800 Crescent Centre Dr.
Suite 200
Franklin, TN 37067
800 264.4000
aetnaseniorproducts.com

Telephone Interview - Required

M - F 8am-8pm CT

877.568.2759 opt 1

AGES 60-89

Application

Whole Life Insurance

Underwritten by

An Aetna Company **American Continental Insurance Company**

Pennsylvania

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American Continental Insurance Company
An Aetna Company
800 Crescent Centre Dr.
Suite 200
Franklin, TN 37067

Application for Whole Life Insurance
from American Continental Insurance Company

- Print clearly and use blue or black ink.
- Use Section 4 for additional remarks, requests, or explanations.

1. Proposed insured information

If insured's mailing address is different than residential address, use remarks (Section 4).

If billing address is different than residential address, use remarks (Section 4).

Write the date of birth that is on the birth certificate.

Full name of proposed insured *First, M.I., Last*

Residential address (No P.O. Boxes) | Phone

City | State | Zip

E-mail | Social Security Number

Birth date *mm/dd/yyyy* | Age

Height *Feet and inches* | Weight *Pounds* | ○ Male ○ Female

Are you a legal resident of the United States? ○ Yes ○ No

Have you used any form of tobacco in the past 12 months? ○ Yes ○ No

2. Benefits, beneficiary and replacement information

To determine which Plan the applicant qualifies for, complete the health questions in Section 3.

Unless otherwise requested, the effective date is the application date as long as the application is received at the Home Office within 15 days.

If a nonforfeiture option is not selected, extended term insurance is the default.

You have a choice of four payment modes for paying your premium. The Company does not charge you more based on the premium mode you select. There may be reasons, such as the time value of money, you would want to consider in making a decision on which premium mode to choose. Your agent can explain the differences in modes and help you decide which is best for you.

Initial amount of insurance applied for:
$

Plan requested: ○ Graded benefit plan ○ Level benefit plan

Riders requested (if available):

Requested effective date:

Nonforfeiture options:
○ Automatic premium loan
○ Paid-up insurance
○ Extended term insurance

Amount paid with this application:
$

Initial premium method: ○ EFT ○ Check or money order

Payment mode: ○ Annually ○ Quarterly ○ Semi-Annually ○ Monthly EFT (Electronic Funds Transfer)

Full name of primary beneficiary *First, M.I., Last* | Relationship to insured

Contingent beneficiary *First, M.I., Last* | Relationship to insured

Does the proposed insured currently have any life insurance or annuity in force? ○ Yes ○ No

Will insurance applied for in this application replace, reduce or modify premiums paid for any existing life insurance or an annuity in force? ○ Yes ○ No

If the answer to either question is "yes", please provide the information below:

Company name	Face amount	Policy number

3. Health questions

A. Graded benefit plan

If you answered "yes" to any questions in Section A, you are not eligible for insurance coverage.

1. Do any of the following apply to you?
   - A. currently hospitalized, in a nursing facility, confined to a bed, receiving hospice care ◯ Y ◯ N
   - B. require use of oxygen for any lung or respiratory disorder ◯ Y ◯ N
   - C. have been diagnosed by a medical professional as having an aneurysm that has not been surgically repaired ◯ Y ◯ N
2. At any time have you been diagnosed or treated by a medical professional or had surgery for any of the following?
   - A. any condition requiring bone marrow, stem cell, or organ transplant ◯ Y ◯ N
   - B. kidney disease requiring dialysis ◯ Y ◯ N
   - C. Alzheimer's Disease, dementia, mental incapacity ◯ Y ◯ N
   - D. Lou Gehrig's Disease (ALS) ◯ Y ◯ N
   - E. a life expectancy of 12 months or less ◯ Y ◯ N
   - F. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), tested positive for the Human Immunodeficiency Virus (HIV) ◯ Y ◯ N
3. Do you have diabetes:
   - A. diagnosed by a medical professional before age 40 ◯ Y ◯ N
   - B. in combination with any heart or circulatory disorder diagnosed by a medical professional (excluding high blood pressure) ◯ Y ◯ N
   - C. requiring 40 or more units of insulin daily ◯ Y ◯ N
4. Within the past 12 months has a medical professional diagnosed you as having or have you had surgery for a heart attack, heart valve disorder, heart blockage, stroke or transient ischemic attack (TIA)? ◯ Y ◯ N
5. Within the past 12 months, have you been diagnosed or treated by a medical professional or had surgery for any of the following?
   - A. any lung or respiratory disorder requiring the use of a nebulizer ◯ Y ◯ N
   - B. any lung or respiratory disorder and currently use tobacco ◯ Y ◯ N
   - C. internal cancer, melanoma, lymphoma, multiple myeloma, leukemia, systemic lupus (SLE) ◯ Y ◯ N
   - D. chronic pancreatitis, chronic hepatitis, cirrhosis ◯ Y ◯ N
6. Within the past 12 months, have you been recommended by a medical professional to have any of the following?
   - A. treatment or counseling for alcohol or drug abuse ◯ Y ◯ N
   - B. test, surgery, treatment or further evaluation that has not been performed or are there any test results pending ◯ Y ◯ N

B. Level benefit plan

If you answered "yes" to any questions in Section B, you qualify for the Graded benefit plan.

If you answered "no" to ALL questions in Section B, you qualify for the Level benefit plan.

7. Within the past 24 months, has a medical professional diagnosed you as having or have you had surgery for an aneurysm, heart attack, any circulatory disorder, stroke, or transient ischemic attack (TIA)? ◯ Y ◯ N
8. Within the past 24 months, have you been diagnosed or treated by a medical professional or had surgery for any of the following?
   - A. emphysema, chronic obstructive pulmonary disease (COPD) ◯ Y ◯ N
   - B. internal cancer, melanoma, leukemia ◯ Y ◯ N
   - C. neuromuscular disorder including, but not limited to, cerebral palsy, multiple sclerosis, muscular dystrophy ◯ Y ◯ N
   - D. any connective tissue disorder, ulcerative colitis, Crohn's disease ◯ Y ◯ N
9. At any time, have you been diagnosed or treated by a medical professional or had surgery for any of the following?
   - A. congestive heart failure, cardiomyopathy, Parkinson's disease ◯ Y ◯ N
   - B. any permanent paralysis, amputation caused by disease ◯ Y ◯ N
10. Are you dependent on a wheelchair or motorized mobility device? ◯ Y ◯ N

4. Remarks

5. Privacy notice

Your application and telephone interview are American Continental Insurance Company's primary sources of information in determining whether to provide coverage to you. The Company, its affiliates, or its reinsurer(s) may also in certain circumstances release information collected by us to third parties without authorization from you. Upon written request, we will provide you with the information contained in your file. Should you wish to request correction, amendment or deletion of any information in your file, which you believe inaccurate, please contact us and we will advise you of the necessary procedures.

6. Producer compensation

When you purchase insurance from us, we pay compensation to the licensed agent, who represents us for such limited purposes as taking your insurance application, collecting your initial premiums and delivering your policy, and to any intermediaries through which the licensed agent works. This compensation may include commissions when a policy is purchased or renewed, and fees for marketing and administrative services and educational opportunities. The compensation may vary by the type of insurance purchased, or the particular features included with your policy. Additionally, some licensed agents and/or their intermediaries may also receive discounts on their own policy premiums and bonuses, and incentive trips or prizes associated with sales contests based on sales criteria, such as the overall sales volume of an agent or intermediary with our companies, or for the percentage of completed sales. (Generally, this will not be the case for registered variable insurance products or for fixed products sold through banks or broker-dealers.) Intermediaries may also pay compensation directly to the licensed agent. If the licensed insurance agent can sell insurance policies from other insurance carriers, those carriers may pay compensation that differs from ours.

7. Applicant agreement

I hereby apply to American Continental Insurance Company for a policy to be issued in reliance on my answers to the questions in this application. The applicant and agent represent that the applicant has read, or had read to applicant, the completed application, and the applicant understands that any false statements or misrepresentations made in the application may result in loss of coverage under the policy to which this application is a part.

I, the applicant, represent that the statements and answers given in the application are true, complete and correctly recorded to the best of my knowledge and belief. I agree that no insurance shall be in effect until the application has been accepted and approved by the Company and the first full modal premium has been paid. I understand that no insurance agent is authorized to waive any part of any answer on the application, to approve insurability, make or modify any contract or waive any of the Company's rights or requirements.

I understand and agree that, if I choose to pay my premium by electronic funds transfer (EFT) from my checking or savings account, I am accepting the terms and conditions of the EFT authorization attached to this application.

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, which is a crime and subjects such person to criminal and civil penalties.

Applicant signature | Date signed

X

Owner signature (if not proposed insured) | Owner Social Security Number

X

Signed in *City and State*

If owner is different than insured, indicate name, address and relationship to insured in remarks (Section 4).

Application for Whole Life Insurance

Applicant Initials

8. Account information

Complete this section if you are requesting electronic funds transfer (EFT) for premium payment.

Include a voided check with the application.

Proposed insured's name

Account owner name, if different than proposed insured's

Account owner relationship to proposed insured:
○ Business owned by proposed insured
○ Living trust
○ Employer
○ Power of Attorney
○ Conservator/guardian
○ Family member; specify

Financial institution name

○ Checking ○ Savings

Routing number

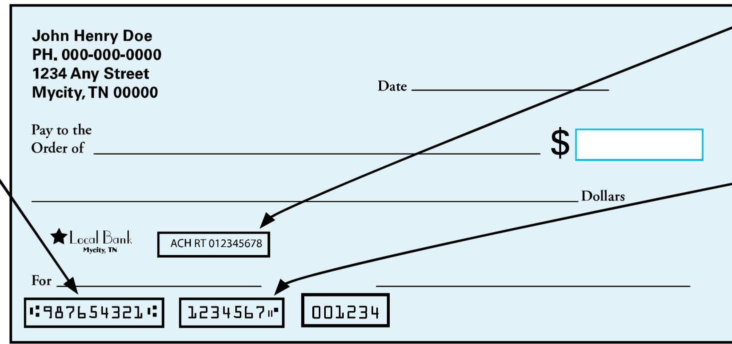
Account number

Initial premium will be drafted when the policy is approved and issued.

Do you prefer to have the initial premium drafted on the Effective Date? ○ Yes

This is an example of a personal check. A business check may be different.

For all other checks, use the nine-character bank **routing number**, which appears between the ⑆ symbols, usually at the bottom left corner of the check.



For checks with an **ACH RT (Automated Clearing House Routing) number**, please use this number.

The **account number** is up to 17 characters long and appears next to the ⑈ symbol at the bottom of the check and usually to the right of the bank routing number.

9. Electronic funds transfer (EFT) authorization

I understand and accept these terms and conditions:

- We are authorized to withdraw funds periodically from your account to pay insurance premiums for the insured.
- If your financial institution does not honor an EFT request, we will NOT consider your premium paid.
- If your financial institution does not honor an EFT request, we may make a second attempt within five business days.
- We have the right to end EFT payments at any time and bill you directly either quarterly or less frequently for premiums due.
- Information as to each EFT charge will be provided by entry on your account statement or by any other means provided by your financial institution. You will not receive premium notices from us.
- If you want to cancel or change this authorization, you must contact us at least three business days before a scheduled withdrawal.
- Any refund of unearned premium will be made to the policy owner or the policy owner's estate.

Signature only required if the account owner is different than the proposed insured.

Signature of account owner

X

Date

10. Agent Statement

Number 4 is applicable only if agent has personally recorded the information on the application.

I represent the following:

1. That the insurance being applied for is suitable for the owner's insurance needs.
2. I have explained to the applicant the premium mode options.
3. I have provided all required forms on or before the date the application was taken.
4. I have accurately recorded the information supplied by the applicant.

Does the proposed insured have any existing life insurance or annuity contracts? ○ Yes ○ No

Will the policy applied for be a replacement or change existing life insurance or an annuity? ○ Yes ○ No

If the answer to either question is "yes", have you complied with the requirements of the Company and your state regarding this replacement? ○ Yes ○ No

The writing number reflects where commissions will be paid.

Agent name *Printed* .... Writing number (agent or company) ....

Agent signature

X ....

Phone .... E-mail ....

11. Policy delivery

The policy will be mailed directly to the policyholder.

12. Agent request to split commissions

This section must be completed with this application in order to split commissions.

If this application results in an issued policy through American Continental Insurance Company (ACI), the agents listed below have agreed to split the commissions earned on the policy.

- Both agents must be properly licensed and appointed with ACI in the policy's state of issue.
- Split commissions are calculated as a percentage of commissionable premium and will apply while the policy remains inforce.
- The percentage of the premium split can be for any amount but must be stated in whole numbers and total 100%. (For example, the percentage for the premium split can be from 1% to 99% but cannot be 0% or 100%.)
- Calculation of each agent's commissions are based on their respective ACI commission schedule.

Writing agent *Printed* .... Percentage .... %

Secondary agent *Printed* .... Writing number .... Percentage .... %

By signing this form, the writing agent agrees to split his/her commission with the secondary agent as indicated above.

Writing agent signature

X ....

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An Aetna Company

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Franklin, TN 37067

Health Information Authorization

from American Continental Insurance Company

- Print clearly and use blue or black ink.
- This is a HIPAA Compliant Authorization.

To Agent: Have applicant complete and sign home office copy to submit with application. Applicant keeps one copy.

Applicant declarations

Please read these statements carefully

I authorize the use and disclosure of health information about me as described herein.

Health Information to be Used or Disclosed: This Authorization applies to information about: my past, present, or future physical or mental health or condition; health care I receive; the past, present, or future payment for my health care; and any related diagnosis, treatment, or prognosis. This includes, but is not limited to, information about: drugs; alcoholism and mental illness; and may be in electronic or paper form. It does not include information about previously administered tests for t-cell counts, HIV antibodies, AIDS or ARC.

Who May Request or Use Information: This information may be disclosed to and used and or disclosed by: American Continental Insurance Company; its insurance support organizations; its affiliates and reinsurers.

Who is Authorized to Disclose Information: All of the following persons or entities are authorized to disclose health information or records about me: physicians; health professionals; hospitals; clinics; the Veterans Administration; or other medical or medically related facilities; care providers or evaluators; insurance companies; reinsurers; consumer reporting agencies; insurance support organizations.

Purpose: This health information may be used or disclosed to: evaluate and underwrite my application; determine premium amounts, adjudicate claims and to support the operations of our health plans.

Statements of Understanding: I understand that: (1) I will receive a copy of this Authorization; and that a copy of it is as valid as the original; (2) this Authorization will be valid for 24 months from the date signed; (3) if I do not sign this Authorization, or revoke it by writing to American Continental Insurance Company at its Administrative Office, the Company may decline my application; and (4) If I revoke this Authorization, my revocation is not effective for any information that might have been used or disclosed in reliance on this Authorization (5) Some of the health information obtained may be disclosed to persons or organizations that are not subject to federal health information privacy laws, resulting in the information no longer being protected under such laws. I further understand that such information may be redisclosed only in accordance with applicable laws or regulations.

Primary applicant please fill in this information

Signature of applicant	Date	
X	.	
Printed name of applicant		
X		
City	State	Zip
.	.	.

Other important information

Producer Compensation

When you purchase insurance from us, we pay compensation to the licensed agent, who represents us for such limited purposes as taking your insurance application, collecting your initial premiums and delivering your policy, and to any intermediaries through which the licensed agent works. This compensation may include commissions when a policy is purchased or renewed, and fees for marketing and administrative services and educational opportunities. The compensation may vary by the type of insurance purchased, or the particular features included with your policy. Additionally, some licensed agents and/or their intermediaries may also receive discounts on their own policy premiums and bonuses, and incentive trips or prizes associated with sales contests based on sales criteria, such as the overall sales volume of an agent or intermediary with our Companies, or for the percentage of completed sales. (Generally, this will not be the case for registered variable insurance products or for fixed products sold through banks or broker-dealers.) Intermediaries may also pay compensation directly to the licensed agent. If the licensed insurance agent can sell insurance policies from other insurance carriers, those carriers may pay compensation that differs from ours.

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- Print clearly and use blue or black ink.
- This is a HIPAA Compliant Authorization.

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Applicant declarations

Please read these statements carefully

I authorize the use and disclosure of health information about me as described herein.

Health Information to be Used or Disclosed: This Authorization applies to information about: my past, present, or future physical or mental health or condition; health care I receive; the past, present, or future payment for my health care; and any related diagnosis, treatment, or prognosis. This includes, but is not limited to, information about: drugs; alcoholism and mental illness; and may be in electronic or paper form. It does not include information about previously administered tests for t-cell counts, HIV antibodies, AIDS or ARC.

Who May Request or Use Information: This information may be disclosed to and used and or disclosed by: American Continental Insurance Company; its insurance support organizations; its affiliates and reinsurers.

Who is Authorized to Disclose Information: All of the following persons or entities are authorized to disclose health information or records about me: physicians; health professionals; hospitals; clinics; the Veterans Administration; or other medical or medically related facilities; care providers or evaluators; insurance companies; reinsurers; consumer reporting agencies; insurance support organizations.

Purpose: This health information may be used or disclosed to: evaluate and underwrite my application; determine premium amounts, adjudicate claims and to support the operations of our health plans.

Statements of Understanding: I understand that: (1) I will receive a copy of this Authorization; and that a copy of it is as valid as the original; (2) this Authorization will be valid for 24 months from the date signed; (3) if I do not sign this Authorization, or revoke it by writing to American Continental Insurance Company at its Administrative Office, the Company may decline my application; and (4) If I revoke this Authorization, my revocation is not effective for any information that might have been used or disclosed in reliance on this Authorization (5) Some of the health information obtained may be disclosed to persons or organizations that are not subject to federal health information privacy laws, resulting in the information no longer being protected under such laws. I further understand that such information may be redisclosed only in accordance with applicable laws or regulations.

Primary applicant please fill in this information

Signature of applicant
X

Date

Printed name of applicant
X

City

State

Zip

Other important information

Producer Compensation

When you purchase insurance from us, we pay compensation to the licensed agent, who represents us for such limited purposes as taking your insurance application, collecting your initial premiums and delivering your policy, and to any intermediaries through which the licensed agent works. This compensation may include commissions when a policy is purchased or renewed, and fees for marketing and administrative services and educational opportunities. The compensation may vary by the type of insurance purchased, or the particular features included with your policy. Additionally, some licensed agents and/or their intermediaries may also receive discounts on their own policy premiums and bonuses, and incentive trips or prizes associated with sales contests based on sales criteria, such as the overall sales volume of an agent or intermediary with our Companies, or for the percentage of completed sales. (Generally, this will not be the case for registered variable insurance products or for fixed products sold through banks or broker-dealers.) Intermediaries may also pay compensation directly to the licensed agent. If the licensed insurance agent can sell insurance policies from other insurance carriers, those carriers may pay compensation that differs from ours.

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800 264.4000
aetnaseniorproducts.com
office hours 7:30 a.m. - 4:30 p.m. CST

Receipt And Conditional Insurance Agreement

from American Continental Insurance Company
(herein called "Company")

- Print clearly and use blue or black ink.
- Applicant keeps this receipt for their records.

Receipt for Initial Premium: This acknowledges receipt of the initial premium to be applied in connection with your application to Company for a whole life insurance policy. Company will return your premium payment if Company does not approve your application. This receipt will be void and of no effect if: 1) your check is not payable to American Continental Insurance Company or is not paid upon presentation; or 2) If your EFT bank draft is not honored due to insufficient funds in your bank account.

Proposed insured's name *Printed* | Date of application

Initial payment collected (if applicable)
$ ◯ Check ◯ Money order

EFT draft amount (EFT authorization must be completed and signed)
$

Agent name *Printed* | Phone

Agent signature
X

If you requested an effective date that is later than your application date, the following agreement will not apply and Company underwriting may consider any changes in your health status which occur after the application date.

Agreement: This Agreement applies only if all of the following requirements have been satisfied:

1. You submit your check payable to American Continental Insurance Company for the initial premium set forth above; or, if payment is made by EFT, you complete the account information and sign the EFT authorization and your financial institution honors the EFT request for payment; and
2. You did not request in writing, an effective date that is later than your application date; and
3. You truthfully answered "NO" to all the health questions in Section 3 of the application; and
4. No material misrepresentation or misstatement was made in the application.

When all of these requirements are satisfied, you and Company agree that:

1. Company will not disapprove your application based on any change in your health status that occurs after the application date.
2. **If Company approves your application, Company will provide insurance under the policy for which application was made, and the policy will be effective as of the application date.**
3. If Company disapproves your application, you will have no insurance coverage.

No applicant, agent, producer or representative has any power or authority to change any of the provisions of this Agreement.

Thank you for choosing American Continental Insurance Company!

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American Continental Insurance Company

An Aetna Company

800 Crescent Centre Dr., Suite 200 • Franklin, Tennessee 37067 • 800 264.4000

NOTICE REGARDING REPLACEMENT OF LIFE INSURANCE AND ANNUITIES

You have indicated that you intend to replace existing life insurance or annuity coverage in connection with the purchase of our life insurance or annuity policy. As a result, we are required to send you this notice. Please read it carefully.

Whether it is to your advantage to replace your existing insurance or annuity coverage, only you can decide. It is in your best interest, however, to have adequate information before a decision to replace your present coverage becomes final so that you may understand the essential features of the proposed policy and your existing insurance or annuity coverage.

You may want to contact your existing life insurance or annuity company or its agent for additional information and advice or discuss your purchase with other advisors. Your existing company will provide this information to you. The information you receive should be of value to you in reaching a final decision.
If either the proposed coverage or the existing coverage you intend to replace is participating, you should be aware that dividends may materially reduce the cost of insurance and are an important factor to consider. Dividends, however, are not guaranteed.

You should recognize that a policy which has been in existence for a period of time may have certain advantages to you over a new policy. If the policy coverages are basically similar, the premiums for a new policy may be higher because rates increase as your age increases. Under your existing policy, the period of time during which the issuing company could contest the policy because of a material misrepresentation or omission concerning the medical information requested in your application, or deny coverage for death caused by suicide, may have expired or may expire earlier than it will under the proposed policy. Your existing policy may have options which are not available under the policy being proposed to you or may not come into affect under the proposed policy until a later time during your life.

Also, your proposed policy's cash values and dividends, if any, may grow slower initially because the company will incur the cost of issuing your new policy. On the other hand, the proposed policy may offer advantages which are more important to you.

If you are considering borrowing against your existing policy to pay the premiums on the proposed policy, you should understand that in the event of your death, the amount of any unpaid loan, including unpaid interest, will be deducted from the benefits of your existing policy thereby reducing your total insurance coverage.

After we have issued your policy, you will have 20 days from the date the new policy is received by you to notify us you are cancelling the policy issued on your application and you will receive back all payments you made to us.

You are urged not to take action to terminate or alter your existing life insurance or annuity coverage until you have been issued the new policy, examined it and have found it acceptable to you.

American Continental Insurance Company

An Aetna Company

800 Crescent Centre Dr., Suite 200 • Franklin, Tennessee 37067 • 800 264.4000

PRODUCER STATEMENT

In connection with a Replacement of Insurance Transaction:
I certify that:

- I have used only American Continental Insurance Company approved sales material
- I have left all sales materials and the Replacement Notice with the applicant, and
- This sale conforms with the company's replacement policy.

The form number(s) of the sales materials left with the applicant are noted below.
If no sales materials were used, state "none".

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

Date: ________________________ __________________________
Producer's Signature

____
Producer's Name

Replacement Policy

We believe that the replacement of an existing life insurance policy must be appropriate for the customer and must meet his or her needs or financial objectives. From a customer's perspective, an appropriate replacement is one that is justified from either an economic or personal standpoint. The costs, provisions, features and benefits of both the current and proposed policy should be considered in relation to the customers needs, circumstances and goals.

Some examples of the types of provisions that should be considered are premium rate differences and differences in suicide and incontestability provisions. In addition, factors such as the age and health of the customer must be considered. Producers are expected to provide all material information that the customer needs in order to ascertain whether replacement of an existing policy or contract is appropriate.

All replacements must be in compliance with applicable regulations and company rules. Many states require accurate written comparisons of existing and proposed contracts be provided to the customer when proposing a replacement. Producers are expected to know and comply with these requirements.

American Continental Insurance Company

An Aetna Company

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DISCLOSURE STATEMENT

THIS DISCLOSURE STATEMENT WITH ALL APPLICABLE BLANKS FILLED IN IS FOR YOUR PROTECTION. IT GIVES YOU BASIC INFORMATION ABOUT THE COST AND COVERAGE OF THE INSURANCE BEING SOLICITED. READ IT CAREFULLY BEFORE SIGNING ANY AGREEMENT TO BUY LIFE INSURANCE.

THIS DISCLOSURE STATEMENT SHALL NOT BE CONSIDERED AS AN OFFER TO CONTRACT OR AS ALTERING OR MODIFYING ANY POLICY OR RIDER THAT MAY BE ISSUED.

Name of Proposed Insured________________________Age________Sex________

*Name of Agent preparing disclosure________________________

*Agent home or agency address________________________

*Telephone number of Agent________________________

Name of Insurer________________________

Home Office Address of Insurer (City and State)________________________

Direct all correspondence to (Insurer's home, executive or administrative office)________________________

____

	Descriptive Title Of Coverage	Face Amount of Coverage (1) If not applicable, Description of Coverage	Annual Premium If not known, Premium for Mode Quoted (2)
*Policy			
*Rider(s)			
*SupplementalBenefits (Built into policy)			The cost is included in the premium for the policy

*(1) The face amount of coverage of the policy and rider(s) (if applicable) changes as follows________________________

____

(2) Total (Initial) annual premium for the policy and rider will be ________________________.

*Guaranteed Cash Value. If you continuously pay your premiums on this policy as they come due, you will have the following guaranteed cash value for each $1000 (or face amount). *You may borrow against this cash value at an annual ______% loan interest charge.

Number of Years Policy Has Been in Force	5	10	20	40
Total Accumulated Cash Value Per $1000 (or Total Face Amount)				

Upon request either the company or agent will furnish you with additional information about the insurance described.

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DISCLOSURE STATEMENT

THIS DISCLOSURE STATEMENT WITH ALL APPLICABLE BLANKS FILLED IN IS FOR YOUR PROTECTION. IT GIVES YOU BASIC INFORMATION ABOUT THE COST AND COVERAGE OF THE INSURANCE BEING SOLICITED. READ IT CAREFULLY BEFORE SIGNING ANY AGREEMENT TO BUY LIFE INSURANCE.

THIS DISCLOSURE STATEMENT SHALL NOT BE CONSIDERED AS AN OFFER TO CONTRACT OR AS ALTERING OR MODIFYING ANY POLICY OR RIDER THAT MAY BE ISSUED.

Name of Proposed Insured____________________Age________Sex________

*Name of Agent preparing disclosure____________________

*Agent home or agency address____________________

*Telephone number of Agent____________________

Name of Insurer____________________

Home Office Address of Insurer (City and State)____________________

Direct all correspondence to (Insurer's home, executive or administrative office)____________________

____

	Descriptive Title Of Coverage	Face Amount of Coverage (1) If not applicable, Description of Coverage	Annual Premium If not known, Premium for Mode Quoted (2)
*Policy			
*Rider(s)			
*SupplementalBenefits (Built into policy)			The cost is included in the premium for the policy

*(1) The face amount of coverage of the policy and rider(s) (if applicable) changes as follows____________________

____

(2) Total (Initial) annual premium for the policy and rider will be ____________________.

*Guaranteed Cash Value. If you continuously pay your premiums on this policy as they come due, you will have the following guaranteed cash value for each $1000 (or face amount). *You may borrow against this cash value at an annual ______% loan interest charge.

Number of Years Policy Has Been in Force	5	10	20	40
Total Accumulated Cash Value Per $1000 (or Total Face Amount)				

Upon request either the company or agent will furnish you with additional information about the insurance described.

Final Expense Cash Values
Level Benefits

No commissions on issue ages 45-59

ISSUE AGE	Annual rates and values per $1,000 sum insured					
	MALE NON-SMOKER			MALE SMOKER		
	YEAR 10	YEAR 20	AGE 65	YEAR 10	YEAR 20	AGE 65
45	123.15	311.30	311.30	141.51	337.82	337.82
46	128.66	322.05	301.80	146.68	346.63	326.88
47	134.29	333.05	291.75	151.84	355.59	315.32
48	140.07	344.31	281.04	157.02	364.74	303.02
49	145.99	355.85	269.59	162.22	374.11	289.83
50	152.03	367.67	257.34	167.40	383.71	275.71
51	158.16	379.73	244.25	172.49	393.56	260.61
52	164.32	391.91	230.30	177.35	403.49	244.55
53	170.45	404.11	215.43	181.92	413.40	227.50
54	176.57	416.42	199.59	186.22	423.53	209.46
55	182.76	428.92	182.76	190.45	433.96	190.45
56	189.11	441.66	164.90	194.75	444.67	170.41
57	195.68	454.56	145.88	199.27	455.59	149.24
58	202.48	467.45	125.53	204.01	466.46	126.68
59	209.53	480.10	103.68	208.99	476.97	102.49
60	216.86	492.42	80.22	215.39	487.79	77.88
61	224.47	504.35	55.09	223.18	498.80	52.89
62	232.28	515.90	28.25	231.39	509.55	26.59
63	240.21	527.20		239.94	520.28	
64	248.76	538.45		249.11	531.07	
65	259.28	550.28		258.85	541.61	
66	270.13	561.43		268.98	551.44	
67	281.18	571.67		279.32	560.22	
68	292.17	580.78		289.49	567.70	
69	302.82	588.59		299.11	573.67	
70	312.98	594.99		308.01	577.97	
71	322.54	600.19		316.10	580.92	
72	331.60	604.61		323.61	583.08	
73	340.39	608.26		330.96	584.59	
74	348.76	610.96		338.03	585.29	
75	356.43	612.44		344.41	584.78	
76	363.07	612.83		349.57	583.07	
77	368.37	612.58		353.16	580.65	
78	372.20	611.57		355.06	577.48	
79	374.49	609.58		355.24	573.32	
80	375.11	606.04		353.54	567.60	
81	374.43	601.20		350.45	560.64	
82	372.96	596.22		346.63	553.80	
83	370.48	591.03		341.84	547.03	
84	366.78	585.54		335.93	541.08	
85	361.65	579.90		328.65	535.95	
86	355.67	574.36		320.53	531.62	
87	349.83	569.40		312.79	527.23	
88	344.16	564.77		305.54	524.52	
89	338.39	560.69		298.53	522.08	

Final Expense Cash Values
Level Benefits

No commissions on issue ages 45-59

ISSUE AGE	Annual rates and values per $1,000 sum insured					
	FEMALE NON-SMOKER			FEMALE SMOKER		
	YEAR 10	YEAR 20	AGE 65	YEAR 10	YEAR 20	AGE 65
45	102.65	261.92	261.92	127.15	303.63	303.63
46	106.68	271.11	253.15	130.84	311.87	292.91
47	110.77	280.58	243.89	134.45	320.28	281.57
48	114.94	290.33	234.10	138.07	328.86	269.61
49	119.19	300.35	223.77	141.76	337.64	257.02
50	123.59	310.68	212.86	145.53	346.63	243.80
51	128.16	321.30	201.35	149.44	355.75	229.90
52	132.91	332.17	189.20	153.48	364.96	215.29
53	137.88	343.32	176.39	157.69	374.24	199.93
54	143.10	354.75	162.87	162.14	383.57	183.80
55	148.57	366.43	148.57	166.85	392.99	166.85
56	154.31	378.40	133.47	171.83	402.58	149.01
57	160.35	390.66	117.52	177.10	412.33	130.24
58	166.67	403.21	100.65	182.59	422.22	110.42
59	173.26	416.05	82.76	188.26	432.27	89.46
60	180.10	429.18	63.75	194.10	442.51	67.27
61	187.16	442.32	43.50	200.00	452.48	43.72
62	194.40	455.13	21.92	205.88	461.63	18.72
63	201.79	467.65		212.52	470.55	
64	209.34	479.93		220.13	479.47	
65	217.03	491.89		227.72	487.68	
66	224.86	503.77		235.34	495.70	
67	232.86	515.25		243.00	503.16	
68	241.01	525.68		250.76	509.17	
69	251.29	536.20		258.64	513.75	
70	262.02	546.00		266.73	517.42	
71	272.75	556.70		274.53	522.71	
72	283.07	569.16		281.38	531.04	
73	293.05	581.96		287.32	540.80	
74	302.77	593.75		292.50	550.79	
75	312.12	603.11		296.81	558.74	
76	321.41	609.15		300.92	562.67	
77	330.20	611.51		304.29	562.12	
78	337.57	613.20		305.60	560.75	
79	343.37	617.86		304.76	563.32	
80	347.89	623.31		302.39	567.18	
81	353.87	628.58		302.61	571.27	
82	362.99	633.89		308.26	576.11	
83	373.19	639.03		317.01	581.75	
84	382.38	643.72		326.98	588.41	
85	388.41	647.63		334.84	595.53	
86	389.48	650.30		336.89	601.47	
87	385.19	651.95		332.84	606.53	
88	381.05	653.17		329.50	611.49	
89	383.11	653.87		334.21	616.35	

Final Expense Cash Values
Graded Benefits

No commissions on issue ages 45-59

ISSUE AGE	Annual rates and values per $1,000 sum insured					
	MALE NON-SMOKER			MALE SMOKER		
	YEAR 10	YEAR 20	AGE 65	YEAR 10	YEAR 20	AGE 65
45	125.73	313.32	313.32	145.74	341.09	341.09
46	131.37	324.16	303.98	151.19	350.07	330.43
47	137.11	335.22	294.06	156.55	359.17	319.13
48	142.98	346.53	283.48	161.91	368.44	307.07
49	149.03	358.14	272.19	167.36	377.95	294.19
50	155.24	370.06	260.15	172.86	387.75	280.46
51	161.58	382.25	247.33	178.36	397.86	265.86
52	168.00	394.59	233.69	183.72	408.11	250.40
53	174.44	406.98	219.20	188.89	418.40	234.08
54	180.93	419.51	203.83	193.89	428.96	216.91
55	187.53	432.25	187.53	198.84	439.83	198.84
56	194.28	445.22	170.23	203.86	450.95	179.80
57	201.24	458.33	151.78	209.04	462.23	159.61
58	208.44	471.43	132.06	214.44	473.44	138.11
59	215.96	484.32	110.97	221.48	485.23	116.66
60	223.86	496.95	88.44	229.59	497.06	94.57
61	232.14	509.25	64.44	238.34	508.59	71.38
62	240.72	521.22	38.93	247.62	519.90	47.15
63	250.08	533.34	12.62	257.26	531.21	21.87
64	260.95	545.94		267.47	542.54	
65	272.15	558.09		278.17	553.56	
66	283.67	569.57		289.20	563.84	
67	295.40	580.15		300.40	573.09	
68	307.12	589.63		311.47	581.07	
69	318.59	597.90		322.09	587.65	
70	329.73	604.87		332.20	592.73	
71	340.50	610.79		341.80	596.67	
72	350.93	616.04		351.00	599.97	
73	361.14	620.59		360.06	602.65	
74	371.02	624.26		368.97	604.67	
75	380.37	626.85		377.41	605.68	
76	388.93	628.55		384.94	605.74	
77	396.51	629.84		391.34	605.40	
78	403.01	630.63		396.49	604.62	
79	408.34	630.71		400.34	603.17	
80	412.39	629.55		402.75	600.52	

Final Expense Cash Values
Graded Benefits

No commissions on issue ages 45-59

ISSUE AGE	Annual rates and values per $1,000 sum insured					
	FEMALE NON-SMOKER			FEMALE SMOKER		
	YEAR 10	YEAR 20	AGE 65	YEAR 10	YEAR 20	AGE 65
45	104.84	263.73	263.73	130.36	306.20	306.20
46	108.99	272.99	255.08	134.30	314.61	295.72
47	113.21	282.55	245.96	138.21	323.22	284.68
48	117.53	292.40	236.35	142.18	332.05	273.09
49	121.96	302.55	226.21	146.25	341.11	260.91
50	126.56	313.02	215.53	150.44	350.38	248.14
51	131.36	323.79	204.28	154.80	359.81	234.75
52	136.36	334.83	192.43	159.32	369.35	220.71
53	141.60	346.15	179.94	164.05	378.97	205.98
54	147.10	357.76	166.77	169.05	388.65	190.54
55	152.88	369.64	152.88	174.33	398.45	174.33
56	158.96	381.82	138.23	179.91	408.41	157.32
57	165.34	394.29	122.77	185.78	418.53	139.41
58	172.01	407.04	106.42	191.89	428.80	120.54
59	178.96	420.07	89.09	198.21	439.23	100.62
60	186.18	433.41	70.69	204.72	449.86	79.56
61	193.64	446.77	51.12	211.34	460.24	57.27
62	201.29	459.80	30.29	219.02	470.54	34.95
63	209.13	472.54	8.08	227.36	480.53	12.14
64	217.15	485.07		235.65	489.83	
65	225.36	497.30		243.97	498.46	
66	233.76	509.47		252.39	506.94	
67	242.55	521.38		260.92	514.92	
68	253.22	533.31		269.63	521.53	
69	264.23	544.22		278.55	526.81	
70	275.63	554.37		287.81	531.29	
71	287.11	565.45		296.90	537.42	
72	298.26	578.29		305.16	546.56	
73	309.13	591.46		312.65	557.12	
74	319.83	603.69		319.44	567.90	
75	330.26	613.58		325.49	576.74	
76	340.71	620.27		331.45	581.77	
77	350.78	623.45		336.85	582.61	
78	359.57	626.05		340.42	582.78	
79	367.04	631.64		342.24	586.87	
80	373.69	638.21		343.24	592.52	