☐ 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.

FINAL EXPENSE

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

LIFE INSURANCE APPLICATION (**Please print in black ink**) **Telephone Case No:**_____

Proposed Insured _____ (First) (Middle) (Last)
Address (No. & Street)_____
City State Zip Code

Telephone interview completed ☐ Yes ☐ No ☐ am ☐ pm
_____ Phone _____ Best time to call
E-mail Address

Name/Address Secondary Addressee (for notice of possible lapse due to nonpayment of premiums):

☐ Male ☐ Female	Date of Birth / /	Age	State of Birth	Social Security Number / /	Height ft in	Weight lbs

Owner: Name_____Relationship_____SS#_____ /____/_____
Address City/State/Zip

Primary Beneficiary	Relationship	Contingent Beneficiary	Relationship

Plan: _____ **Face Amount of Insurance $**_____
☐ Immediate Death Benefit
☐ Graded Death Benefit (Percentage of Face Amount)
☐ Return of Premium Death Benefit

☐ Check here if you are willing to accept any plan for which you qualify based on this application. The insurance for which you qualify may have a graded or return of premium death benefit for the first two (2) or three (3) years, a face amount less than any indicated on this application, and riders may not be available.

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

Rider: ☐ Grandchild/Great Grandchild Coverage ____ Number of Children Applying ____ Units ☐ Other _____
☐ Child Rider* Units ☐ ADB* Amt $ (*not available on Return of Premium Death Benefit)
Automatic Premium Loan Elected? ☐ Yes ☐ No

Mode: ☐ Bank Draft ☐ Draft 1st Prem on Req. Date ☐ Other Modal Prem $
CWA: ☐ E-Check Immediate 1st Prem ☐ Collected $
Mail Policy To: ☐ Agent ☐ Insured ☐ Owner
Requested Policy Date: / /

A. Do you have existing life insurance or an annuity contract? ☐ Yes ☐ No
B. Will you replace an existing life insurance policy or an annuity? ☐ Yes ☐ No
Company
Policy # Amount of Coverage $

Physician Name: City/State: Phone:

HEALTH INFORMATION

1. Are you currently hospitalized, confined to a nursing facility, a bed, or a wheelchair due to chronic illness or disease, currently using oxygen equipment to assist in breathing, receiving Hospice Care or home health care, or had an amputation caused by disease, or do you currently have any form of cancer diagnosed by a licensed medical professional (excluding basal cell skin cancer), or do you require assistance (from anyone) with activities of daily living such as bathing, dressing, eating or toileting? ☐ Yes ☐ No
2. Have you had or been medically advised to have an organ transplant or kidney dialysis, or have you been diagnosed by a licensed medical professional as having congestive heart failure (CHF), Alzheimer's, dementia, mental incapacity, Lou Gehrig's disease (ALS), liver failure, respiratory failure, or any terminal illness or end-stage disease? ☐ Yes ☐ No
3. Have you tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection? ☐ Yes ☐ No

If any answer to questions 1 through 3 is answered "Yes" the Proposed Insured is not eligible for any coverage.

4. Have you been diagnosed or treated by a licensed medical professional for complications of diabetes, including insulin shock, diabetic coma, retinopathy (eye), nephropathy (kidney), neuropathy (nerve damage/pain), or used insulin prior to age 50? ☐ Yes ☐ No
5. Have you been diagnosed or treated by a licensed medical professional or taken medication for renal insufficiency, kidney failure, chronic kidney disease, or more than one occurrence of cancer in your lifetime (excluding basal cell skin cancer)? ☐ Yes ☐ No
6. Within the past 2 years have you had any diagnostic testing (excluding tests related to Human Immunodeficiency Virus (HIV)), surgery, or hospitalization advised by a licensed medical professional which has not been completed or for which the results have not been received? ☐ Yes ☐ No
7. Within the past 2 years have you:
   a. been diagnosed or treated by a licensed medical professional for angina (chest pain), stroke or TIA, cardiomyopathy, systemic lupus (SLE), cirrhosis, Hepatitis C, chronic hepatitis, chronic pancreatitis, chronic obstructive pulmonary disease (COPD), emphysema, chronic bronchitis, or required oxygen equipment to assist in breathing? ☐ Yes ☐ No
   b. been diagnosed or treated by a licensed medical professional for a heart attack or aneurysm or been advised to have any type of heart, brain or circulatory surgery (including, but not limited to a pacemaker insertion, defibrillator placement), or any procedure to improve circulation? ☐ Yes ☐ No
   c. been diagnosed by a licensed medical professional, or treated, or taken medication for any form of cancer (excluding basal cell skin cancer)? ☐ Yes ☐ No
   d. used illegal drugs, had or been recommended by a licensed medical professional or licensed counselor to discontinue the use of alcohol or drugs or to have treatment or counseling for alcohol or drugs? ☐ Yes ☐ No

If any answer to questions 4 through 7 is answered "Yes" the Proposed Insured should apply for the Return of Premium Death Benefit Plan.

8. Within the past 3 years have you been diagnosed or treated by a licensed medical professional, or hospitalized for:
   a. stroke, angina (chest pain), heart attack, aneurysm, heart or circulatory surgery or any procedure to improve circulation? ☐ Yes ☐ No
   b. or taken medication for any form of cancer (excluding basal cell skin cancer), emphysema, chronic bronchitis, chronic obstructive pulmonary disease (COPD), ulcerative colitis, cirrhosis, Hepatitis C, or liver disease? ☐ Yes ☐ No
   c. paralysis of two or more extremities or any neuro-muscular disease or disorder (including, but not limited to cerebral palsy, multiple sclerosis, seizures, or Parkinson's disease)? ☐ Yes ☐ No

If any answer to question 8 is answered "Yes" the Proposed Insured should apply for the Graded Death Benefit Plan.

If all questions 1 through 8 are answered "No" the Proposed Insured should apply for the Immediate Death Benefit Plan.

CHILD, GRANDCHILD, AND GREAT GRANDCHILD COVERAGE - Children Proposed for Insurance (list additional children on a separate sheet):

Proposed Insured Name	Sex	Birthdate	Relationship	Proposed Insured Name	Sex	Birthdate	Relationship

I certify that I have legal guardianship for any children proposed for life insurance.

SIGNATURE:_____ DATE:_____

PROPOSED CHILDREN'S HEALTH STATEMENT—To the best of my knowledge and belief, none of the children listed above for coverage have been treated for, or diagnosed by a licensed medical professional that they have or had any of the following medical conditions: Hypertension, heart or circulatory disorder, malignancy in any form, diabetes, sickle cell anemia, seizures, Down's Syndrome, cystic fibrosis, cerebral palsy, hydrocephalus, paralysis, or hospitalized for asthma or any respiratory disorder in past 12 months. List the names of children that are exceptions to PROPOSED CHILDREN'S HEALTH STATEMENT. ***Children listed as an exception are excluded from the appropriate Child Rider Coverage.*** Exceptions are:_____

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.

AUTHORIZATION—In order to properly classify my application for life insurance, I authorize 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 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. 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.

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 two years from this date. A copy of this authorization shall be as valid as the original.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

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

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

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

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

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 Terminal Illness Accelerated Benefit Rider Disclosure Form has been presented to the applicant.

AGENT'S REMARKS:_____

_____ _____ _____ _____

AGENT'S PRINTED NAME DATE AGENT'S PRINTED NAME DATE

Agent _____ Agent Printed Name _____%_____

SIGNATURE LICENSE IDENTIFICATION NUMBER

Agent _____ Agent Printed Name _____%_____

SIGNATURE LICENSE IDENTIFICATION NUMBER

PREAUTHORIZATION CHECK PLAN - AUTHORIZATION TO HONOR CHARGE DRAWN

Insured_____Account Holder_____

Financial Institution_____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.

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

Received of_____the sum of $_____as first payment on this application.

Date_____Agent_____

If (1) an amount equal to the first full premium is submitted; and if (2) all underwriting requirements, including any medical examinations required by the Company's rules, are completed; and (3) 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, or (b) the date of the latest medical exam required by the Company. THE 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 $30,000.00 (INCLUDING LIFE INSURANCE AND ACCIDENTAL DEATH BENEFITS).

If any of the above conditions are not met, 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. 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.

- ☐ 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 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.

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:_____

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.

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:_____

OCCIDENTAL LIFE INSURANCE COMPANY OF NORTH CAROLINA
P.O. BOX 2595, WACO, TEXAS 76702-2595
PH: 254-297-2775

NOTICE TO APPLICANT REGARDING REPLACEMENT OF LIFE INSURANCE

A decision to buy a new policy and discontinue or change an existing policy may be a wise choice or a mistake.

Get all the facts. Make sure you fully understand both the proposed policy and your existing policy or policies. New policies may contain clauses which limit or exclude coverage of certain events in the initial period of the contract, such as the suicide and incontestable clauses which may have already been satisfied in your existing policy or policies.

Your best source for facts on the proposed policy is the proposed company and its agent. The best source on your existing policy is the existing company and its agent.

Hear from both before you make your decision. This way you can be sure your decision is in your best interest.

If you indicate that you intend to replace or change an existing policy, Florida regulations require notification of the company that issued the policy.

Florida regulations give you the right to receive a written Comparative Information Form which summarizes your policy values. Indicate whether or not you wish a Comparative Information Form from the proposed company and your existing insurer or insurers by placing your initials in the appropriate box below.

☐ **YES** ☐ **NO**

DO NOT TAKE ACTION TO TERMINATE YOUR EXISTING POLICY UNTIL YOUR NEW POLICY HAS BEEN ISSUED AND YOU HAVE EXAMINED IT AND FOUND IT ACCEPTABLE.

I have read this notice and received a copy of it.

_____ _____
Applicant's Signature Date

_____ _____
Agent's Signature Date

_____
Agent's Name (Printed or Typed)

_____
Agent's Address (Printed or Typed)

_____
Agent's Company (Printed or Typed)

Information on Policies which may be replaced:

Company Name	Policy Number	Name of Insured

OCCIDENTAL LIFE INSURANCE COMPANY OF NORTH CAROLINA
P.O. BOX 2549 • WACO, TX 76702
PH: 254-297-2775

PLEASE READ CAREFULLY. This information has been prepared for you so that you may make an informed decision on the use of any of your policy values to fund the purchase of a new policy. Please see the reverse side of this form for explanatory notes and instructions as to how this form has been completed.

PART A - CURRENT POLICY INFORMATION. ☐ LIFE ☐ ANNUITY

Policyowner's Name: _____ Policy Number: _____

Current Death Benefit: $ _____Current Premium Amount: $_____ Mode of Payment: _____

Cash SurrenderValue: $ _____ Paid-up Addition Value: $ _____ Dividend Value: $ _____
(The BENEFIT and VALUES stated above will be reduced as funds are used to purchase the policy proposed in Part B below.)

PART B - PROPOSED POLICY INFORMATION. ☐ LIFE ☐ ANNUITY

Initial Death Benefit: _____ Proposed Premium Amount: _____ Mode of Payment: _____
Proposed Effective Date: _____ Premium Payable to Age _____ or for _____ Years

NOTE: If you are replacing your current policy, or using 25% or more of your policy values, you may request a **WRITTEN** comparison between your current policy and the proposed policy. The comparison is to illustrate the policy values for both policies.

PART C - SOURCE OF FUNDING FOR THE PROPOSED POLICY.

A loan in the amount of $ _____ will be taken from the value of your CURRENT POLICY each _____ (mode), bearing a current loan interest rate of _____ %.

A partial surrender in the amount of $ _____ will be taken from the value of your CURRENT POLICY each _____ (mode).

A dividend withdrawal in the amount of $ _____ will be taken from the value of your CURRENT POLICY each _____(mode).

PART D - YOUR CURRENT POLICY COULD TERMINATE.

If the policy values of your CURRENT POLICY are used as a source of funding for the purchase of an additional policy, it is estimated that your CURRENT POLICY will terminate on _____ (date).

It is estimated that you will begin making premium payments for the PROPOSED POLICY from your own funds on _____ (date) in the amount of $ _____ to be paid each _____ (mode).

NOTE: Since the values and premiums stated on this form may change over time, the estimated date upon which you will need to begin making premium payments from your own funds for the PROPOSED POLICY may also change. Estimates as to dates when policies will terminate or payments must begin assume the continuation of current (or guaranteed) factors, and such calculations are based upon the assumption that any premiums or interest due on loans are paid when due.

Policyowner Signature: _____ Date:_____

Agent or Company Officer Signature:_____ Date: _____

Florida Licensed Agent ID No. or Corporate Title: _____

Form D14-1180 (9/95)

POLICY DISCLOSURE FORM AND INSTRUCTIONS
COMPLETE ONE FORM FOR EACH PREVIOUSLY ISSUED POLICY.
ANY REQUIRED REPLACEMENT AND SALES FORMS MUST ALSO BE COMPLETED.
ONE COPY IS DELIVERED TO THE POLICYOWNER AND ONE COPY MAINTAINED BY THE INSURER.

Any and all information applicable to the transaction shall be fully and completely disclosed on Form D14-1180. If the information requested does not apply to the transaction, the words "not applicable" or "N/A" shall be entered.

PART A
The information to be disclosed in Part A of Form D14-1180 shall apply to the current, in-force policy for which policy values are being utilized as a source of funding for the purchase of additional insurance contract(s). For purposes of this form, "current death benefit" is defined as the sum of the death benefit payable under the base policy, as life insurance riders covering the principal insured (other than special contingency death riders), paid-up additional insurance and dividends, minus outstanding indebtedness. The term "cash surrender value" is defined as the cash value of the policy or contact net of any outstanding indebtedness and surrender charges, and less any dividend values. The term "paid-up addition value" is defined as the cash value of additonal insurance purchased with dividends. The term "dividend value" is definded as the total cash value of all policy dividends left on deposit with the company to accumulate at interest.

PART B
The information to be disclosed in Part B of Form D14-1180 shall apply to the proposed additional insurance contract(s) being funded by policy values in a current, in-force policy. For purposes of this form, "proposed premium amount" is defined as any recurring payment which is planned to be paid or which is required to be paid under the proposed policy.

PART C
The information to be disclosed in Part C of Form D14-1180 shall apply to the current, in-force policy, and shall indicate the manner in which the policy values are being used to fund the purchase of the proposed policy. Part C is not to be completed if the current policy is totally surrendered. However, in the event of total surrender of the current policy, Parts A, B, D, and the signature block of this form must still be completed.

When completing Part C of this form, each and every source of funding for the proposed policy must be identified, i.e., whether a policy loan, partial surrender, or dividend withdrawal or any combination thereof is being utilized. If more than one source of funding will be utilized to fund the initial and/or future premiums for the proposed policy, all applicable sections of Part C shall be completed.

For purposes of this form, a "partial surrender" is defined as any amount taken from the value of the current policy which is less than the total cash value available under such policy. The term "mode" is defined as the frequency upon which a policy loan, partial surrender or dividend withdrawal will be taken from the value of the current policy. In the event of a single loan, surrender or withdrawal, the words "one time only" shall be entered in the space provided. The term "loan interest rate" is defined as the rate of interest in effect on the date that this form is completed, as specified in the current policy contract.

PART D
The information to be disclosed in Part D of Form D14-1180 shall apply to the current, in-force policy and the proposed additional policy, respectively.

SIGNATURES
In order to evidence that the required disclosure has been made, Form D14-1180 shall be signed and dated by the soliciting agent or by a Corporate Officer, as well as by the policyowner. For identification purposes, the agent or Corporate Officer shall enter his or her Florida License Number or Corporate title, respectively, in the space provided.

OCCIDENTAL LIFE INSURANCE COMPANY OF NORTH CAROLINA
P.O. BOX 2595, WACO, TEXAS 76702-2595
PH: 254-297-2775

NOTICE TO APPLICANT REGARDING REPLACEMENT OF LIFE INSURANCE

A decision to buy a new policy and discontinue or change an existing policy may be a wise choice or a mistake.

Get all the facts. Make sure you fully understand both the proposed policy and your existing policy or policies. New policies may contain clauses which limit or exclude coverage of certain events in the initial period of the contract, such as the suicide and incontestable clauses which may have already been satisfied in your existing policy or policies.

Your best source for facts on the proposed policy is the proposed company and its agent. The best source on your existing policy is the existing company and its agent.

Hear from both before you make your decision. This way you can be sure your decision is in your best interest.

If you indicate that you intend to replace or change an existing policy, Florida regulations require notification of the company that issued the policy.

Florida regulations give you the right to receive a written Comparative Information Form which summarizes your policy values. Indicate whether or not you wish a Comparative Information Form from the proposed company and your existing insurer or insurers by placing your initials in the appropriate box below.

☐ **YES** ☐ **NO**

DO NOT TAKE ACTION TO TERMINATE YOUR EXISTING POLICY UNTIL YOUR NEW POLICY HAS BEEN ISSUED AND YOU HAVE EXAMINED IT AND FOUND IT ACCEPTABLE.

I have read this notice and received a copy of it.

_____ _____
Applicant's Signature Date

_____ _____
Agent's Signature Date

_____
Agent's Name (Printed or Typed)

_____
Agent's Address (Printed or Typed)

_____
Agent's Company (Printed or Typed)

Information on Policies which may be replaced:

Company Name	Policy Number	Name of Insured

OCCIDENTAL LIFE INSURANCE COMPANY OF NORTH CAROLINA
P.O. BOX 2549 • WACO, TX 76702
PH: 254-297-2775

PLEASE READ CAREFULLY. This information has been prepared for you so that you may make an informed decision on the use of any of your policy values to fund the purchase of a new policy. Please see the reverse side of this form for explanatory notes and instructions as to how this form has been completed.

PART A - CURRENT POLICY INFORMATION. ☐ LIFE ☐ ANNUITY

Policyowner's Name: _____ Policy Number: _____

Current Death Benefit: $ _____Current Premium Amount: $_____ Mode of Payment: _____

Cash SurrenderValue: $ _____ Paid-up Addition Value: $ _____ Dividend Value: $ _____
(The BENEFIT and VALUES stated above will be reduced as funds are used to purchase the policy proposed in Part B below.)

PART B - PROPOSED POLICY INFORMATION. ☐ LIFE ☐ ANNUITY

Initial Death Benefit: _____ Proposed Premium Amount: _____ Mode of Payment: _____
Proposed Effective Date: _____ Premium Payable to Age _____ or for _____ Years

NOTE: If you are replacing your current policy, or using 25% or more of your policy values, you may request a **WRITTEN** comparison between your current policy and the proposed policy. The comparison is to illustrate the policy values for both policies.

PART C - SOURCE OF FUNDING FOR THE PROPOSED POLICY.

A loan in the amount of $ _____ will be taken from the value of your CURRENT POLICY each _____ (mode), bearing a current loan interest rate of _____ %.

A partial surrender in the amount of $ _____ will be taken from the value of your CURRENT POLICY each _____ (mode).

A dividend withdrawal in the amount of $ _____ will be taken from the value of your CURRENT POLICY each _____(mode).

PART D - YOUR CURRENT POLICY COULD TERMINATE.

If the policy values of your CURRENT POLICY are used as a source of funding for the purchase of an additional policy, it is estimated that your CURRENT POLICY will terminate on _____ (date).

It is estimated that you will begin making premium payments for the PROPOSED POLICY from your own funds on _____ (date) in the amount of $ _____ to be paid each _____ (mode).

NOTE: Since the values and premiums stated on this form may change over time, the estimated date upon which you will need to begin making premium payments from your own funds for the PROPOSED POLICY may also change. Estimates as to dates when policies will terminate or payments must begin assume the continuation of current (or guaranteed) factors, and such calculations are based upon the assumption that any premiums or interest due on loans are paid when due.

Policyowner Signature: _____ Date:_____

Agent or Company Officer Signature:_____ Date: _____

Florida Licensed Agent ID No. or Corporate Title: _____

Form D14-1180 (9/95)

POLICY DISCLOSURE FORM AND INSTRUCTIONS
COMPLETE ONE FORM FOR EACH PREVIOUSLY ISSUED POLICY.
ANY REQUIRED REPLACEMENT AND SALES FORMS MUST ALSO BE COMPLETED.
ONE COPY IS DELIVERED TO THE POLICYOWNER AND ONE COPY MAINTAINED BY THE INSURER.

Any and all information applicable to the transaction shall be fully and completely disclosed on Form D14-1180. If the information requested does not apply to the transaction, the words "not applicable" or "N/A" shall be entered.

PART A
The information to be disclosed in Part A of Form D14-1180 shall apply to the current, in-force policy for which policy values are being utilized as a source of funding for the purchase of additional insurance contract(s). For purposes of this form, "current death benefit" is defined as the sum of the death benefit payable under the base policy, as life insurance riders covering the principal insured (other than special contingency death riders), paid-up additional insurance and dividends, minus outstanding indebtedness. The term "cash surrender value" is defined as the cash value of the policy or contact net of any outstanding indebtedness and surrender charges, and less any dividend values. The term "paid-up addition value" is defined as the cash value of additonal insurance purchased with dividends. The term "dividend value" is definded as the total cash value of all policy dividends left on deposit with the company to accumulate at interest.

PART B
The information to be disclosed in Part B of Form D14-1180 shall apply to the proposed additional insurance contract(s) being funded by policy values in a current, in-force policy. For purposes of this form, "proposed premium amount" is defined as any recurring payment which is planned to be paid or which is required to be paid under the proposed policy.

PART C
The information to be disclosed in Part C of Form D14-1180 shall apply to the current, in-force policy, and shall indicate the manner in which the policy values are being used to fund the purchase of the proposed policy. Part C is not to be completed if the current policy is totally surrendered. However, in the event of total surrender of the current policy, Parts A, B, D, and the signature block of this form must still be completed.

When completing Part C of this form, each and every source of funding for the proposed policy must be identified, i.e., whether a policy loan, partial surrender, or dividend withdrawal or any combination thereof is being utilized. If more than one source of funding will be utilized to fund the initial and/or future premiums for the proposed policy, all applicable sections of Part C shall be completed.

For purposes of this form, a "partial surrender" is defined as any amount taken from the value of the current policy which is less than the total cash value available under such policy. The term "mode" is defined as the frequency upon which a policy loan, partial surrender or dividend withdrawal will be taken from the value of the current policy. In the event of a single loan, surrender or withdrawal, the words "one time only" shall be entered in the space provided. The term "loan interest rate" is defined as the rate of interest in effect on the date that this form is completed, as specified in the current policy contract.

PART D
The information to be disclosed in Part D of Form D14-1180 shall apply to the current, in-force policy and the proposed additional policy, respectively.

SIGNATURES
In order to evidence that the required disclosure has been made, Form D14-1180 shall be signed and dated by the soliciting agent or by a Corporate Officer, as well as by the policyowner. For identification purposes, the agent or Corporate Officer shall enter his or her Florida License Number or Corporate title, respectively, in the space provided.

OCCIDENTAL LIFE INSURANCE COMPANY OF NORTH CAROLINA
WACO, TEXAS

DISCLOSURE STATEMENT

TERMINAL ILLNESS ACCELERATED BENEFIT RIDER

TAX IMPLICATIONS. The acceleration-of-life-insurance benefits offered under this Rider may or may not qualify for favorable tax treatment under the Internal Revenue code of 1986. Whether such benefits qualify depends on factors such as your life expectancy at the time benefits are accelerated or whether you use the benefits to pay for necessary long-term care expenses, such as nursing home care. If the acceleration-of-life-insurance benefits qualify for favorable tax treatment, the benefits will be excludable from your income and not subject to federal taxation. Tax laws relating to acceleration-of-life-insurance benefits are complex. You are advised to consult with a qualified tax advisor about circumstances under which you could receive acceleration-of-life-insurance benefits excludable from income under federal law.

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 $100. 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. Payment of the Benefit will reduce the Death Benefit proceeds by the amount of the Benefit paid under the Rider. Any portion remaining after reduction of the death benefit due to payment of any acceleration-of-life-insurance benefit will be paid upon the death of the Insured. 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, then the Policy will terminate with no further value.