INDIVIDUAL WHOLE LIFE INSURANCE
for ILLINOIS

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.℠

Cigna®

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 <u>all</u> 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 **<u>any</u>** 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 **<u>all</u>** 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 **<u>must be</u>** 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						☐ Male ☐ Female	
Spouse/Domestic or Civil Union Partner						☐ Male ☐ 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 ☐ NO ☐
		YES ☐ NO ☐

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?	☐	☐	☐	☐
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?	☐	☐	☐	☐
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? ...	☐	☐	☐	☐
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?	☐	☐	☐	☐
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?	☐	☐	☐	☐
6. Has any Applicant ever been diagnosed as having or treated by a member of the medical profession for Alzheimer's disease or dementia?	☐	☐	☐	☐
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)?	☐	☐	☐	☐

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?	☐	☐	☐	☐
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?	☐	☐	☐	☐
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)?	☐	☐	☐	☐
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?	☐	☐	☐	☐

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 2nd Licensed Agent		Writing Number	Percentage

PRE-AUTHORIZATION AGREEMENT FOR ELECTRONIC FUNDS TRANSFER

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

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

Withdraw Payment: ☐ Monthly ☐ Quarterly ☐ Semi-annually ☐ Annually

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

Name of Employer Group _____

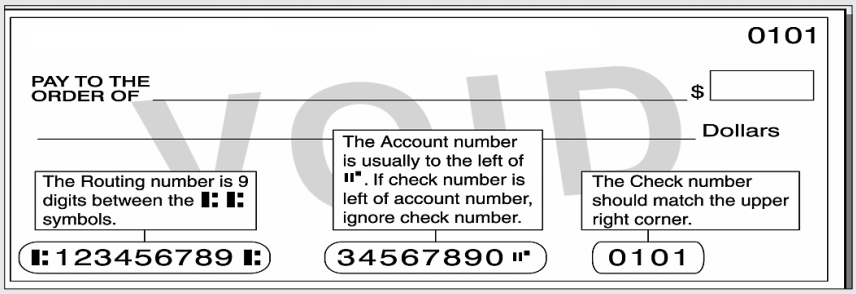
Purpose for submitting this Authorization (check appropriate box(es)):

☐ New authorization ☐ Change in checking/savings account

☐ Change in financial institution ☐ 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.



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

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

Withdraw Payment: ☐ Monthly ☐ Quarterly ☐ Semi-annually ☐ Annually

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

Name of Employer Group _____

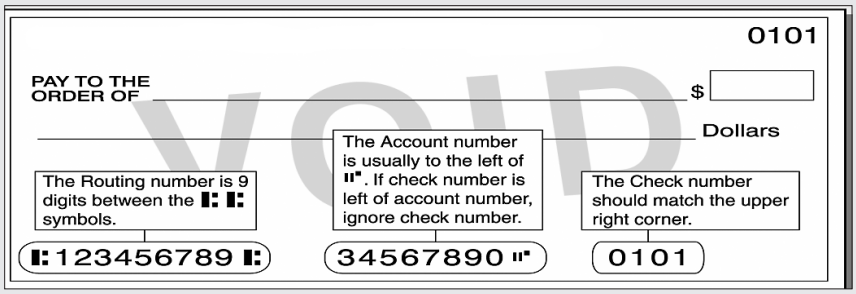
Purpose for submitting this Authorization (check appropriate box(es)):

☐ New authorization ☐ Change in checking/savings account

☐ Change in financial institution ☐ 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.



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:

_____

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**

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**

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

Applicant A Signature **Date**

Name of Applicant A Personal Representative, if applicable

Relationship of Personal Representative to Applicant A

Signature of Personal Representative **Date**

Applicant B Name

Applicant B Signature **Date**

Name of Applicant B Personal Representative, if applicable

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.

Loyal American Life Insurance Company®
PO Box 5725, Scranton, PA 18505-5725 • 866-459-4272

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**	**State/Country**	
		☐ Driver's License/State ID ☐ Passport		
Date of Birth	**Occupation**	☐ Other _____	**Number**	
		☐ Owner is an entity; legal document(s) attached (e.g., Articles of Incorporation, Trust Agreements, etc.)		
Employer			**Date Issued**	**Exp. Date**

Additional Owner

FEIN/SSN	**Person's Name**	**Verification of ID**	**State/Country**	
		☐ Driver's License/State ID ☐ Passport		
Date of Birth	**Occupation**	☐ Other _____	**Number**	
		☐ Owner is an entity; legal document(s) attached (e.g., Articles of Incorporation, Trust Agreements, etc.)		
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

Loyal American Life Insurance Company®
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Customer Service: 866-459-4272

NOTICE REGARDING REPLACEMENT OF LIFE INSURANCE OR ANNUITY

REPLACING YOUR LIFE INSURANCE OR ANNUITY?

Are you thinking about buying a new life insurance policy or annuity and discontinuing or changing an existing one? If you are, your decision could be a good one – or a mistake. You will not know for sure unless you make a careful comparison of your existing benefits and the proposed benefits.

Make sure you understand the facts. You should ask the insurance producer or company that sold you your existing policy to give you information about it.

Hear both sides before you decide. This way you can be sure you are making a decision that is in your best interest.

We are required by law to notify your existing company that you may be replacing their policy.

List below the identification of the policies which are involved in the replacement transaction.

_____ Contract Number

_____ Contract Number

_____ Contract Number

_____ Contract Number

_____ Insurance Agent's Signature

_____ Date

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NOTICE REGARDING PROPOSED REPLACEMENT OF LIFE INSURANCE OR ANNUITY

_____
Name of Existing Insurer

_____
Address

_____
City, State, ZIP Code

Dear _____,
Name of Existing Insurer (above)

You are herewith given notice that we are in receipt of application(s) for life insurance or annuity(ies) for an individual presently insured with your company.

IDENTIFICATION

Name of Insured _____

Address _____

_____

Contract Number _____

Contract Number _____

Contract Number _____

Contract Number _____

_____ _____
Insurance Agent's Signature Date

Sincerely,
LOYAL AMERICAN LIFE INSURANCE COMPANY