

INDIVIDUAL WHOLE LIFE INSURANCE

for AK, AL, AR, AZ, CO, HI, IA, ID, KY, LA, MA, MD, ME, MI, MN, MS, NC, NE, NH, NJ, NM, OH, OK, OR, RI, TX, UT, VA, VT, WA, WI, WV, WY

Insured by Loyal American Life Insurance Company

PREPARE FOR LIFE

- › **APPLICANT INSTRUCTIONS**
- › **APPLICATION**
- › **ELECTRONIC FUNDS TRANSFER AGREEMENT**
- › **MIB PRE-NOTICE**
- › **HIPAA NOTICE**
- › **NOTICE AND CUSTOMER INFORMATION FORM**
- › **ACCELERATED BENEFIT TERMINAL ILLNESS DISCLOSURE**
- › **LIFE REPLACEMENT NOTICE**

Together, all the way.SM



LOYAL AMERICAN LIFE INSURANCE COMPANY®

Applicant Instructions for Whole Life Insurance

Applying for: New coverage Reinstatement Change in benefit coverage
 Add rider(s) to existing policy* Add dependent to existing policy*

*Policyowner's Name _____ Policy Number _____

To The Applicant – Please answer all questions on the Application completely and to the best of Your knowledge.

Section I: Choose the insurance You wish to apply for and when You would like it to be effective.

Section II: Who will be covered – in addition to yourself, would You like to have Your Spouse/Domestic or Civil Union Partner covered by this insurance?

Section III: The Applicant and/or Spouse/Domestic or Civil Union Partner address where You live (a P. O. Box is not acceptable).

Section IV: Name who You would like to designate as your beneficiary to receive the proceeds in the event of your death and how much You would like to leave each person if there is more than one (1) beneficiary. Fill in all blanks. If You do not know this information at the time of application, please call Customer Service at 866-459-4272 to add this information to Your application.

Section V: Choose how You would like to pay your premium.

Section VI: Let us know if You are replacing any current policy(ies) for this policy.

Section VII: Health History – Simplified Issue means that You and/or your Spouse/Domestic or Civil Union Partner may apply for \$2,000 to \$25,000 of coverage by answering the medical questions in this Section. No medical exam is required.

If You and/or your Spouse/Domestic or Civil Union Partner answer YES to any of questions 1 – 7 in Section VII, STOP HERE. You and/or your Spouse/Domestic or Civil Union Partner are not eligible for any coverage to be issued. If You and/or your Spouse/Domestic or Civil Union Partner answer NO to all of questions 1 – 7, then You should continue to answer questions 8 – 11.

If You and/or your Spouse/Domestic or Civil Union Partner answer YES to any of questions 8 – 11 in Section VII, then You and/or your Spouse/Domestic or Civil Union Partner are eligible for the Modified Benefit Plan. If You and/or your Spouse/Domestic or Civil Union Partner answer NO to all of questions 8 – 11, then You and/or your Spouse/Domestic or Civil Union Partner are eligible for the Level Benefit Plan.

Section VIII: Tell us if You or Your Spouse/Domestic or Civil Union Partner are a smoker or use tobacco or nicotine.

Section IX: Please select the Plan type (Level Benefit Plan or Modified Benefit Plan) that You and/or your Spouse/Domestic or Civil Union Partner are eligible for based on the answers to the medical questions in Section VII above. The Plan type selected **must be** the Plan that You and/or your Spouse/Domestic or Civil Union Partner are eligible for based on each person's answers to the medical questions.

You and/or your Spouse/Domestic or Civil Union Partner should complete the Benefit Amount of Life Insurance for each person. (The Benefit Amounts selected do not have to be the same for both.)

For proper premium and rating for couples, the discounted spousal rate will always apply to the youngest applicant. Either spouse may be listed as the primary applicant; however, the discounted rate can only apply to the younger applicant. Entering the incorrect premium will result in processing delays and require submission of a new, corrected application.

If You and/or your Spouse/Domestic or Civil Union Partner want to have the optional Automatic Premium Loan feature or the optional Accidental Death Benefit to Age 100 Rider, please make the appropriate selections in this Section.

Section X: ALL appropriate parties must sign and date the completed application.

The Agent/Broker should leave with You copies of: the Electronic Funds Transfer (EFT) Agreement, if applicable; MIB Pre-Notice; Authorization to Disclose Protected Health Information; Notice and Customer Information Form; Accelerated Benefit Terminal Illness Disclosure, if applicable; and the Important Notice: Replacement of Life Insurance or Annuities.

Policy Insured by **LOYAL AMERICAN LIFE INSURANCE COMPANY®**

11200 Lakeline Blvd., Austin, TX 78717 • (866) 459-4272
 Mailing Address: PO Box 5725, Scranton, PA 18505-5725

PV Case # _____

Individual Whole Life Insurance Application for Insurance

Section I. COVERAGE OPTIONS

1. Applying for: New coverage Reinstatement Change in benefit coverage
 Add rider to existing policy* Add dependent(s) to existing policy*

*existing Policy Number _____

2. Requested Effective Date _____

Section II. APPLICANT(S) APPLYING FOR COVERAGE

Last Name	First Name	M. I.	Age	Date of Birth (MM/DD/YYYY)	Place of Birth	Gender	Soc. Sec. Number
Applicant						<input type="checkbox"/> Male <input type="checkbox"/> Female	
Spouse/Domestic or Civil Union Partner						<input type="checkbox"/> Male <input type="checkbox"/> Female	

Section III. APPLICANT'S INFORMATION

Home Address Required:

Street

City State Zip Code

Mailing Address (if different from Home Address):

Street

City State Zip Code

Preferred Email Address

Cell Phone ()

Home Phone ()

Work Phone ()

Policyowner (if other than Applicant or Spouse/Domestic or Civil Union Partner):

Name

Relationship

Social Security Number

Street

City

State Zip Code

Section IV. BENEFICIARY INFORMATION: Please provide beneficiary information for the Applicant and Spouse/Domestic or Civil Union Partner if applicable.

	Applicant/Policyowner	Spouse/Domestic or Civil Union Partner
Name of Beneficiary		
Address		
Social Security No. (if known)		
Date of Birth (MM/DD/YYYY)		
Relationship to Applicant		
Primary or Contingent % of Benefit		

Section V. PREMIUM PAYMENT METHOD

Select one of the following:

- Electronic Funds Transfer (Bank Draft) (complete the Electronic Funds Transfer Authorization form)

Premium Mode: Monthly Quarterly Semi-annually Annually

- Direct Bill

Premium Mode: Quarterly Semi-annually Annually

Section VI. LIFE REPLACEMENT

1. Does the Applicant or Spouse/Domestic or Civil Union Partner have existing individual life insurance policies or individual annuity contracts with this or any other company? YES NO
 If YES, (a) the Applicant and Agent must complete the required "Important Notice: Replacement of Life Insurance or Annuities" form; (b) the Agent must complete the "Agent Provided Sales Material Statement" below and sign; and (c) provide the following information (use additional sheet, if needed):

Insurance Company Name and Address	Contract or Policy Number	Is Coverage being Replaced?
		YES <input type="checkbox"/> NO <input type="checkbox"/>
		YES <input type="checkbox"/> NO <input type="checkbox"/>

Applicant Signature _____ Date _____

Spouse/Domestic or Civil Union Partner Signature _____ Date _____

2. AGENT PROVIDED SALES MATERIAL STATEMENT (*must be completed by the Agent only if the Applicant is replacing existing life insurance or annuity*): I hereby certify that in connection with my presentation to the Applicant herein, I only used sales material that was previously approved by Loyal American Life Insurance Company and that I left with or provided to the Applicant/Spouse/Domestic or Civil Union Partner a copy of the sales material used in my presentation to the Applicant.

Agent Signature _____ Date _____

Section VII. HEALTH HISTORY INFORMATION

Applicant's Primary Physician: Name	Spouse/Domestic or Civil Union Partner's Primary Physician: Name
Address	Address
Phone ()	Phone ()

***Spouse/Domestic or Civil Union Partner**

- | | Applicant
YES NO | Spouse*
YES NO |
|--|---|---|
| 1. Has any Applicant ever been diagnosed or tested positive by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS); AIDS Related Complex (ARC); or Human Immunodeficiency Virus (HIV) infection? | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| 2. Are you currently waiting to receive or have you received an organ transplant (other than a cornea) or have you ever been diagnosed, treated, or advised by a member of the medical profession as having Amyotrophic Lateral Sclerosis (ALS), Huntington's disease, or any terminal illness? | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| 3. Is any Applicant currently paralyzed, bedridden, or receiving hospice, home health care, confined to a hospital, nursing home or other facility, or has confinement been recommended by a member of the medical profession? ... | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| 4. Within the past two (2) years, has any Applicant been diagnosed by a member of the medical profession for heart attack; cardiomyopathy; angina, angioplasty, stent placement, coronary artery bypass surgery, or other heart surgery? | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| 5. Within the past two (2) years, has any Applicant been diagnosed or treated by a member of the medical profession for congestive heart failure, unresolved aneurysm, any respiratory condition requiring the use of oxygen, any kidney disease requiring dialysis, chronic hepatitis, cirrhosis, other liver disease, or chronic pancreatitis? | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| 6. Has any Applicant ever been diagnosed as having or treated by a member of the medical profession for Alzheimer's disease or dementia? | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| 7. In the past twelve (12) months, has any Applicant been diagnosed or treated by a member of the medical profession for cancer (except basal cell carcinoma) or has any Applicant ever had a recurrence of or metastasis of cancer (except basal cell carcinoma)? | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |

If you answered YES to any of the above questions in (1 - 7), STOP — you are not eligible for coverage.

If you answered NO to questions (1 – 7), continue to questions (8 – 11).

- | | | |
|--|---|---|
| 8. Has any Applicant been diagnosed or treated by a member of the medical profession as having diabetes which was diagnosed prior to the age of 30 or diabetes requiring more than 50 units of insulin to control, or suffered complications from diabetes such as diabetic coma, insulin shock, or diabetic neuropathy? | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| 9. Within the past two (2) years, has any Applicant been diagnosed or treated by a member of the medical profession for any of the following: (a) Emphysema, Chronic Obstructive Pulmonary Disease (COPD), or chronic bronchitis; (b) stroke or Transient Ischemic Attack (TIA); (c) kidney disease other than kidney infection or kidney stones; (d) Multiple Sclerosis or Parkinson's Disease? | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| 10. Within the past four (4) years, has any Applicant been diagnosed or treated by a member of the medical profession for cancer (except basal cell carcinoma)? | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| 11. Within the past year, has any Applicant been treated, counseled, or been recommended to seek treatment for alcoholism, alcohol abuse, or any drug or substance abuse? | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |

If you answered YES to any of the above questions in (8 – 11), then you are eligible for the Modified Benefit Plan only (select the Modified Benefit Plan in Section IX). If you answered NO to all medical questions, you are eligible for the Level Benefit Plan (select the Level Benefit Plan in Section IX).

Section VIII. RATE CLASS

Have you used tobacco/nicotine in the last 12 months? Applicant Yes No Spouse/Domestic or Civil Union Partner Yes No

Section IX. BENEFIT SELECTION

Whole Life Insurance Policy – issue ages 50 - 85

Applicant Plan type:

Level Benefit Plan Benefit Amount \$ _____ Policy Modal Premium \$ _____
(includes Terminal Illness Accelerated Benefit Rider)

Modified Benefit Plan

Spouse/Domestic or Civil Union Partner Plan type:

Level Benefit Plan Benefit Amount \$ _____ Policy Modal Premium \$ _____
(includes Terminal Illness Accelerated Benefit Rider)

Modified Benefit Plan

Automatic Premium Loan (APL) Provision (if no Option(s) selected, will default to "No")

Applicant Yes No Spouse/Domestic or Civil Union Partner Yes No

Optional Rider selection (for an additional premium):

Accidental Death Benefit to Age 100 Rider

Applicant Benefit Amount \$ _____ Policy Modal Premium \$ _____
 Spouse/Domestic or Civil Union Partner Benefit Amount \$ _____ Policy Modal Premium \$ _____

Total Policy and Optional Rider Modal Premium \$ _____

Check enclosed (make checks Payable to: **Loyal American Life Insurance Company**)

Draft bank account for first premium

Section X. POLICYOWNER'S STATEMENTS AND AGREEMENTS

I/We hereby apply to Loyal American Life Insurance Company for insurance coverage to be issued based upon the truth and completeness of the answers to the above questions and understand and agree that: (1) no Agent has the authority to waive the answer to any questions on the Application and (2) no insurance will be effective until (a) this signed Application has been accepted upon review of the answers I/We have provided and any medical information reviewed by Loyal; (b) the initial premium has been paid; and (c) a contract has been issued by Loyal American Life Insurance Company. I/We have received the: Electronic Funds Transfer (EFT) Agreement; MIB Pre-Notice; Authorization to Disclose Protected Health Information; Notice and Customer Information Form; Accelerated Benefit Terminal Illness Disclosure; and Important Notice: Replacement of Life Insurance or Annuity.

I/We understand that any person who knowingly and with intent to defraud any insurance company or other person files an Application for Insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act and may be subject to civil and criminal penalties.

Applicant(s) or Owner must sign and date, acknowledging their understanding and agreement to the conditions listed herein. The above statements are true and complete to the best of my knowledge and belief. I/We understand and agree that for all Applicant(s) these statements shall be the basis for determination of acceptance for coverage under my applicable Loyal policy. I/We acknowledge and agree that any material misrepresentation or material omission of any Applicant may render this contract null and void from its date of issue in accordance with applicable law. If coverage is revoked, I will receive written notice that will explain the decision and my right to appeal. Loyal will return all paid premiums and fees less any claim payments.

Applicant Signature	Today's Date (MM/DD/YYYY)
Spouse/Domestic or Civil Union Partner Signature	Today's Date (MM/DD/YYYY)
Policyowner Signature	Today's Date (MM/DD/YYYY)

Section XI. AGENT(S) CERTIFICATION

Do you have knowledge or reason to believe the replacement of existing insurance may be involved? YES NO

If YES, give name of Company, reason, and termination date _____

I certify that I have interviewed the Applicant(s), asked all of the questions as written on the Application, and I have truly and accurately recorded on the Application the information supplied to me by the Applicant(s).

Printed Name of Licensed Agent	Signature of Licensed Agent	Writing Number	Percentage
Printed Name of 2 nd Licensed Agent		Writing Number	Percentage

PRE-AUTHORIZATION AGREEMENT FOR ELECTRONIC FUNDS TRANSFER

LOYAL AMERICAN LIFE INSURANCE COMPANY® • PO BOX 5725 • SCRANTON, PA 18505-5725

<input type="checkbox"/> Joint Account <i>(only one form is needed for Joint Account)</i> <input type="checkbox"/> Applicant only <input type="checkbox"/> Spouse/Domestic or Civil Union Partner only		
Proposed Insured Name		Policy Number <i>(if available)</i>
Financial Institution Name and Telephone Number		
9-digit Routing Number	Account Number	Requested Withdrawal Date <i>(1st - 28th)</i>

Withdraw Payment: Monthly Quarterly Semi-annually Annually

Type of Account: Personal Checking Account Personal Savings Account Corporate/Business Checking

Name of Employer Group _____

Purpose for submitting this Authorization (check appropriate box(es)):

- | | |
|--|---|
| <input type="checkbox"/> New authorization | <input type="checkbox"/> Change in checking/savings account |
| <input type="checkbox"/> Change in financial institution | <input type="checkbox"/> Change in existing coverage |

For checking account:
Refer to the sections on the sample check.

For savings account:
Please verify with your bank the account and routing number of your savings account.

0101

PAY TO THE ORDER OF _____ \$ _____

Dollars

The Routing number is 9 digits between the **⦿ ⦿** symbols.
⦿ 123456789 ⦿

The Account number is usually to the left of **⦿**. If check number is left of account number, ignore check number.
34567890 ⦿

The Check number should match the upper right corner.
0101

APPLICANT OR SPOUSE/DOMESTIC OR CIVIL UNION PARTNER INFORMATION FOR FINANCIAL INSTITUTIONS: As a convenience to me, I hereby request and authorize you to pay and charge to my account, drafts drawn on my account by and payable to Loyal American Life Insurance Company provided there are sufficient funds in said account to pay the same on presentation. Such drafts will bear my printed name. I also authorize Loyal American Life Insurance Company and any financial institution it uses to initiate credit entries to my account or to provide refund of premium or association fees (if applicable). I authorize you to accept and to credit these entries to my account. In the event Loyal American Life Insurance Company mistakenly deposits funds into my account, I authorize Loyal American Life Insurance to debit my account for an amount not to exceed the original amount of credit. This authorization shall remain in effect until revoked by me in writing, and until you actually receive such notice. I agree that you shall be fully protected in honoring any such draft. I agree that your rights in respect to any such draft shall be the same as if it were a check signed personally by me. I further agree that if any such draft is dishonored, whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

APPLICANT OR SPOUSE/DOMESTIC OR CIVIL UNION PARTNER INFORMATION FOR LOYAL AMERICAN LIFE INSURANCE COMPANY: It is understood that the initial draft will occur when the policy is issued. All subsequent drafts will be drawn on or about the requested date each month. The presentation of such drafts to the above Financial Institution shall constitute notice of premiums being due upon the contract and association fees (if applicable), and no other notice of premiums or association fees (if applicable) due will be given. No premium or association fee (if applicable) shall be deemed to have been paid unless and until actual payment of the draft drawn for such premium or association fee (if applicable) payment has been received by Loyal American Life Insurance Company. The cancelled draft will constitute receipt of premium or association fee (if applicable) payment. The privilege of paying premiums and association fees (if applicable) under this Plan may be revoked by Loyal American Life Insurance Company if any draft is not paid upon presentation. The payment of premiums and association fees (if applicable) under this Plan may be terminated by the Contract Owner, Financial Institution Depositor if other than Contract Owner, or by Loyal American Life Insurance Company upon 30 days written notice.

Name of Payor (if other than Insured) _____ Payor's Address _____

Print name of Depositor (as it appears on account) _____ Signature of Depositor _____ Date _____

PRE-AUTHORIZATION AGREEMENT FOR ELECTRONIC FUNDS TRANSFER

LOYAL AMERICAN LIFE INSURANCE COMPANY® • PO BOX 5725 • SCRANTON, PA 18505-5725

<input type="checkbox"/> Joint Account <i>(only one form is needed for Joint Account)</i> <input type="checkbox"/> Applicant only <input type="checkbox"/> Spouse/Domestic or Civil Union Partner only		
Proposed Insured Name		Policy Number <i>(if available)</i>
Financial Institution Name and Telephone Number		
9-digit Routing Number	Account Number	Requested Withdrawal Date <i>(1st - 28th)</i>

Withdraw Payment: Monthly Quarterly Semi-annually Annually

Type of Account: Personal Checking Account Personal Savings Account Corporate/Business Checking

Name of Employer Group _____

Purpose for submitting this Authorization (check appropriate box(es)):

- | | |
|--|---|
| <input type="checkbox"/> New authorization | <input type="checkbox"/> Change in checking/savings account |
| <input type="checkbox"/> Change in financial institution | <input type="checkbox"/> Change in existing coverage |

For checking account:
Refer to the sections on the sample check.

For savings account:
Please verify with your bank the account and routing number of your savings account.

0101

PAY TO THE ORDER OF _____ \$ _____

Dollars

The Routing number is 9 digits between the **⦿ ⦿** symbols.
⦿ 123456789 ⦿

The Account number is usually to the left of **⦿**. If check number is left of account number, ignore check number.
34567890 ⦿

The Check number should match the upper right corner.
0101

APPLICANT OR SPOUSE/DOMESTIC OR CIVIL UNION PARTNER INFORMATION FOR FINANCIAL INSTITUTIONS: As a convenience to me, I hereby request and authorize you to pay and charge to my account, drafts drawn on my account by and payable to Loyal American Life Insurance Company provided there are sufficient funds in said account to pay the same on presentation. Such drafts will bear my printed name. I also authorize Loyal American Life Insurance Company and any financial institution it uses to initiate credit entries to my account or to provide refund of premium or association fees (if applicable). I authorize you to accept and to credit these entries to my account. In the event Loyal American Life Insurance Company mistakenly deposits funds into my account, I authorize Loyal American Life Insurance to debit my account for an amount not to exceed the original amount of credit. This authorization shall remain in effect until revoked by me in writing, and until you actually receive such notice. I agree that you shall be fully protected in honoring any such draft. I agree that your rights in respect to any such draft shall be the same as if it were a check signed personally by me. I further agree that if any such draft is dishonored, whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

APPLICANT OR SPOUSE/DOMESTIC OR CIVIL UNION PARTNER INFORMATION FOR LOYAL AMERICAN LIFE INSURANCE COMPANY: It is understood that the initial draft will occur when the policy is issued. All subsequent drafts will be drawn on or about the requested date each month. The presentation of such drafts to the above Financial Institution shall constitute notice of premiums being due upon the contract and association fees (if applicable), and no other notice of premiums or association fees (if applicable) due will be given. No premium or association fee (if applicable) shall be deemed to have been paid unless and until actual payment of the draft drawn for such premium or association fee (if applicable) payment has been received by Loyal American Life Insurance Company. The cancelled draft will constitute receipt of premium or association fee (if applicable) payment. The privilege of paying premiums and association fees (if applicable) under this Plan may be revoked by Loyal American Life Insurance Company if any draft is not paid upon presentation. The payment of premiums and association fees (if applicable) under this Plan may be terminated by the Contract Owner, Financial Institution Depositor if other than Contract Owner, or by Loyal American Life Insurance Company upon 30 days written notice.

Name of Payor (if other than Insured) _____ Payor's Address _____

Print name of Depositor (as it appears on account) _____ Signature of Depositor _____ Date _____

MIB, Inc., Pre-Notice

LOYAL AMERICAN LIFE INSURANCE COMPANY®

PO Box 5725, Scranton, PA 18505-5725 • 866-459-4272

Information regarding your insurability will be treated as confidential. Loyal American Life Insurance Company or its reinsurers may, however, make a brief report thereon to MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734.

Loyal American Life Insurance Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

AUTHORIZATION FORM FOR DISCLOSURE OF AN APPLICANT'S PROTECTED HEALTH INFORMATION

I hereby authorize the disclosure of protected health information about me as described below.

1. The Company, as used in this authorization, shall mean American Retirement Life Insurance Company, Loyal American Life Insurance Company®, Cigna Health and Life Insurance Company, Cigna National Health Insurance Company, and their affiliates as described below.
2. I authorize any licensed physician, medical practitioner, hospital, clinic, Pharmacy Benefit Manager, or other medical or medically-related facility, the U. S. Veterans Administration and Selective Service System, insurance company, MIB, Inc., or any other organization, institution, or person that has any records or information available as to the diagnosis, treatment, and prognosis with respect to any physical or mental condition and/or treatment relating to me or my family to disclose to the Company's underwriting, new business, claims, sales agents, and premium accounting representatives any such records or information. However, MIB, Inc., information will only be shared with the Company's underwriting staff and Medical Director.
3. I authorize the Company to make a brief report of my protected health information to MIB, Inc.
4. The protected health information described above will be disclosed to the Company to determine my or my family's eligibility to obtain coverage under the policy for which I/we have applied, and to determine the rates and terms which apply to the policy.
5. This medical or health information includes information on the diagnosis and treatment of mental illness, alcohol, and drug use. This also includes information on the diagnosis, treatment, and testing results related to HIV, AIDS, and sexually-transmitted diseases unless otherwise restricted by state law.
6. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by the Company in reliance on this authorization, by sending a written revocation to the Company's Privacy Office at PO Box 5700, Scranton, PA 18505-5700.
7. I understand that the information which will be provided under this authorization is necessary for the Company to determine my eligibility for coverage under the policy and that the Company will condition its approval and issuance of the policy on my providing this authorization, and my application may be denied if I refuse to provide this authorization.
8. I understand that if the person or entity that receives my protected health information is not a health care provider or health plan covered by the federal privacy regulations, the information may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.
9. I understand that a photocopy, facsimile copy, or other electronic copy of this authorization shall be considered as effective and valid as the original. I also understand that I or my personal representative am entitled to receive a copy of this authorization upon request. This authorization will expire twenty-four (24) months from the date it is signed.
10. If you are the representative of an Applicant, describe the scope of your authority to act on the Applicant's behalf:

<hr/>		<hr/>	
APPLICANT A Name		Name of APPLICANT A Personal Representative, if applicable	
APPLICANT A Social Security Number		Relationship of Personal Representative to APPLICANT A	
APPLICANT A Signature	Date	Signature of Personal Representative	Date
<hr/>		<hr/>	
APPLICANT B Name		Name of APPLICANT B Personal Representative, if applicable	
APPLICANT B Social Security Number		Relationship of Personal Representative to APPLICANT B	
APPLICANT B Signature	Date	Signature of Personal Representative	Date
<hr/>		<hr/>	
Signature of Company's Agent	Date		

A signed copy of this form will be provided with the policy if issued and any other time upon request.

**AUTHORIZATION FORM FOR DISCLOSURE OF A CONSUMER'S
PROTECTED HEALTH INFORMATION FOR MARKETING PURPOSES
("Authorization")**

1. I hereby authorize the use and disclosure of all my health information, including but not limited to my personal and medical information contained in the Company's records ("Protected Health Information") to American Retirement Life Insurance Company, Loyal American Life Insurance Company®, Cigna Health and Life Insurance Company, Cigna National Health Insurance Company, and their affiliates ("Company") as described below.
2. I authorize the Company to use the Protected Health Information contained in the Company's records, including its underwriting and claim records, to help determine whether I might be interested in or can benefit from other non-health-related insurance products offered by the Company.
3. I understand that the Company will disclose the Protected Health Information to its underwriting staff, new business staff, sales agents, or marketing management for the purpose of marketing non-health-related products to me.
4. I understand that I may revoke this Authorization at any time, except to the extent that action has been taken by the Company in reliance on this Authorization, by sending a written revocation to the Company's Privacy Steward at PO Box 5700, Scranton, PA 18505-5700.
5. I understand that the Protected Health Information which the Company will use and disclose under this Authorization is not necessary for the Company to determine my eligibility for coverage under the policy and that the Company will not condition its approval and issuance of the policy on my providing this Authorization.
6. I understand that if the person or entity that receives my Protected Health Information is not a health care provider or health plan covered by the federal privacy regulations, the information may be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.
7. I understand that a photocopy, facsimile copy, or other electronic copy of this Authorization is as effective and valid as the original. I also understand that I or my personal representative am entitled to receive a copy of this Authorization. This Authorization will remain in effect for two (2) years from the day my policy(ies) is terminated or the day I revoke my permission.
8. By providing my telephone number(s) on the attached application for insurance, I consent to receive calls, texts, or autodialed or prerecorded telemarketing messages from Cigna and its affiliates.

If you are the representative of a Consumer, describe the scope of your authority to act on the Consumer's behalf:

APPLICANT A Name

Name of APPLICANT A Personal Representative, if applicable

APPLICANT A Signature

Date

Relationship of Personal Representative to APPLICANT A

Signature of Personal Representative

Date

APPLICANT B Name

Name of APPLICANT B Personal Representative, if applicable

APPLICANT B Signature

Date

Relationship of Personal Representative to APPLICANT B

Signature of Company's Agent

Date

Signature of Personal Representative

Date

A signed copy of this form will be provided to you.

Notice and Customer Information Form

To help the government fight the funding of terrorism and money laundering activities, Federal law requires us to obtain all relevant customer-related information necessary to run an effective anti-money laundering program.

What this means to you: When submitting an application/order ticket/request form, we ask that the Producer obtain the client's name, street address, date of birth, tax identification number, and other customer-related information that will allow us to identify the customer and fulfill our obligations under Federal law. Picture documentation, such as a driver's license or other identifying documents, will be used to verify the information given at the time of the sale.

By acknowledging receipt of this Notice and Customer Information Form, the undersigned authorizes any law enforcement agency, public or private institution, information service bureau, or other entity contacted by the Company identified above to furnish information sufficient to confirm the personal information of the undersigned as required by Federal law. This information is confidential and will not be used for any other purpose. The undersigned hereby releases all persons, agents and agencies, and entities providing confirming information from any and all liability arising out of the request for or the release of confirming information.

The owner information section must be completed in its entirety. If identification documents are not available, the customer must sign the form and the information will be verified by the Company.

The following information must be obtained for each tax identification number or social security number disclosed on the application for insurance.

I. Owner

FEIN/SSN	Owner Name	Verification of ID <input type="checkbox"/> Driver's License/State ID <input type="checkbox"/> Passport <input type="checkbox"/> Other _____ <input type="checkbox"/> Owner is an entity; legal document(s) attached (e.g., Articles of Incorporation, Trust Agreements, etc.)	State/Country	
Date of Birth	Occupation		Number	
Employer			Date Issued	Exp. Date

Additional Owner

FEIN/SSN	Person's Name	Verification of ID <input type="checkbox"/> Driver's License/State ID <input type="checkbox"/> Passport <input type="checkbox"/> Other _____ <input type="checkbox"/> Owner is an entity; legal document(s) attached (e.g., Articles of Incorporation, Trust Agreements, etc.)	State/Country	
Date of Birth	Occupation		Number	
Employer			Date Issued	Exp. Date

II. The source of funds for this transaction is _____

III. The purpose of this transaction is _____

Agent: I have examined and verified the customer's ID as noted above is true and correct to the best of my knowledge and belief.

 Agent's Printed Name

 Agent Number

 Agent's Signature

 Date

----- **COMPLETE THIS PORTION ONLY IF THE APPLICANT DOES NOT HAVE IDENTIFICATION DOCUMENTS** -----

Customer(s): I acknowledge the foregoing notice and certify that the foregoing information is true and correct to the best of my knowledge and belief.

 Owner's Printed Name

 Owner's Signature

 Date

 Additional Owner's Printed Name

 Additional Owner's Signature

 Date

LOYAL AMERICAN LIFE INSURANCE COMPANY®

PO Box 5725, Scranton, PA 18505

Toll Free: 866-459-4272

ACCELERATED BENEFIT TERMINAL ILLNESS RIDER DISCLOSURE STATEMENT

AN ACCELERATED BENEFIT THAT IS PAID ON ACCOUNT OF THIS RIDER WILL REDUCE THE DEATH BENEFITS OF THE POLICY. SUCH PAYMENT WILL ALSO REDUCE THE CASH VALUE OR OTHER VALUES OF THE POLICY, IF ANY. SOME PART OR ALL OF SUCH A PAYMENT MAY BE TAXABLE. AS WITH ALL TAX MATTERS, A TAX ADVISOR SHOULD BE CONSULTED.

What is an accelerated benefit? An accelerated benefit is the payment of a part of the proceeds of your life insurance policy before the death of an Insured. ("You" and "Your" refer to the Owner of the policy to which this rider is attached.)

Who can qualify for an accelerated benefit? An accelerated benefit may be paid with respect to the Insured or any additional Insured. The accelerated benefit will be paid only one time for each Insured.

When can I receive an accelerated benefit? Payment may be made to the Owner when an Insured has been diagnosed with a medical condition that results in a life expectancy of 12 months or less.

How much of the proceeds can be paid as an accelerated benefit? An accelerated benefit is paid from the Present Value of the Eligible Proceeds of your policy. The Eligible Proceeds are the death benefits of the policy (or combined policies) less any decreasing term riders and level term riders that will terminate within one year. Subject to the minimums and maximums described below, you may choose how much of the Eligible Proceeds are to be paid as an accelerated benefit.

In order to receive an accelerated benefit, you must have a least \$10,000 in Eligible Proceeds. The Eligible Proceeds that are to be paid as an accelerated benefit must be at least \$5,000. You may combine all policies that you have in force with us to satisfy these minimums.

You may not have more than 50% of your Eligible Proceeds paid as an accelerated benefit. You may not have more than \$200,000 of Eligible Proceeds paid as an accelerated benefit. These maximums apply to the total of all policies you have in force with us.

When proceeds are to be paid as an accelerated benefit, is there a reduction for early payment? Yes, the Eligible Proceeds that are to be paid as an accelerated benefit are reduced to present value. The present value calculation takes into account the premiums we would have expected to receive in the future had the accelerated benefit not been elected, as well as an administrative fee. This means the amount you receive will always be less than the Eligible Proceeds you choose to be accelerated.

What is the administrative fee when an accelerated benefit is to be paid? We may charge an administrative fee of up to \$100 when an accelerated benefit is to be paid. This fee will be included as par to the present value calculation. We will notify you if an administrative fee is charged.

How is the accelerated benefit paid? You may choose to have the accelerated benefit paid to you in a lump sum or in equal monthly installments. The Limited Life Expectancy Option provides for 12 months of installments.

What if the Insured dies before all payments are made? If the Insured dies before all payments are made, the present value of future payments will be paid to the beneficiary in a lump sum.

Will I have to continue making premium payments on my policy after payment of an accelerated death benefit? Yes. However, you will only have to make premium payments on the portion of your policy that remains in force. For example, if 50% of your Eligible Proceeds were paid as an accelerated benefit, you would continue to pay premiums on the 50% of the Face Amount that remains in force.

How will the payment of an accelerated benefit affect my policy? After the payment of an accelerated benefit, your policy will remain in force for a reduced Face Amount. The policy proceeds and all policy values will be reduced by the percentage of the Eligible Proceeds you elect to accelerate. Policy values that will be reduced include:

- (a) death benefit face amount;
- (b) future policy premiums (excluding the policy fee);
- (c) cash values, if any;
- (d) amounts available under the Reduced Paid-Up Nonforfeiture Option; and
- (e) policy loan amounts outstanding.

Any policy fees associated with the policy will not be reduced.

Here is an example of how an accelerated benefit affects a policy:

Death Benefit (Eligible Proceeds) \$100,000
 Maximum Accelerated Benefits \$ 50,000

	Death Benefit (Eligible Proceeds)	Premium plus any policy fees	Cash Value
Before accelerated payment	\$100,000	\$1,000	\$26,000
After accelerated payment	\$ 50,000	\$ 500	\$13,000

Do I have to pay an additional premium if the Rider is added to my policy? No, there is no additional premium charged if you add the rider to your policy.

When does the Rider terminate? The rider will terminate on the date an accelerated benefit is paid, the date you sent the company a written request to terminate the rider, or the date the policy terminates.

Signature of Proposed Insured	Date
Signature of Spouse/Domestic or Civil Union Partner Insured	Date
Signature of Owner	Date
Signature of Agent or Company Representative	Date

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Signature of Proposed Insured	Date
Signature of Spouse/Domestic or Civil Union Partner Insured	Date
Signature of Owner	Date
Signature of Agent or Company Representative	Date

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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 interests. 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 or contract 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 or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

INSURER NAME	CONTRACT/POLICY NUMBER	INSURED OR ANNUITANT	REPLACED (R) / FINANCED (F)

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 accurate, to the best of my knowledge:

Applicant Signature and Printed Name

Date

Spouse/Domestic or Civil Union Partner Signature and Printed Name

Date

Producer's Signature and Printed Name

Date

I do not want this notice read aloud to me. _____ (Applicant: Initial only if you 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 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 expense 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?

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