# APPLICATION FOR INSURANCE

*Western Reserve Life Assurance Co. of Ohio*
Administrative Office, 4333 Edgewood Road NE, Cedar Rapids, IA 52499

## PROPOSED INSURED INFORMATION

| 1. Name *(First, M.I., Last)* | 2. Mailing Address |
|---|---|

| 3. Home Telephone No. ( ) | 4. Work Telephone No. ( ) | 5. Birth Date | 6. Birth State / Country | 7. E-mail Address (optional) |
|---|---|---|---|---|

| 8. Height | 9. Weight | 10. Marital Status | 11. Sex ☐ Male ☐ Female | 12. U.S. Citizen ☐ Yes ☐ No | 13. *If no, give immigration status/type of visa:* |
|---|---|---|---|---|---|

14. Occupation & Duties

| 15. Annual Income Current Year | 16. Social Security No. or Tax I.D. No. | 17. Drivers License No. and State |
|---|---|---|

18. Have you used any tobacco or nicotine products within the last 5 years? ☐ Yes ☐ No If yes, list type and when used last

## BENEFICIARY AND RELATIONSHIP TO PROPOSED INSURED *(Unless otherwise noted, the beneficiary of other persons proposed for Coverage will be the proposed insured.)*

| 19. Primary | Relationship | 20. Contingent | Relationship |
|---|---|---|---|

## OWNER *(Unless otherwise noted, the Owner will be the Insured.)*

| 21. Name | a. Relationship to Proposed Insured | b. Social Security Number |
|---|---|---|
| c. Address | d. Birth Date | e. Phone ( ) |

## POLICY INFORMATION

| 22. Plan: ______ ☐ Level ☐ Increasing Term Period ______ | 23. Amount of Insurance $ | 24. Planned Premium $ |
|---|---|---|

25. Mode of Payment (for bank draft, complete Check-O-Matic authorization, and collect initial payment.)
☐ Monthly Bank Draft ☐ Annual ☐ Other ______

## 26. ADDITIONAL BENEFITS and AMOUNTS

☐ Additional Insured Rider (AIR) $______
☐ Base Insured Rider (BIR) $______
☐ Children's Benefit Rider (CBR) $______
☐ Guaranteed Insurability Rider (GIR) $______
☐ Accidental Death Benefit (ADB) $______

☐ Waiver of Premium Benefit (WP)
☐ Monthly Disability Income Rider (DIR)
☐ 2 Year ☐ 5 Year $______
☐ Other ______ $______
☐ Other ______ $______

| 27. Name of Proposed Additional Insured(s) including any children applying | Birth Date | Sex | Height | Weight | Social Security Number | Relationship to Insured | Used Tobacco or nicotine products in last 5 years? If yes, list type and when used last |
|---|---|---|---|---|---|---|---|
| | | | | | | | ☐ No ☐ Yes ______ |
| | | | | | | | ☐ No ☐ Yes ______ |
| | | | | | | | ☐ No ☐ Yes ______ |
| | | | | | | | ☐ No ☐ Yes ______ |

## 28. LIFE INSURANCE IN FORCE — If none check this box ☐

| Insured's Name | Company (only need if replacing) | Policy Number (only need if replacing) | Face Amount |
|---|---|---|---|
| | | | $ |
| | | | $ |

## 29. DISABILITY INCOME - INSURANCE IN FORCE — If none check this box ☐

*Complete if applying for disability income and have current coverage. Please include any salary continuation program or employer paid benefits you may be eligible for should you become ill or injured over an extended period of time.*

| Insured's Name | Company | Policy Number | Monthly Amount | Benefit Period | Elimination Period |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |

## GENERAL QUESTIONS Complete the following. *For YES answers, give full details in the space provided in Section 52.*

30. Will the insurance applied for replace or change any existing insurance or annuity? ☐ Yes ☐ No

**Have you or any Proposed Additional Insured (including any children applying),**

31. Been declined, postponed, offered a rated or modified life, health or disability policy or been denied reinstatement? ☐ Yes ☐ No
32. Within the past 5 years,
    a. Been cited or convicted of a moving violation, including DUI, or had a driver's license suspended or revoked? ☐ Yes ☐ No
    (If yes, provide state and drivers license number.) ____________________
    b. Been or is now fully or partially disabled? ☐ Yes ☐ No
    c. Been charged with or convicted of any felony or has been or is currently on probation or parole? ☐ Yes ☐ No
33. Within the past 2 years, *(If any YES answer, complete the Avocation, Aviation, Foreign Travel Questionnaire.)*
    a. Taken part in any type of racing, mountain climbing, underwater or sky diving, hang gliding or plan to? ☐ Yes ☐ No
    b. Flown other than as a passenger, or plan to? ☐ Yes ☐ No
    c. Had a foreign residence, traveled to a foreign country or are you planning to travel to a foreign country in the next two years? ☐ Yes ☐ No
34. Within the past 10 years, used drugs (such as: hallucinogens, barbiturates, excitants or narcotics) except as medication prescribed by a physician, or been treated or counseled for drug or alcohol use? ☐ Yes ☐ No

Questions 35 to 38 apply to you or any Proposed Additional Insured:

35. Family History: Is there a history of cardiovascular disease or cancer in parents/siblings prior to age 60? ☐ Yes ☐ No
36. Do you exercise? If yes, describe type, how often per week and how long per session. ☐ Yes ☐ No
37. Do you drink alcoholic beverages? If yes, please provide type of drinks, number of occasions per year and the number of drinks consumed on those occasions. ☐ Yes ☐ No
38. Have you had any weight change in the past year? ☐ Yes ☐ No
39. Do you or any Proposed Additional Insured (including any children applying) have any health, disability or life insurance pending or contemplated with another company? ☐ Yes ☐ No

## MEDICAL QUESTIONS Each question must be individually asked and answered. *For YES answers, give full details in the space provided in Section 52.*

40. Have you or any Proposed Additional Insured (including any children applying) EVER been diagnosed as having or been treated for AIDS, or AIDS Related Complex (ARC) or tested positive for the HTLV-III Test? ☐ Yes ☐ No

**(Questions 41 to 51) Within the past 10 years, have you or any Proposed Additional Insured (including any children applying) been treated or diagnosed by a health care professional as having:**

41. A heart attack, heart disease, palpitations, heart murmur, chest pain, high blood pressure, stroke, anemia or any other disease or disorder of the blood or circulatory system? ☐ Yes ☐ No
42. Emphysema, asthma, shortness of breath, chronic cough, sleep apnea or any other disease or disorder of the respiratory system? ☐ Yes ☐ No
43. Seizures, epilepsy, multiple sclerosis, mental illness, depression, suicide attempt, eating disorder, dementia, Alzheimer's disease or any other disease or disorder of the brain or nervous system? ☐ Yes ☐ No
44. Sugar, albumin, blood in urine, or any other disease or disorder of the kidneys, bladder, or urinary system? ☐ Yes ☐ No
45. Prostate problems, breast problems, a sexually transmitted disease or any other disease or disorder of the reproductive system? ☐ Yes ☐ No
46. Stomach, intestine, liver disorder or any other disease or disorder of the gastrointestinal system (such as: ulcer, colitis, Crohn's disease or hepatitis)? ☐ Yes ☐ No
47. Diabetes, thyroid disorder or any other disease or disorder of the endocrine system? ☐ Yes ☐ No
48. Lupus, arthritis, back, bone, joint, or any other disease or disorder of the muscle or bone? ☐ Yes ☐ No
49. Tumor(s), polyp(s), cancer, melanoma or other malignancy? ☐ Yes ☐ No
50. Or been advised to have a check-up, consultation, lab test, EKG, X-ray or other diagnostic test? ☐ Yes ☐ No
51. Or are you currently under the observation of a physician or taking medication? ☐ Yes ☐ No

## 52. ADDITIONAL INFORMATION *If additional space required, use Supplemental Form SA-ADINFO.*

| Question Number | Name of Proposed Insured | Details to General and Medical Questions (Diagnosis, Dates, Durations, and Medications, Dosages, Frequency) Medical Facilities & Physicians Names, Addresses, Phone Numbers |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

## 53. PERSONAL PHYSICIAN(S) *If additional space required, use Supplemental Form SA-ADINFO.*

| Name of Proposed Insured | Personal Physician(s) Name, Address, Phone Number | Date Last Visited, Reason, Result |
|---|---|---|
| | | |
| | | |

## ILLUSTRATION CERTIFICATION **The box below MUST be checked if a signed illustration of the policy applied for is NOT enclosed with this application.**

☐ The Applicant/Owner and the Licensed Agent certify that they have each read and agree with their respective statements below regarding the policy applied for:
**Applicant's/Owner's statement:** By signing this application, I, the Applicant/Owner acknowledge that I have NOT received an illustration of the policy applied for and understand that an illustration of the policy as issued will be provided no later than the policy delivery date. **Licensed Agent's statement:** By signing this application, I, the Licensed Agent certify that I have NOT presented an illustration of the policy applied for or discussed any non-guaranteed elements of the policy with the Applicant/Owner. Upon or prior to delivery, I will provide an illustration and explain any non-guaranteed elements of the policy.

**ACKNOWLEDGMENT OF PROPOSED OWNER AND INSURED(S) –** Each of the undersigned hereby certifies and represents as follows: The statements and answers given on this application are true and correct. I acknowledge and agree (A) that this application and any amendments shall be the basis for any insurance issued; (B) that the agent does not have the authority to waive any question on this application, to decide if insurance will be issued, or to modify any term or provision of any insurance which may be issued based on this application, only a writing signed by an officer of the Company can change the terms of this application or the terms of any insurance issued by the Company; (C) no policy applied for shall take effect until all of the following conditions have been met: 1) the first full premium must be received by the Company; 2) during the lifetime of any proposed insured, the proposed owner must have personally received and accepted the policy which was applied for; and 3) on the date of the later of either 1) or 2) above, all of the statements and answers given in this application must be true and complete, and there must have been no change in the insurability of any proposed insured. Unless otherwise stated the undersigned applicant is the premium payor and owner of the policy applied for.

I authorize MIB Group, Inc., my employer or former employer, any consumer reporting agency or governmental agency, or any insurer or reinsurer to provide medical or non-medical information about me to Western Reserve Life Assurance Co. of Ohio, its administrators, representatives or its reinsurers. I understand that this information is to be used by the Company to determine eligibility for insurance and/or eligibility for benefits under an existing policy. This authorization will expire 30 months from the date signed. A copy of this authorization shall be as valid as the original. Either my authorized representative or I may receive a copy of this authorization upon request.

The Company shall have sixty days from the date hereof within which to consider and act on this application and if within such period a policy has not been received by the applicant or if notice of approval or rejection has not been given, then this application shall be deemed to have been declined by the Company.

**I acknowledge receipt of the (1) Notice to Persons Applying for Insurance Regarding Investigative Report, (2) MIB Group, Inc. Pre-Notification, and (3) Notice of Insurance Information Practices. I understand that any omissions or misstatements in this application could cause an otherwise valid claim to be denied under any insurance issued from this application.**

**I also understand that I will not receive any insurance coverage for any money paid with this application unless a policy is issued except in accordance with the terms of the Conditional Receipt.**

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

**Please make checks payable to Western Reserve Life Assurance Co. of Ohio. Do not make checks payable to the agent or leave the payee space blank on your check.**

Amount paid with application: $ ____________ Best time to call for a personal history interview: ________ a.m. / p.m. Okay to contact at work? ☐ Yes ☐ No

Dated at ______________________________ this ________________ day of ______________ , ____________
City State Month Year

Signature of Proposed Insured

Signature of Proposed Owner (if other than Proposed Insured)

Signature of Parent or Legal Guardian (if Proposed Insured is Under 18 years of age)

Signature of Additional Insured

## TAX NOTICE AND TAXPAYER IDENTIFICATION NUMBER CERTIFICATION

Under current federal tax laws, the Company is required to obtain your Taxpayer Identification Number (e.g., a social security or employer identification number, or "TIN") and certification that you are not subject to backup withholding. Please review the following certification and sign accordingly.

Under penalties of perjury, I certify that (1) the TIN listed in this application is my correct TIN; (2) I have not been notified that I am subject to backup withholding or I am not subject to backup withholding because I am an exempt recipient; and (3) I am a U.S. Person, (U.S. citizen/legal resident). If not a U.S. Person, I have completed the appropriate Form W-8BEN. The IRS does not require your consent to any provision of this form other than this certification.

**Signature of Proposed Owner** ______________________________ **Date** ____________

## AGENT INFORMATION & SIGNATURE

| | | |
|---|---|---|
| Signature of Agent | (Print First and Last Name) | Agent # |
| (      ) Telephone Number | (      ) Agent Fax # | Agent E-mail Address |
| Split Agent Signature (If Applicable) | (Print First and Last Name) | Agent # |
| (      ) Telephone Number | (      ) Agent Fax # | Agent E-mail Address |

- Did you ask all questions on the application in the presence of all proposed insureds, record the answers as given, and witness all signatures? ☐ Yes ☐ No
  If not, please provide details. ____________
- Do you have any knowledge or reason to believe that the insurance applied for will replace or change any existing insurance or annuity? ☐ Yes ☐ No
  (If yes, submit the state required forms.)

# CONDITIONAL RECEIPT

(Detach and leave with applicant if money is submitted with application. If within the past 12 months the proposed insured has been treated for or experienced heart trouble, stroke or cancer, no payment may be accepted with the application.)

**PLEASE READ THIS CAREFULLY**

Make all checks payable to the Company. Do not make checks payable to the agent or leave the payee blank or you may jeopardize the insurance for which you have applied.

Received from ________________________________________, the sum of $__________________________ for the insurance or annuity application dated _______________, with ________________________________ as the proposed insured(s) or annuitant. The policy you applied for will not become effective unless and until a policy contract is delivered to you and all other conditions of coverage are met. However, subject to the conditions and limitations of this Receipt, conditional insurance under the terms of the policy applied for may become effective as of the later of (1) the date of application and (2) the date of the last medical examination, tests, and other screenings required by the Company, if any (the "Effective Date"). Such conditional insurance will take effect as of the Effective Date, so long as all of the following requirements are met:

1. Each person proposed to be insured is found to have been insurable as of the Effective Date, exactly as applied for in accordance with the Company's underwriting rules and standards, without any modifications as to plan, amount, or premium rate;
2. As of the Effective Date, all statements and answers given in the application must be true;
3. The payment made with the application must not be less than the full initial premium for the mode of payment chosen in the application and must be received at our Home Office within the lifetime of the proposed insured;
4. All medical examinations, tests, and other screenings required of any proposed insured by the Company are completed and the results received at our Home Office within 60 days of the date the application was completed; and
5. All parts of the application, any supplemental application, questionnaires, addendum and/or amendment to the application are signed and received at our Home Office.

Any conditional coverage provided by this Receipt will terminate on the earliest of: (a) 60 days from the date the application was signed; (b) the date the Company either mails notice to the applicant of the rejection of the application and/or mails a refund of any amounts paid with the application; (c) when the insurance applied for goes into effect under the terms of the policy applied for; or (d) the date the Company offers to provide insurance on terms that differ from the insurance for which you have applied.

The aggregate amount of conditional coverage provided under this Receipt, if any, and any other conditional receipt issued by the Company shall be limited to the lesser of the amount(s) applied for or $500,000 of life insurance. There is no conditional coverage for riders or additional benefits, if any, for which you have applied.

If one or more of this Receipt's conditions have not been met exactly, or if a proposed insured dies by suicide, the Company will not be liable except to return any payment made with the application.

If the Company does not approve and accept the application for insurance within 60 days of the date you signed the application, the application will be deemed to be rejected by the Company and there will be no conditional insurance coverage. In that case, the Company's liability will be limited to returning any payment(s) you have made upon return of this Receipt to the Company.

This Receipt is not valid unless all blanks are completed above and this Receipt is signed by an agent or authorized Company representative. This Receipt does not provide any conditional insurance until all of the conditions and requirements are met as outlined above.

Dated at ____________________________________ this ________________ day of ______________ , ____________

City State Month Year

____________________________________

Signature of Agent

## *DETACH AND LEAVE THIS PAGE WITH APPLICANT*

### NOTICE TO PERSONS APPLYING FOR INSURANCE REGARDING INVESTIGATIVE REPORT

To proposed insureds: In connection with this application, an investigative consumer report may be prepared about you. Such reports are part of the process of evaluating risks for life and health insurance. Typically, this report will contain information about your character, general reputation, personal characteristics and mode of living. The information in the report may be obtained by talking with you or members of your family, business associates, financial sources, neighbors, and others you know. You may ask to be interviewed in connection with the preparation of any such report. Also, we may have the report updated if you apply for more coverage.

**Upon your written request, we will let you know whether a report was prepared and we will give you the name, address, and telephone number of the agency preparing the report. By contacting that agency and providing proper identification, you may obtain a copy of the report.**

### NOTICE OF DISCLOSURE OF INFORMATION

**MIB GROUP, INC. (MIB) PRE-NOTIFICATION** to proposed insured and other persons proposed to be insured, if any. Information regarding your insurability will be treated as confidential. We or our reinsurer(s) may, however, make a brief report on this information to MIB Group, Inc., a non-profit membership organization of insurance companies that operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB may, upon request, supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is: 50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734; and telephone number is 866-692-6901 (TTY 866-346-3642 for hearing impaired).

### NOTICE OF INSURANCE INFORMATION PRACTICES

To proposed insureds: Personal information may be collected from persons other than the individual(s) proposed for coverage. Such information as well as other personal or privileged information subsequently collected by us or our agent may in certain circumstances be disclosed to third parties without authorization. Upon request, you have the right to access your personal information and ask for corrections. You may obtain a complete description of our Information Practices by writing to Western Reserve Life Assurance Co. of Ohio, Attn: Director of Underwriting, 4333 Edgewood Road NE, Cedar Rapids, Iowa 52499.

## AGENT'S REPORT

How well do you know proposed insured?______________________________

| | Yes | No |
|---|---|---|
| Do you know of any information not given in the application which might affect the insurability of any person proposed for insurance? *(If "yes", explain in Remarks Section)* | ☐ | ☐ |
| Is this case personal business? (Is it written on your life, spouse, child, grandchild, parent, or spouse's parent?) *(If "yes", explain relationship ______________________________)* | ☐ | ☐ |
| Did you see all of those to be insured on the date the application was written? *(If "no", explain in Remarks Section)* | ☐ | ☐ |

Rate Class:

| Universal and Term | Other Term and IUL |
|---|---|
| ☐ Preferred Choice (Term Only) | ☐ Preferred Elite |
| ☐ Standard Plus Non-Tobacco | ☐ Preferred Plus |
| ☐ Standard Non-Tobacco | ☐ Preferred |
| ☐ Standard Plus Tobacco | ☐ Non-Tobacco |
| ☐ Standard Tobacco | ☐ Preferred Tobacco |
| | ☐ Tobacco |

| Agent's Name | Agent No. | % if Split |
|---|---|---|
| 1. Agent's Name | | |
| 2. Agent's Name | | |

**COMPLETE ONLY IF THE OWNER OR PAYOR IS OTHER THAN INSURED**

What is the relationship of the Owner to the primary insured (please explain)?

______________________________

What is the relationship of the Payor to the primary insured (please explain)?

______________________________

ADDITIONAL REMARKS

I submit this application assuming full responsibility for delivery of any policy issued and for payment to the company of the first premium, when collected. I know of no condition affecting the insurability of the proposed insured not fully set forth herein. I will not deliver the policy if the health of the insured has changed.

______________________________

Signature of Writing Agent

**Monumental Life Insurance Company**
**Stonebridge Life Insurance Company**
**Transamerica Life Insurance Company**
**Western Reserve Life Assurance Co. of Ohio**
4333 Edgewood Road NE, Cedar Rapids, IA 52499

# HIPAA Authorization for Release of Health-Related Information

**This authorization complies with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.**

| Name of Primary Proposed Insured/Patient | Date of birth | Last four digits of SSN |
|---|---|---|
| ____________________ | __________ | __________ |
| Name of Secondary Proposed Insured/Patient | Date of birth | Last four digits of SSN |
| ____________________ | __________ | __________ |
| Name(s) of Unemancipated Minors | Date(s) of birth | Last four digits of SSN(s) |
| ____________________ | __________ | __________ |

I hereby authorize the use or disclosure of health information, as described below, about me or my above-named unemancipated minor children and revoke any previous restrictions concerning access to such information:

1. **Person(s) or group(s) of persons authorized to use and/or disclose the information:** Any health plan, physician, health care professional, hospital, clinic, long-term care facility, medical or medically-related facility, laboratory, pharmacy, pharmacy benefit manager, insurance company [including the Companies noted above (the "Companies")], insurance support organization such as MIB Group, Inc., or other medical practitioner or health care provider that has provided payment, treatment or services to me or on my behalf or to or on behalf of my unemancipated minor children.
2. **Person(s) or group(s) of persons authorized to collect or otherwise receive and use the information:** The Companies, their affiliates and reinsurers, and their agents, employees, or other representatives. I further authorize the Companies and their affiliates and reinsurers to redisclose the information to MIB Group, Inc., which operates an information exchange on behalf of life and health insurance companies.
3. **Description of the information that may be used or disclosed:** This authorization specifically includes the release of all information related to my health or that of my unemancipated minor children and my or my unemancipated minor children's insurance policies and claims, including, but not limited to, information on the diagnoses, prognoses, treatments, prescription drug information, and information regarding diagnosis, prognosis and treatment of mental illness, communicable or infectious conditions, such as HIV or AIDS, and use of alcohol, drugs and tobacco. **This Authorization excludes psychotherapy notes that are separated from the rest of my medical records.**
4. **The information will be used or disclosed only for the following purpose(s):** For the purpose of underwriting my insurance application with the Companies, to support the operations of our business, and, if a policy is issued, for evaluating contestability and eligibility for benefits, for the continuation or replacement of the policy, for reinstatement of the policy or to contest a claim under the policy.

## STATEMENTS OF UNDERSTANDING & ACKNOWLEDGMENT:

- I understand that health information about me provided to the Companies may be protected by state and federal privacy regulations including the HIPAA Privacy Rule and that the Companies will only use and disclose such information as permitted by applicable regulations and as described in their privacy notices. However, I also understand that any information disclosed under this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal regulations such as the HIPAA Privacy Rule governing privacy and confidentiality of health information.
- I understand that if I refuse to sign this authorization to release my health information or that of my unemancipated minor children, the Companies may not be able to process my application, or if coverage is issued may not be able to make any benefit payments.
- I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on it, or to the extent that other law provides the Companies with the right to contest a claim under the policy or the policy itself, by sending a written revocation to the Companies' Privacy Official at the address at the top of this form. I also understand that the revocation of this authorization will not affect uses and disclosures of my health information for purposes of treatment, payment and business operations, including agent commission statements.
- This authorization shall remain in force for 24 months (12 months in Kansas) from the date signed, regardless of my condition and whether living or deceased.
- I acknowledge I have received a copy of this authorization.

______________________________ ______________
Signature of Primary Proposed Insured/Patient or Personal Representative Date

______________________________ ______________
Signature of Secondary Proposed Insured/Patient or Personal Representative Date

**If signed by an individual's personal representative or the parent or guardian of an unemancipated minor, describe authority to sign on behalf of the individual:**

❑ Parent ❑ Legal guardian ❑ Power of Attorney ❑ Other (please describe): ____________________

(NOTE: If more than one individual is named above, please specify the individual(s) to which the personal representative applies.)

Policy or contract number (if known): ____________________

**A copy of this authorization will be considered as valid as the original.**

**Monumental Life Insurance Company**
**Stonebridge Life Insurance Company**
**Transamerica Life Insurance Company**
**Western Reserve Life Assurance Co. of Ohio**
4333 Edgewood Road NE, Cedar Rapids, IA 52499

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| | | |
| Name(s) of Unemancipated Minors | Date(s) of birth | Last four digits of SSN(s) |
| | | |

I hereby authorize the use or disclosure of health information, as described below, about me or my above-named unemancipated minor children and revoke any previous restrictions concerning access to such information:

1. **Person(s) or group(s) of persons authorized to use and/or disclose the information:** Any health plan, physician, health care professional, hospital, clinic, long-term care facility, medical or medically-related facility, laboratory, pharmacy, pharmacy benefit manager, insurance company [including the Companies noted above (the "Companies")], insurance support organization such as MIB Group, Inc., or other medical practitioner or health care provider that has provided payment, treatment or services to me or on my behalf or to or on behalf of my unemancipated minor children.
2. **Person(s) or group(s) of persons authorized to collect or otherwise receive and use the information:** The Companies, their affiliates and reinsurers, and their agents, employees, or other representatives. I further authorize the Companies and their affiliates and reinsurers to redisclose the information to MIB Group, Inc., which operates an information exchange on behalf of life and health insurance companies.
3. **Description of the information that may be used or disclosed:** This authorization specifically includes the release of all information related to my health or that of my unemancipated minor children and my or my unemancipated minor children's insurance policies and claims, including, but not limited to, information on the diagnoses, prognoses, treatments, prescription drug information, and information regarding diagnosis, prognosis and treatment of mental illness, communicable or infectious conditions, such as HIV or AIDS, and use of alcohol, drugs and tobacco. **This Authorization excludes psychotherapy notes that are separated from the rest of my medical records.**
4. **The information will be used or disclosed only for the following purpose(s):** For the purpose of underwriting my insurance application with the Companies, to support the operations of our business, and, if a policy is issued, for evaluating contestability and eligibility for benefits, for the continuation or replacement of the policy, for reinstatement of the policy or to contest a claim under the policy.

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- I understand that if I refuse to sign this authorization to release my health information or that of my unemancipated minor children, the Companies may not be able to process my application, or if coverage is issued may not be able to make any benefit payments.
- I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on it, or to the extent that other law provides the Companies with the right to contest a claim under the policy or the policy itself, by sending a written revocation to the Companies' Privacy Official at the address at the top of this form. I also understand that the revocation of this authorization will not affect uses and disclosures of my health information for purposes of treatment, payment and business operations, including agent commission statements.
- This authorization shall remain in force for 24 months (12 months in Kansas) from the date signed, regardless of my condition and whether living or deceased.
- I acknowledge I have received a copy of this authorization.

______________________________________________ ____________________
Signature of Primary Proposed Insured/Patient or Personal Representative Date

______________________________________________ ____________________
Signature of Secondary Proposed Insured/Patient or Personal Representative Date

**If signed by an individual's personal representative or the parent or guardian of an unemancipated minor, describe authority to sign on behalf of the individual:**

❑ Parent ❑ Legal guardian ❑ Power of Attorney ❑ Other (please describe): ____________________

(NOTE: If more than one individual is named above, please specify the individual(s) to which the personal representative applies.)

Policy or contract number (if known): ____________________

**A copy of this authorization will be considered as valid as the original.**

- ☐ **Monumental Life Insurance Company**
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- ☐ **Western Reserve Life Assurance Co. of Ohio**

4333 Edgewood Road NE, Cedar Rapids, IA 52499

# Notice and Consent for HIV-Related Testing OHIO

In order for us to evaluate your eligibility for insurance coverage, we request that you provide a blood or other bodily fluid sample for HIV testing and analysis. The test that will be performed will determine the presence of antibodies to the HIV virus. By signing and dating this form, you agree that the HIV antibody test may be performed on your blood or other bodily fluid sample and that underwriting decisions may be based on the test results. A positive test result will adversely affect your insurance application. It also may result in uninsurability for life, health, or disability insurance for which you may apply in the future.

**Human Immunodeficiency Virus (HIV)**

The HIV virus causes a life-threatening disorder of the immune system called Acquired Immune Deficiency Syndrome (AIDS). Antibodies to HIV are found in the blood and other bodily fluids of people who have been exposed to the virus. You do not have to have AIDS to have antibodies against HIV. The virus is spread by sexual contact with an infected person, by exposure to infected blood (as in needle sharing during intravenous drug use or, rarely, as a result of a blood transfusion), or from an infected mother to her new-born infant.

The HIV antibody test is actually a series of tests performed upon your blood or other bodily fluid sample by a medically accepted procedure which is extremely reliable. The testing will be performed by a licensed laboratory.

**Pre-testing Consideration**

Many public health organizations have recommended that before taking an HIV virus antibody test a person seek counseling to become informed about the implications of such tests. You may wish to consider counseling, at your expense, prior to being tested.

**Disclosure Of Test Results**

All test results are confidential, except as provided by law. State law requires that the laboratory notify the Ohio Department of Health of positive test results.

The results of the test will be reported to the insurance company designated on your application for insurance. The insurer may not by law, release positive test results except as provided below:

> If your HIV antibody test result is normal (negative), you will not be notified. You will be notified of an abnormal (positive) test result if you indicate that you desire a positive result be made known to you. You may also identify another person to whom you want the positive results released.
>
> If you want a physician or other health care provider to be notified of an abnormal HIV antibody test result, you must indicate the name and address of that physician or provider.
>
> Abnormal test results may be disclosed to persons hired by the insurer who participate in medical underwriting decisions of the insurer. Abnormal test results may also be disclosed to affiliates of the insurer who require the results for medical underwriting purposes.

In addition, if your HIV antibody test is abnormal, a generic code signifying a non-specific blood, oral fluid (saliva), or urine abnormality may be made known to the Medical Information Bureau, Inc. (MIB). The MIB is an organization of life and health insurance companies which operates as an information exchange on behalf of its members. There will be no record with the MIB that you had a positive HIV antibody test; however, there will be a record at the MIB that you have some blood, oral fluid (saliva) or urine abnormality. If you apply to another MIB member company for life or health insurance coverage, the MIB, upon request, will supply the information on you in its file to that member.

**Notice and Consent for HIV-Related Testing OHIO**

**Test Results**

While a positive test result does not necessarily mean that you have AIDS, it does mean that you are at a greater risk of developing AIDS or AIDS-related conditions if you do not take appropriate medications. If you are infected with HIV, you are infectious to others. You should seek medical follow-up care with your personal health care provider.

HIV test results are highly reliable but not 100% accurate. If the test gives a positive result you should consider retesting in order to confirm the result. If the test gives a negative result, there is still a small possibility you may be infected with HIV. This is most likely to happen in recently infected persons. It takes at least 4 to 12 weeks for a positive test result to develop after a person is infected, and may take as long as 6 to 12 months.

**Other Sources Of Information**

For more information about HIV or AIDS you may ask a doctor, a nurse, a counselor, or call the Ohio AIDS Hotline at 1-800-332-AIDS (2437), or the National AIDS Hotline at 1-800-872-2437. The hotline is a free call.

**Consent**

**I have read and I understand this *HIV Notice and Consent form*. I voluntarily consent to the withdrawal of blood or to the providing of another bodily fluid sample, the testing of my blood or other bodily fluid for HIV antibodies, and the disclosure of the test results as described above. I will be given a copy of this form. This CONSENT is valid for ninety (90) days from the date of my signature below. Insurer agrees to complete testing and provide the authorized notifications, as appropriate, within this 90 (ninety) day period.**

**Notification of Positive Test Result**

In the event of a positive test result:

☐ Send the result to me at:

Street

City, State, Zip Code

☐ I authorize the Insurer to send the result to the following physician or health care provider:

Name

Address

Phone Number

☐ I authorize the Insurer to send the result to another person:

Name

Address

**Authorization**

Proposed Insured (*Please Print*)

Date of Birth

Signature of Proposed Insured

Date Signed

Signature of Person Obtaining Consent

Date Signed

☐ **Transamerica Financial Life Insurance Company**
Home Office: Purchase, New York
☐ **Monumental Life Insurance Company**
☐ **Stonebridge Life Insurance Company**
☐ **Transamerica Life Insurance Company**
☐ **Western Reserve Life Assurance Co. of Ohio**
Administrative Office: 4333 Edgewood Road NE, Cedar Rapids, IA 52499

## Disclosure
## Military Sales Practice

In accordance with applicable law, the following information is provided with respect to the life insurance policy for which you have applied (the "Policy") with the Companies noted above (the "Companies").

- As a member of the United States Armed Forces, you are advised that subsidized life insurance is available to you from the Federal Government under the Servicemembers' Group Life Insurance (SGLI) program. The SGLI program provides up to $400,000 of term life insurance at a cost of $.07 per $1,000 of coverage or $28 per month.

- This Policy is not offered or provided by the Federal Government, and the Federal Government has in no way sanctioned, recommended, or encouraged the sale of the Policy being offered.

- No person has received any referral fee or incentive compensation in connection with the offer or sale of the Policy, unless such person is a licensed agent/producer of the Companies.

- This Policy contains a "free look" period of no less than 10 days. (The "free look" period may be more depending on your state of residence.) You may choose to return the Policy during the "free look" period. If returned to the Company at the address shown on the cover of the Policy, your Policy becomes void, and we will refund your premiums paid (according to the terms stated in the Policy).

With respect to a sale or solicitation on Federal land or facilities located outside of the United States, if you need the assistance of the governmental agency that regulates insurance; or if you have a complaint you have been unable to resolve with your insurer, you may contact the state insurance commission for the State having primary jurisdiction: http://www.naic.org/cis/fileComplaintMap.do

I acknowledge that I have read and understand the information about the Policy's "free look" provision and I have received a copy of an illustration and/or the application.

______________________________ ______________________________
Signature of Proposed Insured Date

______________________________ ______________________________
Signature of Proposed Applicant/Owner Date

*If the policy was solicited on a military installation, the producer must read and sign below.*

DD Form 2885 was left with the client, and other required forms were reviewed, completed and copies were left with the client.

______________________________ ______________________________
Producer Signature Date

**A copy of this disclosure will be considered as valid as the original.**

# MO 70 - NEW BUSINESS CHECKLIST

Date: ______________________ Number of Pages (including cover page): ____________

☐ **Spanish speaking preferred**

☐ Check here only if this is a **TRIAL APPLICATION** (do not send in premium or order any medical testing)

## INSURED / AGENT INFORMATION

Primary Insured

First MI Last

Companion (if applicable)

First MI Last

Agent Name ______________________ Agent Number ______________________

First Last

## FORMS CHECKLIST (Check all that apply)

| | PI | AIR |
|---|---|---|
| HIPAA Authorization | ☐ | ☐ |
| Initial Premium (Check One): ☐ Sending check to WRL ☐ Pre-Auth/Draft ☐ COD | | |
| ABR Disclosure Form | ☐ | N/A |
| HIV Consent Form | ☐ | ☐ |
| Replacement Form / Agent Advertising Statement | ☐ | ☐ |
| Transfer or 1035 Exchange Form | ☐ | ☐ |
| Illustration | ☐ | N/A |
| Health Questionnaire ( list type) | ☐ | ☐ |
| Index UL Forms | ☐ | ☐ |
| Supplemental Application | ☐ | ☐ |
| Other (please explain) | ☐ | ☐ |

## UNDERWRITING REQUIREMENTS (Check all that apply)

| | PI | AIR |
|---|---|---|
| Oral Fluids Taken | ☐ | ☐ |
| Blood, HOS, Vitals | ☐ | ☐ |
| Paramed Exam | ☐ | ☐ |
| Other (please explain) | ☐ | ☐ |

**Company Scheduled to do Paramed**

☐ APPS ☐ ExamOne

☐ EMSI ☐ Portamedic

Lab Slip/Bar Code #: ____________ Date Taken: ____________

## RATE CLASS

**Universal and Term**

☐ Preferred Choice Non-tobacco ☐ Standard Plus Tobacco

☐ Standard Plus Non-tobacco ☐ Standard Tobacco

☐ Standard Non-tobacco ☐ Rating (if applicable) ________

☐ AIR (if applicable) ________

**Other (Select Term and IUL)**

☐ Preferred Elite ☐ Non-tobacco ☐ Tobacco

☐ Preferred Plus ☐ Preferred Tobacco ☐ Rating (if applicable) ________

☐ Preferred

☐ AIR (if applicable) ________

Remarks: ______________________________________________

______________________________________________

☐ Please send policy to MGA office.

## MGA CONTACT INFORMATION (can also use stamp or label in square) – required for communication to administrator at MGA office

Name:

Telephone:

E-mail:

# REPLACEMENT ADVERTISING
## AGENT STATEMENT

I, ____________________________, have complied with the following in connection with the replacement sales transaction:

a. I have used only company approved sales advertising.

b. I have given a copy of all sales advertising used during the presentation to the applicant, including printed copies of any electronically presented sales materials.

______________ ______________________________________

**DATE** **AGENT SIGNATURE**

☐ **Monumental Life Insurance Company** ☐ **Transamerica Life Insurance Company**

☐ **Stonebridge Life Insurance Company** ☐ **Western Reserve Life Assurance Co. of Ohio**

Administrative Office located at: 4333 Edgewood Road N.E., Cedar Rapids, Iowa 52499. Telephone: (319) 355-8511

**IMPORTANT NOTICE:**
**REPLACEMENT OF LIFE INSURANCE OR ANNUITIES**

This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy, to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interest. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1. **Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? ___ YES ___ NO**

2. **Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ___ YES ___NO**

If you answered "yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy number or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

| INSURER NAME | CONTRACT OR POLICY # | INSURED | REPLACED (R) OR FINANCING (F) |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. [If you request one, an in-force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer.] Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because ________________________________________.
I certify that the responses herein are, to the best of my knowledge, accurate:

_________________________________________ _____________________
Applicant's Signature and Printed Name Date

_________________________________________ _____________________
Producer's Signature and Printed Name Date

**______ I do not want this notice read aloud to me. (Applicants must initial only if they do not want the notice read aloud.)**

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

PREMIUMS:

Are they affordable?
Could they change?
You're older – are premiums higher for the proposed new policy?
How long will you have to pay premiums on the new policy? On the old policy?

POLICY VALUES:

New policies usually take longer to build cash values and to pay dividends.
Acquisition costs for the old policy may have been paid; you will incur costs for the new one.
What surrender charges do the policies have?
What expenses and sales charges will you pay on the new policy?
Does the new policy provide more insurance coverage?

INSURABILITY:

If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.
You may need a medical exam for a new policy.
[Claims on most new policies for up to the first two years can be denied based on inaccurate statements.
Suicide limitations may begin anew on the new coverage.]

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:

How are premiums for both policies being paid?
How will the premiums on your existing policy be affected?
Will a loan be deducted from death benefits?
What values from the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:

Will you pay surrender charges on your old contract?
What are the interest rate guarantees for the new contract?
Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:

What are the tax consequences of buying the new policy?
Is this a tax-free exchange? (See your tax advisor)
Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?
Will the existing insurer be willing to modify the old policy?
How does the quality and financial stability of the new company compare with your existing company?

## 30 DAY RIGHT TO CANCEL

In the event of a replacement transaction, you may cancel this policy by delivering or mailing a written request to the Company. You must return the policy to the Company before midnight of the thirtieth day after the day you receive it. You will receive an unconditional full refund of all premiums or considerations paid on it, less any withdrawals and indebtedness, including any policy fees or charges or, in the case of a variable or market value adjustment policy, payment of the cash surrender value provided under the policy plus the fees and other charges deducted from the gross premiums or considerations or imposed under the policy. Your written request given by mail and return of the policy by mail are effective on being postmarked, properly addressed and postage prepaid.

*Western Reserve Life Assurance Co. of Ohio*
Administrative Office, 4333 Edgewood Road NE, Cedar Rapids, IA 52499

# Supplemental Information to the Application for Life Insurance

Proposed Primary Insured Name: ______________________________ Social Security Number: ____________________

## ADDITIONAL INFORMATION

| Question Number | Name of Proposed Insured | Details to General and Medical Questions (Diagnosis, Dates, Durations, and Medications, Dosages, Frequency) Medical Facilities & Physicians Names, Addresses, Phone Numbers |
|---|---|---|
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## ADDITIONAL INFORMATION

Dated at ______________________________ this ______________ day of ____________, ____________
City State Month Year

Signature of Proposed Insured

Signature of Proposed Owner (if other than Proposed Insured)

Signature of Parent or Legal Guardian (if Proposed Insured is Under 18 years of age)

Signature of Additional Insured

Signature of Agent

❑ **Monumental Life Insurance Company**

❑ **Transamerica Life Insurance Company**

❑ **Stonebridge Life Insurance Company**

❑ **Western Reserve Life Assurance Co. of Ohio**

## Terminal Illness Accelerated Death Benefit Disclosure Form

The owner may apply for the single sum accelerated benefit when the insured has been diagnosed with a terminal illness. A terminal illness is a condition resulting from injury or illness which, as determined by a physician, has reduced life expectancy to not more than 12 months from the date of the physician's statement. The company requires proof of a terminal condition, including an attending physician's statement and any other proof that we may require. We reserve the right to seek a second medical opinion or have you examined at our expense by a physician we choose.

This benefit cannot be exercised:

1. if the policy is not in force;
2. is only in force as extended term insurance;
3. if the policy is within two years of endowment; or
4. if any eligible rider is within two years of expiration.

The single sum benefit may only be requested once. If there is an irrevocable beneficiary or assignee, they must consent in writing to payment of this benefit.

The policy's specified amount, policy value, surrender charge and indebtedness, if any, will be reduced by the election percentage. We will provide you with revised policy specification pages.

**RECEIPT OF ACCELERATED BENEFITS MAY BE TAXABLE AND YOU SHOULD CONSULT YOUR PERSONAL TAX ADVISOR.**

By signing below, you agree that you have read the above and received a copy of this disclosure form.

________________
Date

________________________________
Owner's (Applicant's) Signature

________________________________
Agent's Signature

**IMPORTANT: The signed original must be submitted with the application for life insurance. The copy is to be left with the applicant.**

- [ ] **Life Investors Insurance Company of America**
- [ ] **Peoples Benefit Life Insurance Company**
- [ ] **Western Reserve Life Assurance Co. of Ohio**
- [ ] **Monumental Life Insurance Company**
- [ ] **Transamerica Life Insurance Company**

## Terminal Illness Accelerated Death Benefit Disclosure Form

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This benefit cannot be exercised:

1. if the policy is not in force;
2. is only in force as extended term insurance;
3. if the policy is within two years of endowment; or
4. if any eligible rider is within two years of expiration.

The single sum benefit may only be requested once. If there is an irrevocable beneficiary or assignee, they must consent in writing to payment of this benefit.

The policy's specified amount, policy value, surrender charge and indebtedness, if any, will be reduced by the election percentage. We will provide you with revised policy specification pages.

Receipt of accelerated benefits may be taxable and you should consult your personal tax advisor.

By signing below, you agree that you have read the above and received a copy of this disclosure form.

_________________ Date

_________________________________ Owner's (Applicant's) Signature

_________________________________ Agent's Signature

**IMPORTANT: The signed original must be submitted with the application for life insurance. The copy is to be left with the applicant.**

❑ Western Reserve Life Assurance Co. of Ohio ❑ Monumental Life Insurance Company

❑ Transamerica Life Insurance Company

# TERMINAL ILLNESS, CRITICAL ILLNESS, and CHRONIC ILLNESS ACCELERATED DEATH BENEFIT DISCLOSURE FORM

Accelerated Benefits are payments made to the Owner during the lifetime of the Insured. Such benefits will be paid in lieu of payment of the full Death Benefit of the Policy or Additional Insured Rider upon death of the Insured. The conditions under which accelerated benefits may be elected vary by Rider as described below.

**NOTE: Your Policy may not be eligible for coverage under all the Accelerated Death Benefit Riders described below. Please check your Policy and the Riders for details on each Accelerated Death Benefit Rider that is included with your Policy and the Insured's coverage under each Rider.**

## TERMINAL ILLNESS ACCELERATED DEATH BENEFIT RIDER

Benefits may be elected under this Rider if the Insured has a Terminal Condition. Terminal Condition means a condition resulting from injury or illness that with reasonable medical certainty, as determined by a Physician, will result in death within 12 months from the date of the Physician's Statement.

## CHRONIC ILLNESS ACCELERATED DEATH BENEFIT RIDER

Benefits may be elected under this Rider if the Insured is Chronically Ill. Chronically Ill means that the Insured has been certified, within the last 12 months, by a Licensed Health Care Practitioner as:

1. Being unable to perform, without substantial assistance from another person, at least two Activities of Daily Living for a period of at least 90 consecutive days; or
2. Requiring substantial supervision for a period of at least 90 consecutive days by another person to protect oneself from threats to health and safety due to Severe Cognitive Impairment.

Activities of Daily Living are bathing, continence, dressing, eating, toileting, and transferring.

No Application for Election of Accelerated Benefits will be accepted under the Chronic Illness Accelerated Benefits Rider during the first two years that it is in effect.

The maximum Death Benefit accelerated in any year is the lesser of 24% of the life insurance coverage on the initial Election Date or $240,000. This amount will be prorated over other periods of time, such as 2% each month, 6% every 3 months, or 12% every 6 months. The maximum Death Benefit accelerated over the lifetime of the Insured is the lesser of 90% of the Initial Face Amount or $500,000.

## CRITICAL ILLNESS ACCELERATED DEATH BENEFIT RIDER

Benefits may be elected under this Rider if the Insured has experienced a covered Qualifying Event. The Qualifying Events covered under this Rider are:

1. **Heart attack (myocardial infarction)** - The death of a portion of the heart muscle resulting from inadequate blood supply to the relevant area. Heart attack does not include angina or the chance finding of electrocardiographic (EKG) changes indicative of a previous Heart Attack. The diagnosis of heart attack must be based on the presence of all of the following:
   a. Chest pain;
   b. Associated new EKG changes which support the diagnosis; and
   c. Elevation of cardiac (heart) enzymes above standard laboratory levels.

2. **Stroke** - A cerebrovascular accident or infarction (death) of brain tissue caused by hemorrhage, embolism, or thrombosis lasting more than 24 hours and producing measurable neurological deficit which persists for at least 30 consecutive days following the occurrence of the Stroke. Stroke does not include transient ischemic attacks.

3. **Diagnosis of Cancer**. Cancer means a disease manifested by the presence of one or more malignant tumors and characterized by the uncontrolled growth and spread of malignant cells and the invasion of normal tissue. Cancer does not include:
   a. Any skin cancer, except invasive malignant melanoma into the dermis or deeper;
   b. Pre-malignant lesions, benign tumors, or polyps; and
   c. Carcinoma in-situ.

4. **Diagnosis of End Stage Renal Failure**. End Stage Renal Failure means an irreversible and total failure of both kidneys which requires the undergoing of renal transplantation or regular renal dialysis.

5. **Major Organ Transplant** - The receipt by transplant of any of the following organs or tissues: heart, lungs, liver, kidney, pancreas, or bone marrow.

6. **Diagnosis of ALS (Amyotrophic Lateral Sclerosis)** by a qualified Physician.

No Accelerated Benefit will be paid under the Critical Illness Accelerated Benefit Rider for any Qualifying Event that occurs on or before the 30th day following the Effective Date of the Rider unless such Qualifying Event directly resulted from accidental injury.

No Accelerated Benefit will be paid under the Critical Illness Accelerated Death Benefit Rider for any Qualifying Event that directly or indirectly results from self-inflicted injury or attempted suicide.

The Owner may elect to accelerate all or a portion of the Insured's Death Benefit in force under the Policy on the Election Date. **We reserve the right to set a maximum amount that we will pay under any of the Accelerated Benefits Riders on the life of any Insured person. If we do so, the lifetime maximum will be no more than $500,000. If the Insured becomes eligible for benefits under the Chronic Illness Accelerated Death Benefit Rider, the Death Benefit that may be accelerated in any year will also be subject to a maximum amount.**

Accelerated Benefits are paid as a lump sum, provided, however, that payments under the Chronic Illness Accelerated Death Benefit Rider may be prorated as described above. The following factors may be used by us in the determination of the amount:

1. The Death Benefit accelerated;
2. The Cash Surrender Value of the Policy or Rider;
3. Future Premiums payable under the Policy or Rider;
4. Our assessment of the future expected lifetime of the Insured;
5. Any administrative fee assessed; and
6. The Accelerated Benefits Interest Rate in effect.

The benefit will first be used to pay a pro-rata share of any outstanding debt to us. The benefit will never exceed 90% of the Death Benefit accelerated for the Critical Illness or Chronic Illness Accelerated Death Benefit Riders, 100% for the Terminal Illness Accelerated Death Benefit Rider. It will never be less than the Cash Surrender Value, if any, corresponding to the portion of the Death Benefit accelerated.

The Insured's Death Benefit in force will be reduced each time an Accelerated Benefit is paid. The reduction will equal the portion of the Death Benefit that is accelerated on the Election Date. The Face Amount or Coverage Amount, and if applicable, the Cash Value, Cash Surrender Value, Accumulated Value, Surrender Charge, and outstanding debt under the Policy will be reduced in the same proportion as the reduction in the Insured's Death Benefit. The new premiums and charges for the remaining portion will be as if the contract had been originally issued at the reduced amount.

As an example of the impact that election of Accelerated Benefits has on Policy values, consider the following situation:

| Prior to Election | Upon Partial Election of 50%of Death Benefit | Upon Full Election |
|---|---|---|
| Death Benefit = $200,000<br>Cash Value or Cash Surrender Value = 80,000<br>Outstanding Debt = 50,000<br>Annual Premium = 4,000 | Remaining Death Benefit = $100,000<br>Remaining Cash Value or Cash Surrender Value = 40,000<br>Remaining Outstanding Debt = 25,000<br>Remaining Annual Premium = 2,000 | Death Benefit = $0<br>Cash Value or Cash Surrender Value = 0<br>Outstanding Debt = 0<br>Annual Premium = 0 |

Dollar values showing specific impact that acceleration will have on your Policy values will be provided when you apply for Accelerated Benefits.

**Payment of Accelerated Benefits will reduce the Death Benefit otherwise payable under the Policy. Receipt of Accelerated Benefits may be a taxable event. Please consult your personal tax advisor to determine the tax status of any benefits paid under these Riders.**

Date ______________________

Owner's (Applicant's) Signature ______________________

Agent's Signature ______________________