☐ American-Amicable Life Insurance Company of Texas
☐ IA American Life Insurance Company
☐ Pioneer American Insurance Company
☐ Pioneer Security Life Insurance Company
☒ Occidental Life Insurance Company of North Carolina

NEW BUSINESS
FAX APPLICATION COVER PAGE

FAX APPLICATION PHONE NUMBER: 254-297-2100
(USE THIS FAX NUMBER **ONLY** FOR SUBMITTING NEW BUSINESS APPLICATIONS)

_____ # pages including cover

Agent's Name_____ Agent's Number_____

Agent Phone:_____-_____-_____ Agent Fax Number:_____-_____-_____

Agent Email Address_____@_____

Proposed Ins. Name_____ SSN:_____-_____-_____

Special Instructions:_____

PAYMENT INFORMATION

_____eCheck-Immediate Draft for Cash with Application (CWA) in the amount of $_____. eCheck Authorization (Either Form 9409(1/07) or the eCheck Bank Draft Authorization Section of Form 9903).

_____Draft the first/initial payment in the amount of $_____. Preauthorization Check Plan completed on the back of the application or Bank Authorization (Either Form 1963(10/02) or the Bank Draft Authorization Section of Form 9903). Be sure to include a void check, deposit slip, or Bank Account Verification (Bank Draft Verification Section of Form 9903).

_____First payment is being mailed in the amount of $_____. Include copy of this fax cover memo with the payment. DO NOT mail the application with the payment. Preauthorization Check Plan completed on the back of the application or (Either Form 1963(10/02) or the Bank Draft Authorization Section of Form 9903). Be sure to include a void check, deposit slip, or Bank Account Verification (Bank Draft Verification Section of Form 9903). (FAX A COPY OF THE PAYMENT WITH THIS APPLICATION).

IMPORTANT INSTRUCTIONS

- **Fax only to 254-297-2100.**
- **Each application must be faxed with its own Fax Cover page. When faxing multiple applications it is imperative that a Bar Coded Fax Cover Page be placed between each individual application and it's paperwork.**
- Always fax originals only.
- Do Not write in margins of application as this information may not be received in fax transmission.
- Applications to be faxed in following order: Cover Memo, Front of application, Back of application, HIPAA form, Payment (echeck, void check, deposit slip, check), and any other supporting documents.
- Before faxing smaller items, such as void check, make a copy on a full page, making sure placed at top of page.
- When feeding documents, make sure the tops of all documents are fed into fax machine first and all documents are facing in same direction.
- DO NOT forward original application to Home Office unless instructed to do so by home office personnel.
- Keep the original application until the application has been approved and the policy delivered.
- Make sure to use the application with the correct state variations.

APPLICATION FOR LIFE INSURANCE

OCCIDENTAL LIFE INSURANCE COMPANY OF NORTH CAROLINA
P.O. BOX 2595, WACO, TX 76702-2595 • (254) 297-2775

EASY TERM

Please print all answers

Proposed Insured: _____ (First) (Middle) (Last)

Address: (No. & Street) _____

City: State: Zip Code:

Telephone interview done (if applicable) ☐ Yes ☐ No

_____ _____ ☐ am ☐ pm
Phone Best time to call

E-mail Address @

Sex	Date of Birth	Age	State of Birth	SS# — —	Height: ____ft___in	Occupation: _____
☐ Male ☐ Female	Mo. Day Yr / /			DL#	Weight: lbs	Annual Salary: $

Owner: Name _____ SS# _____ Address: _____
Payor: Name SS# Address:

Primary Insured: Primary Beneficiary _____ Relationship _____
Contingent Beneficiary Relationship

Plan: _____ ☐ Return of Premium (not available on 10 year term plan)

Face Amount $

During the past 12 months have you used tobacco in any form (excluding occasional pipe and cigar use)? ☐ Yes ☐ No

Riders: ☐ Waiver of Premium ☐ ADB $_____ ☐ CIA_____Units
☐ Disability Income $ ☐ Critical Illness % ☐ Other

Policy Date Request: / /

Mail Policy: ☐ Agent ☐ Insured ☐ Owner

Mode: ☐ Bank Draft ☐ Draft 1st Prem on Req. Date ☐ Payroll Deduction
☐ Qtrly ☐ Other Modal Prem $

CWA: ☐ E-Check Immediate 1st Prem
☐ Collected $

Do you have any existing life or disability insurance or annuity contract? ☐ Yes ☐ No
Will you replace an existing life or disability insurance policy or an annuity? ☐ Yes ☐ No

Company
Policy # Amount of Coverage $

Other Proposed Insureds: Name	Rider	Amt.	Sex	Birthdate	St. of Birth	Height	Weight	Relationship

SECTION A: Answer Questions 1, 2 and 3 for all Proposed Insureds.

1. Has any Proposed Insured been diagnosed or treated for, taken medication for or currently under treatment for *(circle condition that applies):*
   a. high blood pressure, heart attack, angina, arrhythmia, aneurysm, stroke, TIA, heart or circulatory disease or disorder? ..... Yes ☐ No ☐
   b. diabetes, pancreas disorder, hepatitis, Crohn's Disease, ulcerative colitis, liver or digestive disease or disorder? ..... Yes ☐ No ☐
   c. cancer in any form, lung disease or disorder, seizures, mental or nervous disorder, bi-polar disorder, paralysis, blindness? ..... Yes ☐ No ☐
   d. any disease or disorder of the kidneys, urinary bladder, prostate, reproductive organs, or sexually transmitted disease? ..... Yes ☐ No ☐
   e. connective tissue disease, systemic lupus (SLE), anemia, arthritis, or any disorder of the back, joints, muscles? ..... Yes ☐ No ☐
   f. any other disease or disorder, injury, surgery **within the past 24 months**? ..... Yes ☐ No ☐
2. **Within the past 2 years** has any proposed insured participated in parachuting, hang gliding, rock or mountain climbing, rodeo events, sky diving, scuba diving, organized racing of any kind, any professional sport, or aviation? ..... Yes ☐ No ☐
3. Has any Proposed Insured:
   a. been medically treated or diagnosed by a medical professional as having Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC), or any immune deficiency related disorder or tested positive for the Human Immunodeficiency Virus (HIV)? Yes ☐ No ☐
   b. **within the past 5 years,** been convicted of any misdemeanor or felony charge, had their driver's license suspended or revoked, or convicted of driving under the influence of alcohol or drugs, or driver's license currently suspended or revoked? ... Yes ☐ No ☐
   c. **within the past 5 years,** used illegal drugs, abused alcohol or drugs, or had or been recommended by a medical professional or licensed counselor to discontinue the use of alcohol or drugs or to have treatment or counseling for alcohol or drug use? .... Yes ☐ No ☐
   d. **within the past 6 months,** been on probation, parole, or been prohibited from actively working full time (30 hours or more per week) at their regular occupation due to any illness, injury, or health related problem, or are you **currently** disabled? ..... Yes ☐ No ☐
   e. **within the past 12 months,** consulted a physician, had surgery, been hospitalized, or had diagnostic tests such as EKG, Xray, MRI, CAT scan? ..... Yes ☐ No ☐
   f. **within the past 12 months,** had diagnostic testing, surgery, or hospitalization recommended by a medical professional which has not been completed or for which the results have not been received? ..... Yes ☐ No ☐

SECTION B: If applying for Critical Illness Rider answer Question 4. *(Provide: name, relationship, age at onset, medical condition.)*

4. Has primary insured had a natural parent, brother or sister, suffer from diabetes, kidney disease, require a major organ transplant or been diagnosed with heart disease, cerebrovascular disease, or internal cancer prior to age 60? ..... Yes ☐ No ☐

SECTION C: Give details to all "Yes" answers in Sections A and B and list current medications (use COMMENTS section on back for additional space).

Illness, Injury, Disease, or Symptoms	Dates	Treatment	Name and Address of Physician and/or Hospital
	/ /		
	/ /		
	/ /		

COMMENTS: _____

_____

_____

_____

AGREEMENT—I agree with Occidental Life Insurance Company of North Carolina (the Company) as follows: (1) To the best of my knowledge and belief, all answers and statements contained in this application are true, complete and correctly recorded; and (2) This application and any policy issued on the basis of such application shall form the entire contract; and (3) No change in this contract shall be effected without my written consent with regard to: (a) the amount of insurance; (b) age at issue; (c) classification of risk; (d) plan of insurance; or (e) benefits. If this application is declined by the Company, I will accept the return of any premium paid. Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

AUTHORIZATION—In order to properly classify my application for life insurance, I authorize any and all licensed physicians, medical practitioners, hospitals, clinics, medical or medically-related facilities, health plans, laboratories, pharmacy benefit managers, pharmacies or pharmacy-related facilities; insurance companies and their business associates and those persons or entities providing services to the insurer's business associates which are related in any way to their insurance plans; the MIB, Inc. or other organization that has knowledge or records of me and my health to give such information to: (a) Occidental Life Insurance Company of North Carolina; and (b) its reinsurers. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization or the insurance company exercises a legal right to contest a claim or the policy itself. I may revoke the authorization by sending a written revocation to the Company address of 425 Austin Ave., Waco TX 76701.

All said sources, except the MIB, Inc., are authorized to give records or knowledge such as statements regarding hobbies, employment, criminal records or medical history that might be required to determine eligibility for insurance to any agency employed by the Company to collect and transmit data. I authorize Occidental Life Insurance Company of North Carolina to disclose any personal data gathered while processing this application. This data may be released to the following: (a) reinsuring companies; (b) the MIB, Inc.; (c) other persons or groups performing services in connection with this application; or (d) any others to whom it may be lawfully required or authorized. This authorization shall remain valid for 30 months from this date. A copy of this authorization shall be as valid as the original. A copy of this authorization will be provided to you or your authorized representative.

CERTIFICATION—I hereby certify, under penalties of perjury, that (1) the social security number indicated above is my correct taxpayer identification number and (2) that I am not subject to backup withholding under Section 3406 (a) (1) (c) of the Internal Revenue Code. The Internal Revenue Service does not require your consent to any provision of this document other than the certification required to avoid backup withholding.

I acknowledge receiving the Fair Credit Reporting Act Notice and the MIB, Inc. Pre-Notice. I acknowledge receiving the Accelerated Living Benefit Rider Disclosure Form and the Terminal Illness Accelerated Benefit Rider Disclosure Form, if applicable.

Signed at _____ Date of Application _____
CITY STATE MONTH DAY YEAR

_____ _____
SIGNATURE OF PROPOSED INSURED SIGNATURE OF OWNER (IF OTHER THAN PROPOSED INSURED)

AGENT'S REPORT

I certify that I have personally asked each question on this application to the proposed insured(s), I have truly and completely recorded on the application the information supplied by him/her, and I witnessed their signature. I certify that the Accelerated Living Benefit Rider Disclosure Form and the Terminal Illness Accelerated Benefit Rider Disclosure Form have been presented to the applicant, if applicable.

Does the proposed insured have any existing life or disability insurance or annuity contract? ..... ☐ Yes ☐ No

Is the proposed insurance intended to replace or change any existing life or disability insurance or annuity? ..... ☐ Yes ☐ No

Agent _____ No: _____%_____ Agent _____ No: _____%_____
SIGNATURE SIGNATURE

PREAUTHORIZATION CHECK PLAN - AUTHORIZATION TO HONOR CHARGE DRAWN

Insured_____ Account Holder_____

Financial Institution (name/address)_____

Transit / ABA Number_____ Account Number_____ ☐ Checking ☐ Savings Requested Draft Day (1st-28th)____

ATTACH VOIDED CHECK OR DEPOSIT SLIP

As a convenience to me, I hereby request and authorize you to pay and charge to my account amounts drawn on my account, whether by electronic or paper means, by and payable to the order of Occidental Life Insurance Company of North Carolina, for the purpose of paying premiums on life insurance policy, provided there are sufficient funds in said account to pay the same upon presentation. I agree that your rights with respect to each such charge shall be the same as if it were signed personally by me. This authorization is to 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 check. I further agree that if any such check be dishonored, whether with or without cause, and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

SIGNATURE (As on Financial Institution Records)_____ DATE_____

OCCIDENTAL LIFE INSURANCE COMPANY OF NORTH CAROLINA
P.O. BOX 2595, WACO, TX 76702-2595

CONDITIONAL RECEIPT

NO COVERAGE WILL BECOME EFFECTIVE PRIOR TO POLICY DELIVERY UNLESS AND UNTIL ALL CONDITIONS OF THIS RECEIPT ARE MET. NO AGENT HAS THE AUTHORITY TO ALTER THE TERMS OR CONDITIONS OF THIS RECEIPT. THIS RECEIPT SHALL BE INVALID AND MAY NOT BE ISSUED WITH RESPECT TO PROPOSED PAYMENT OF THE INITIAL PREMIUM TENDERED BY MEANS OF A POST-DATED CHECK.

ALL PREMIUM CHECKS MUST BE PAYABLE TO THE COMPANY. DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE PAYEE BLANK.

Received from_____ the sum of $_____as first payment on this application for

Proposed Insured _____Date_____Agent_____

If (1) an amount equal to the first full premium is submitted or a payroll deduction authorization,a government allotment authorization, or a bank draft authorization has been fully implemented in an amount sufficient to pay the first full monthly premium, (2) any check or bank draft authorization given in payment of the initial premium is honored when first presented, (3) all underwriting requirements, including any medical examinations required by the Company's rules, are completed, and (4) the proposed insured is, on the date of application, a risk acceptable for insurance exactly as applied for without modification of plan, premium rate, or amount under the Company's rules and practices, **then** insurance under the policy applied for shall become effective on the latest of (a) the date of application, (b) the date the payroll deduction authorization or government allotment authorization is submitted for processing, or (c) the requested draft date specified in the bank draft authorization, or (d) the date of the latest medical exam required by the Company. THE TOTAL AMOUNT OF LIFE INSURANCE, INCLUDING ANY AMOUNT IN FORCE OR BEING APPLIED FOR, WHICH MAY BECOME EFFECTIVE PRIOR TO THE DELIVERY OF THE POLICY SHALL IN NO EVENT EXCEED $150,000.00. (INCLUDING LIFE INSURANCE AND ACCIDENTAL DEATH BENEFITS).

If any of the above conditions are not met exactly, the liability of the Company shall be limited to the return of any amount paid.

NOTICE

Printed in compliance with Public Law 91-508

Thank you for considering Occidental Life Insurance Company of North Carolina for your insurance needs. This is to inform you that as part of our procedure for processing your insurance application, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. You may request to be interviewed in connection with the preparation of this report and you may make a written request to receive a copy of the investigative consumer report. This inquiry includes information as to your character, general reputation and personal characteristics. You have the right to make a written request within a reasonable period of time to receive additional detailed information about the nature and scope of this investigation.

MIB, INC. PRE-NOTICE

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

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

Occidental Life Insurance Company of North Carolina, or its reinsurers, may also release information from 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, Inc. may be obtained on its website at www.mib.com.

Form No. OL9702-VA(Rev.12/08)

- ☐ American-Amicable Life Insurance Company of Texas
- ☐ IA American Life Insurance Company
- ☐ Occidental Life Insurance Company of North Carolina
- ☐ Pioneer American Insurance Company
- ☐ Pioneer Security Life Insurance Company

Please note charge may appear on statement under American-Amicable Group of Companies

P.O. Box 2549 Waco TX 76702-2549

Bank Draft Authorization - Please Attach a Voided Check

The Company indicated above is authorized to initiate debit entries to the account indicated below, and the Bank named below is authorized to debit the same to such account. This authority can be terminated by the undersigned at any time by written notification to the Company, provided only that the Company and the bank will have a reasonable opportunity to act on such notification. By signing below, I authorize the Company indicated above and/or their representative to receive information from the banking facility named so my account number and routing number may be verified.

Bank Name _____

Bank Address _____

Transit/ABA Number _____ **Account Type:** Checking Savings (Circle One)

Account Number _____ **Amount $** _____

Requested Draft Date, If Any (1st-28th) _____ **OR** **Circle One of the Following:** 1st 2nd 3rd 4th Wednesday of Every Month

_____ _____

SIGNATURE (AS ON FINANCIAL INSTITUTION RECORDS) **DATE**

Bank Account Verification
COMPLETE ONLY IN ABSENCE OF VOID CHECK, DEPOSIT SLIP OR BANK STATEMENT

Telephone No: _____ **Person you spoke to at Bank/Credit Union:** _____ **Ext:** _____

I certify that I have contacted the applicant's bank or credit union and have verified that the above account is an active account and can be drafted for insurance premiums. I understand that if the information is incorrect or invalid that I will not be advanced on additional new business without a void check, deposit slip, or a copy of the proposed insured's bank statement. I also understand that if the information provided is found to be falsified my agent contract will be terminated immediately.

_____ _____ _____

DATE **AGENT NUMBER** **AGENT SIGNATURE**

By signing below, I authorize the Company indicated above and/or one of their representatives to receive information from the banking facility named above so my account number and routing number may be verified.

_____ _____

SIGNATURE (AS ON FINANCIAL INSTITUTION RECORDS) **DATE**

E-Check Bank Draft Authorization
COMPLETE THIS SECTION TO IMMEDIATELY DRAFT PREMIUM

Immediately upon receipt of My Application, please draft $_____ from my account listed above and identified with a void check, deposit slip, bank statement or Bank Account Verification above.

_____ _____

SIGNATURE **DATE**

AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS
Occidental Life Insurance of North Carolina (here after referred to as the Company)

This Authorization complies with the HIPAA Privacy Rules

The Authorization must be fully completed as a condition of obtaining coverage. A refusal to sign this authorization will result in a rejection of your application for the insurance. A copy of this authorization will be considered as valid as the original.

1. I hereby authorize the following person(s) or group of persons to disclose information to the company: Any and all physicians, medical practitioners, hospitals, clinics, medical or medically-related facilities, health plans, pharmacy benefit managers, pharmacies or pharmacy-related facilities; insurance companies and their business associates and those persons or entities providing services to the insurers' business associates which are related in any way to their insurance plans.

2. This authorization specifically includes the release of **all medical records** including without limitation those containing information relating to diagnoses, treatments, consultation, care, advice, laboratory or diagnostic tests, physical examinations, recommendations for future care, prescription drug information, alcohol or drug abuse, mental illness or information regarding communicable or infectious conditions, such as HIV and/or AIDS.

3. Person(s) or group of persons authorized to receive and use the information: The Company and its business associates and those persons or entities providing services to the Company plans.

4. The information will be used to make enrollment/eligibility for benefit determinations, specifically including, but not limited to, underwriting and risk rating determinations. If coverage is issued, such determinations may include determinations as to whether coverage should be rescinded or reformed if I have made any material omission(s) or misrepresentation(s) in my application.

5. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

6. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization or the insurance company exercises a legal right to contest a claim or the policy itself. I may revoke the authorization by sending a written revocation to the Company address of 425 Austin Ave, Waco TX 76701.

7. I understand that if I refuse to sign this authorization to release my complete medical records, my application for insurance with the Company will be rejected.

8. This authorization will expire 24 months after the date signed.

9. I have received a coy of the "Authorization for the release of Medical Records".

Signature of Proposed Insured who is Age 18 and over, Parent (on behalf of a minor) or Legal Representative:

Proposed Insured:_____ Date:_____

Spouse (if applicable):_____ Date:_____

Signature of minor's parent or legal guardian:_____ Date:_____

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2. This authorization specifically includes the release of **all medical records** including without limitation those containing information relating to diagnoses, treatments, consultation, care, advice, laboratory or diagnostic tests, physical examinations, recommendations for future care, prescription drug information, alcohol or drug abuse, mental illness or information regarding communicable or infectious conditions, such as HIV and/or AIDS.

3. Person(s) or group of persons authorized to receive and use the information: The Company and its business associates and those persons or entities providing services to the Company plans.

4. The information will be used to make enrollment/eligibility for benefit determinations, specifically including, but not limited to, underwriting and risk rating determinations. If coverage is issued, such determinations may include determinations as to whether coverage should be rescinded or reformed if I have made any material omission(s) or misrepresentation(s) in my application.

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Proposed Insured:_____ Date:_____

Spouse (if applicable):_____ Date:_____

Signature of minor's parent or legal guardian:_____ Date:_____

OCCIDENTAL LIFE INSURANCE COMPANY OF NORTH CAROLINA
WACO, TEXAS

DISCLOSURE STATEMENT

TERMINAL ILLNESS ACCELERATED BENEFIT RIDER

NOTE: PAYMENT OF AN ACCELERATED BENEFIT MAY BE TAXABLE. YOU SHOULD SEEK THE ASSISTANCE OF YOUR PERSONAL TAX AND/OR LEGAL ADVISOR IF YOU ARE CONSIDERING ELECTING THIS BENEFIT.

ANY MEDICAID OR OTHER GOVERNMENT ENTITLEMENT FOR WHICH YOU ARE ELIGIBLE MAY BE AFFECTED BY PAYMENTS RECEIVED UNDER THIS RIDER.

The Accelerated Benefit Rider attached to your Policy allows you to receive up to 100% of the Death Benefit proceeds of the Policy when the Insured has a medical condition that reasonably can be expected to result in death within 12 months. Upon receipt of proof satisfactory to the Company of the Insured's reduced life expectancy and written consent of any assignee or irrevocable beneficiary we will pay an accelerated benefit. It will be paid in a lump sum. It is payable only once.

The Benefit to be paid will be reduced by an Actuarial Adjustment Factor and an Administrative Charge of $150. We will deduct from the Benefit paid any outstanding indebtedness, but only in proportion to the percentage of Death Benefit paid. We will also return to you a proportionate amount of any premium paid beyond the date any Benefit under this Rider is paid. The Cash Value, the amount available for loans and the premium, excluding the Policy fee, for the Policy will decrease in proportion to the amount of Benefit paid. Continued payment of the reduced premium is necessary for the Policy to remain in force. If the entire Death Benefit is paid under this Rider, then the Policy will terminate with no further value.

ACTUARIAL ADJUSTMENT FACTOR

Any benefit paid under this Rider will be reduced by the product of (A) and (B) where:

A) .06 and,
B) Number of months of life expectancy as certified by a physician not to exceed 12, divided by 12. If the number of months of life expectancy is not available or otherwise undeterminable, then the midpoint of 6 months will be used.

I have received a copy of this Disclosure Statement.

Applicant:_____ Date:_____

I certify that this Disclosure Statement has been presented to the applicant.

Agent:_____ Date:_____

Signature Required by State
1 Copy - Home Office / 1 Copy - Applicant

OCCIDENTAL LIFE INSURANCE COMPANY OF NORTH CAROLINA
WACO, TEXAS

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Applicant:_____ Date:_____

I certify that this Disclosure Statement has been presented to the applicant.

Agent:_____ Date:_____

Signature Required by State
1 Copy - Home Office / 1 Copy - Applicant

OCCIDENTAL LIFE INSURANCE COMPANY OF NORTH CAROLINA

WACO, TEXAS

DISCLOSURE—ACCELERATED DEATH BENEFIT RIDER

TAXATION—Receipt of the accelerated benefit paid under the Rider may be taxable. Assistance should be sought from your personal tax advisor. The benefit paid may also affect your eligibility for Medicaid and other government benefits.

COVERED CONDITIONS—

Heart Attack—The death of a portion of the heart muscle (myocardium) resulting from a blockage of one or more coronary arteries and resulting in a loss of the normal function of the heart. A Physician must furnish us in writing a diagnosis of the condition. This diagnosis must include documentation supported by clinical, radiological, histological, or laboratory evidence of the condition. The following are excluded: Angina, chest pains associated with restricted blood supply to the heart.

Coronary Artery Bypass Graft (CABG)—10% of the accelerated living benefit will be paid for the first ever open chest surgery to correct narrowing or blockage of two or more coronary arteries with bypass grafts, either saphenous vein or internal mammary graft. The surgery must have been proven to be necessary by means of coronary angiography. A cardiologist must recommend surgery. In the absence of extensive surgical treatment, the medical condition would result in a drastically limited life span. The following are excluded: angioplasty, laser relief of an obstruction, and other intra-arterial procedures.

Stroke—A cerebral vascular incident caused by hemorrhage, embolism, thrombosis producing measurable neurological deficit persisting for at least 30 days following the occurrence of the stroke. The diagnosis must be supported by new changes on a CT or MRI scan. The following are excluded: neurological symptoms due to transient ischemic attack (TIA) or mini-stroke, migraine, cerebral injury resulting from trauma or hypoxia, vascular disease affecting the eye, optic nerve and vestibular function.

Cancer—Only those types of cancer manifested by the presence of a malignant tumor, characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissue which would, in the absence of medical treatment, result in a drastically limited life span. Cancer includes: Leukemia, Malignant Lymphoma, Hodgkin's Disease (except Stage 1 Hodgkin's Disease). Diagnosis of cancer must be established according to the criteria of malignancy established by The American Board of Pathology after a study of the histocytologic architecture or pattern of the suspect tumor, tissue or specimen. The following are excluded: pre-malignant tumors or polyps, cancer in-situ (e.g. cervical dysplasia), transitional carcinoma of urinary bladder Stage 0, prostate cancer Stage A or equivalent TNM Classification (T1, T1a, T1b), colon cancer Dukes Stage A, hyperkeratoses, basal cell and squamous skin cancers, malignant melanomas of the skin classified Clark Level 2 or less, or has a Breslow thickness measurement 0.75mm or less.

Kidney Failure—End stage kidney disease presented as chronic irreversible failure of both kidneys to function. The undergoing of regular renal dialysis or undergoing a renal transplant must evidence this. The following are excluded: single kidney failure, temporary kidney failure.

Major Organ Transplant Surgery—The actual undergoing as a recipient (human to human) of a transplant of the heart, lung, liver, pancreas, kidney or bone marrow. The transplant must be medically necessary and based on objective confirmation of organ failure.

Terminal Illness—The insured must be suffering from a condition, which in the opinion of a physician will lead to death within twenty-four (24) months.

FACE AMOUNT—In the Rider, the term "Face Amount" refers to the Face Amount under the Policy to which the Rider is attached.

PREMIUM CHANGE—The Company may change the premium for this Rider. The changed premium may be greater than or less than the Rider premium at issue but will not be greater than the maximum premium shown in the Benefit Description Page 3B of the Policy. The premium may not be changed before the end of the first five years and may not be changed more often than once a year thereafter. Notice of a change of premium will be sent to the Owner at least 30 days before the change becomes effective. Upon any Rider premium increase, the Owner has the option to: a) Pay the new Rider premium; or b) Reduce the Rider benefit proportionally. If the Owner does not elect a) above in writing within 60 days after notification of the premium increase, the Company will automatically reduce the benefit of this Rider Proportionally.

ACCELERATED DEATH BENEFIT—Upon receipt of proof of a qualifying event and written consent of all irrevocable beneficiaries and all assignees, we will pay an accelerated benefit. It will be paid in a single sum. The qualifying event must occur on or after the 30th day following the date of issue of this Rider or in the case of accident, the effective date is the date of issue of this Rider. The benefit will be the lesser of: (a) the percent, indicated in the Benefit Description Page of the Policy, of the Face Amount, or (b) $250,000.

The applicable percentage shall be the lesser of a) or b) above divided by the Face Amount.

Then we will subtract: (a) the applicable percentage of any outstanding loan and loan interest due and unpaid on the date of the qualifying event; and (b) any premium due and unpaid which applies to a period prior to the date a qualifying event occurs.

On the date payment is made, the following will be reduced by the applicable percentage: 1) the Face Amount; 2) the Policy's base premium excluding the Policy fee (if any); 3) the cash value (if any); 4) any policy loans. The premium rate for any riders on the Policy will not be reduced. The accelerated benefit rider and its associated premium will terminate, unless the qualifying event for which payment was made is for Coronary Artery Bypass Graft. Upon payment of 10% of the accelerated benefit due to the occurrence of Coronary Artery Bypass Graft, the rider premium continues unchanged and future acceleration of any other benefit under the Rider will be reduced proportionately.

OCCIDENTAL LIFE INSURANCE COMPANY OF NORTH CAROLINA
P.O. Box 2549, Waco, Texas 76702-2549

IMPORTANT NOTICE
REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

Note-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 life insurance policy or annuity contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A *replacement* occurs when a new life insurance policy or annuity contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing life insurance policy or annuity contract, or an existing life insurance policy or annuity 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 or annuity contract 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 life insurance policy or annuity contract to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

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

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

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing life insurance policy or annuity contract? _____YES _____NO
2. Are you considering using funds from your existing life insurance policy or annuity contract to pay premiums due on the new life insurance policy or annuity contract? _____YES _____NO

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

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

Make sure you know the facts. Contact your existing company or its agent for information about the old life insurance policy or annuity 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 life insurance policy or annuity contract is being replaced because_____

_____

_____

I certify that the responses herein are, to the best of my knowledge, accurate:

_____ _____
Applicant’s Signature and Date Insurance Producer’s Signature and Date

_____ _____
Applicant’s Printed Name Insurance Producer’s Printed Name

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

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing life insurance policy or annuity contract and the proposed life insurance policy or annuity contract. One way to do this is to ask the company or agent that sold you your existing life insurance policy or annuity contract to provide you with information concerning your existing life insurance policy or annuity contract. This may include an illustration of how your existing life insurance policy or annuity 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 insurance producer/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?

OCCIDENTAL LIFE INSURANCE COMPANY OF NORTH CAROLINA
P.O. BOX 2549, Waco, Texas 76702-2549

APPLICANT: _____
Printed name of proposed insured

DATE:_____

STATEMENT REGARDING SALES MATERIALS USED IN PRESENTATION OF A LIFE INSURANCE POLICY OR ANNUITY

I VERIFY THAT ONLY COMPANY APPROVED SALES MATERIALS WERE USED IN THE SALES PRESENTATION OF A LIFE INSURANCE POLICY OR ANNUITY TO THE APPLICANT SHOWN ABOVE.

IN ADDITION, A COPY OF ALL MATERIALS USED IN THE PRESENTATION WAS LEFT WITH THE APPLICANT.

_____ _____
Signature of Insurance Producer Insurance Producer No.

OCCIDENTAL LIFE INSURANCE COMPANY OF NORTH CAROLINA
P.O. Box 2549, Waco, Texas 76702-2549

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