Policy only when: 1) the Policy has been delivered to and accepted by me; 2) the initial premium has been paid in full during the lifetime of the Proposed Insured; and 3) the Proposed Insured remains in the same state of health and insurability as described in each part of the application at the time conditions 1) and 2) are met.

I have paid \$ _____ to the Agent/Representative in exchange for the Temporary Life Insurance Agreement, and I acknowledge that I fully understand and accept its terms.

3. No agent, broker or medical examiner has the authority to make or modify any Company contract or to waive any of the Company's requirements.
4. I HAVE READ, or have had read to me, the completed Application for Life Insurance before signing below. All statements and answers in this application are correctly recorded, and are full, complete and true. **Caution: If your answers on this application are incorrect or untrue, the Company may have the right to deny benefits or rescind coverage under the policy and any riders attached to it.**
5. For employer owned life insurance policies, the owner hereby acknowledges its sole responsibility for ensuring that it complies with all legal and regulatory requirements related to life insurance it purchases on its employees, including appropriate disclosure to each employee whose life is insured under such a life insurance policy.

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- I hereby **REJECT** default Compound Increases at 5% and apply for Optional Inflation Protection as shown in the Policy Information section, question 2d, on page 1.
- I hereby **REJECT** all options for Optional Inflation Protection.

SIGNATORY SECTION

Signed in _____, this _____ day of _____ (state) (month) (year)

Signature of Proposed Insured

Signature of Witness

Signature of Applicant/Owner/Trustee (If other than Proposed Insured)
(Provide Officer's Title if policy is owned by a Corporation)

Signature of Witness

TO BE COMPLETED BY AGENT ONLY (All questions are required to be answered.)

- (i) Does the applicant have any existing life insurance policies or annuities? Yes No
- (ii) Do you know or have you any reason to believe that replacement of insurance is involved? Yes No
If a replacement is involved, I certify that only company approved sales materials were used in this sale and that copies of all sales materials were left with the applicant.
- (iii) List all Long-Term Care or Health Insurance that: 1) You have sold to the Proposed Insured that is still in force. 2) You have sold to the Proposed Insured in the last 5 years that is no longer in force.

Company	Policy Number	Year of Issue	
			<input type="checkbox"/> In Force <input type="checkbox"/> No Longer In Force
			<input type="checkbox"/> In Force <input type="checkbox"/> No Longer In Force

I declare that I have accurately answered all questions contained in this section.

I declare that I have provided each Proposed Insured and Owner(s) with the Important Notice as well as a copy of the Privacy Practices Notice.

Signature of Licensed Agent, Broker or Registered Representative

Name of Licensed Agent, Broker or Registered Representative
(Please Print)