

- 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.

CONFIDENTIALITY NOTICE: This communication in this fax message, including any attachments, is intended only for the use of the individual or entity to which it is addressed and contains information which may be confidential and/or privileged. If you are not the intended recipient, any disclosure, copying, distribution, or use of the contents of this information is strictly prohibited. If you have received this communication in error, notify the sender immediately and destroy all copies. Thank you for your compliance.

OCCIDENTAL LIFE INSURANCE COMPANY OF NORTH CAROLINA

P.O. BOX 2595, WACO, TX 76702-2595 • (254) 297-2775

TERM MADE SIMPLE

INDIVIDUAL LIFE INSURANCE APPLICATION (Please print in black ink)

Telephone Case No: _____

Proposed Insured: _____ <small>(First) (Middle) (Last)</small>			Telephone interview done (if applicable) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> am <input type="checkbox"/> pm	
Address: (No. & Street) _____ City: _____ State: _____ Zip Code: _____			Phone _____ Best time to call _____ E-mail Address _____ @ _____	

<input type="checkbox"/> Male <input type="checkbox"/> Female	Sex	Date of Birth Mo. Day Yr / /	Age	State of Birth	SS#	DL#	Height ft in	Weight lbs
						State of Issue		

Occupation/Duties: _____ Hire date (MM/YY): _____ Annual Salary: \$ _____

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

Primary Primary Beneficiary _____ SS# _____ Relationship _____
Insured: Contingent Beneficiary _____ SS# _____ Relationship _____

Plan: _____ **Face Amount \$** _____ Non-Tobacco Tobacco Preferred Non-Tobacco
 Have you used tobacco or nicotine products in any form in the past 12 months? Yes No.....or during the past 36 months? Yes No

Riders: Waiver of Premium Unemployment Rider Other: _____
 Critical Illness % Child Rider (Units): (complete Form No. 3215) ADB \$

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
Policy Date Request: / /

Physician: Name: _____ City/State _____ Phone: _____

List current prescribed medications: _____

SECTION A: Health Questions-Answer Questions 1 through 4 for Proposed Insured. (circle all conditions that apply)

1. **Within the past 10 years**, have you been treated for, or tested positive for, or been diagnosed by a medical professional with:
 - a. high blood pressure, high cholesterol, heart attack, angina (cardiac chest pain), angioplasty, bypass surgery or stent, pacemaker or defibrillator, cardiomyopathy, congestive heart failure (CHF), irregular heartbeat, peripheral vascular disease (PVD), carotid artery disease, or any heart or circulatory disease or disorder? Yes No
 - b. stroke, transient ischemic attack (TIA), amputation caused by disease, aneurysm, hemophilia, or anemia? Yes No
 - c. diabetes, cirrhosis, hepatitis, pancreas disorder, Crohn's disease, ulcerative colitis, or any digestive or liver disease or disorder?..... Yes No
 - d. asthma, emphysema, chronic obstructive pulmonary disease (COPD), sleep apnea, or any respiratory or lung disease or disorder? Yes No
 - e. cancer in any form, Hodgkin's disease, leukemia, lymphoma, multiple myeloma, or organ transplant? Yes No
 - f. migrane headaches, seizures, bi-polar disorder, schizophrenia, Alzheimer's, memory loss, dementia, anxiety or depression, mental retardation, mental incapacity, mental or nervous disorder, psychiatric disorder, or a suicide attempt? Yes No
 - g. any disease or disorder of the kidneys, urinary bladder, prostate, breast, reproductive organs, or sexually transmitted disease? Yes No
 - h. connective tissue disease, systemic lupus (SLE), multiple sclerosis, Parkinson's, cerebral palsy, muscular dystrophy, cystic fibrosis? Yes No
 - i. arthritis, paralysis of two or more extremities or any disorder of the back, joints, muscles, or nervous system? Yes No
 - j. any other disease or disorder, injury, surgery, birth defect, or deformity? Yes No
 - k. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or any immune deficiency related disorder or the Human Immunodeficiency Virus (HIV)? Yes No
2. Are you currently unemployed due to medical reasons or been prohibited from actively working full time (30 hours or more per week) at your regular occupation due to any illness, injury, or health related problem, or are you currently receiving benefits, compensation, or pension for disability? Yes No
3. Are you currently hospitalized, confined to a nursing facility, receiving Hospice Care or home health care, or do you require assistance (from anyone) with activities of daily living such as bathing, dressing, eating or toileting? Yes No
4. **Within the past 12 months**, have you:
 - a. consulted a medical professional, had surgery, or been hospitalized, or had diagnostic tests (excluding HIV/AIDS) such as EKG, Xray, MRI, CAT scan? Yes No
 - b. had any diagnostic testing (excluding HIV/AIDS), surgery, or hospitalization recommended by a medical professional which has not been completed or for which the results have not been received, or been referred to a medical professional? Yes No
 - c. been declined, postponed, rated, or modified for life or medical insurance? Yes No

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

Condition	Dates	Treatment	Name/Address/Phone No. of Physician/Hospital
	/ /		
	/ /		
	/ /		
	/ /		

SECTION C: Answer Questions 1 through 5 for Proposed Insured. (circle all conditions that apply)

1. Have you had a natural parent or sibling diagnosed or treated by a licensed medical professional for diabetes, kidney disease, require a major organ transplant, or been medically diagnosed with heart disease, cerebrovascular disease, internal cancer prior to age 60? (If yes, list in COMMENTS section: name, relationship, age at onset, medical condition, age if living or age at death.) Yes No
2. a. **Within the next 24 months**, do you intend to work, travel, or reside outside of the U.S. for more than 30 days? Yes No
If yes, where? _____
b. **Within the past 24 months**, have you made or contemplated making any flights as a pilot, student pilot, or crew member of any aircraft? Yes No
3. a. **Within the past 5 years**, have you pled guilty to or been convicted of a felony or misdemeanor (including DUI or DWI) or do you have such charge currently pending against you or have you had a driver's license suspended or revoked or is currently suspended or revoked, any motor vehicle violations or **within the past 6 months**, have you been on probation or parole? Yes No
b. **Within the past 5 years**, participated in motorized racing, hang gliding, rock or mountain climbing, rodeo events, sky diving, or skin or scuba diving? Yes No
4. **Within the past 10 years**, have you used illegal drugs, or abused alcohol or drugs, or had or been recommended by a medical professional or a licensed counselor to discontinue the use of alcohol or drugs or to have treatment or counseling for alcohol or drugs? Yes No

5. Do you have any existing life or disability insurance or annuity contract? <input type="checkbox"/> Yes <input type="checkbox"/> No	Company
Will you replace an existing life or disability insurance policy or an annuity? <input type="checkbox"/> Yes <input type="checkbox"/> No	Policy # Coverage Amount \$

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. I will notify the Company of any changes in the statements or answers given in this application between the time of application and delivery of the policy; 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 knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under 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, 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 disclosed 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 the time limit, if any, permitted by applicable law in the state where the policy is delivered or issued for delivery. A copy of this authorization shall be as valid as the original.

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, the Terminal Illness Accelerated Benefit Rider Disclosure Form, the Accelerated Benefit Rider-Confined Care Rider and Chronic Illness Accelerated Death Benefit Rider Disclosure Forms if applicable.

Signed at (City) _____ (State) _____ Date of Application (MM/DD/YY) _____

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, the Terminal Illness Rider Disclosure Form, the Confined Care Accelerated Benefit Rider and Chronic Illness Accelerated Death Benefit Rider Disclosure Forms have been presented to the applicant, if applicable.

Agent's Remarks: _____

- 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
- Has the proposed insured applied for any life insurance or annuity in the last ninety (90) days? Yes No

Agent Signature _____ Agent Printed Name _____ No: _____ %
 Agent Signature _____ Agent Printed Name _____ No: _____ %

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. 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 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.

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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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.
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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: _____

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: OCCIDENTAL LIFE INSURANCE COMPANY OF NORTH CAROLINA

Home Office Address of Insurer: P.O. Box 2595 / Waco, Texas 76702-2595

Direct all correspondence to Insurer's Home Office.

Policy	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)
* Rider(s) and Supplemental Benefit(s)			

*(1) The face amount of coverage of the Policy Rider Supplemental Benefit changes as follows

*(2) The premium for the Policy Rider Supplemental Benefit changes; the ultimate Annual Monthly premium will be \$ _____ at policy year _____.

Total (Initial) Annual Monthly 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 \$1,000 (or face amount).

* You may borrow against this cash value at an annual 7.4% loan interest charge.

Number of Years Policy Has Been in Force	5	10	20	AGE 65
Total Accumulated Cash Value per \$1,000 (or Total Face Amount)				

* A Surrender Comparison Index will be provided upon delivery of the policy or earlier if requested. This Index provides one means of comparing the relative costs of two or more similar policies.

* The prospective insured has has not requested an earlier delivery of the Index.

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

* If inapplicable to insurance being offered, section may be deleted entirely or clearly marked "Not Applicable".

I certify that this written Disclosure Statement was given to the applicant at the time the application was signed.

Agent's Signature

DISCLOSURE STATEMENT

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Name of Proposed Insured _____ Age _____ Sex _____

Name of Agent preparing disclosure _____

Agent home or agency address _____

Telephone number of Agent _____

Name of Insurer: OCCIDENTAL LIFE INSURANCE COMPANY OF NORTH CAROLINA

Home Office Address of Insurer: P.O. Box 2595 / Waco, Texas 76702-2595

Direct all correspondence to Insurer's Home 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) and Supplemental Benefit(s)			

*(1) The face amount of coverage of the Policy Rider Supplemental Benefit changes as follows

*(2) The premium for the Policy Rider Supplemental Benefit changes; the ultimate Annual Monthly premium will be \$ _____ at policy year _____.

Total (Initial) Annual Monthly 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 \$1,000 (or face amount).

* You may borrow against this cash value at an annual 7.4% loan interest charge.

Number of Years Policy Has Been in Force	5	10	20	AGE 65
Total Accumulated Cash Value per \$1,000 (or Total Face Amount)				

* A Surrender Comparison Index will be provided upon delivery of the policy or earlier if requested. This Index provides one means of comparing the relative costs of two or more similar policies.

* The prospective insured has has not requested an earlier delivery of the Index.

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

* If inapplicable to insurance being offered, section may be deleted entirely or clearly marked "Not Applicable".

I certify that this written Disclosure Statement was given to the applicant at the time the application was signed.

Agent's Signature

OCCIDENTAL LIFE INSURANCE COMPANY OF NORTH CAROLINA
P.O. Box 2595, Waco, Texas 76702-2595
Ph: (254) 297-2775

IMPORTANT NOTICE REGARDING REPLACEMENT OF LIFE INSURANCE

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 effect 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 coverages.

After we issue 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.

Applicants Signature _____
Date

Agent's Signature _____
Date

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

Insured's Name	Company	Contract Number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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 2595, Waco, Texas 76702-2595
Ph: (254) 297-2775

IMPORTANT NOTICE REGARDING REPLACEMENT OF LIFE INSURANCE

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 effect 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 coverages.

After we issue 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.

Applicants Signature _____
Date

Agent's Signature _____
Date

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

Insured's Name	Company	Contract Number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**OCCIDENTAL LIFE INSURANCE COMPANY OF NORTH CAROLINA
WACO, TEXAS**

DISCLOSURE STATEMENT

TERMINAL ILLNESS ACCELERATED DEATH BENEFIT RIDER

TAX IMPLICATIONS. The acceleration-of-life-insurance benefits offered under this Rider are not intended to qualify for favorable tax treatment. Tax laws relating to acceleration-of-life-insurance benefits are complex. You are advised to consult with a qualified tax advisor. The acceleration-of-life-insurance benefits do not, and are not intended to, qualify as long-term care insurance.

Receipt of acceleration-of-life-insurance benefits may affect your, your spouse or your family's eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children (AFDC), supplementary social security income (SSI), and drug assistance programs. You are advised to consult with a qualified tax advisor and with social service agencies concerning how receipt of such a payment will affect you, your spouse and your family's eligibility for public assistance.

The Terminal Illness Accelerated Death 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 24 months or less. 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, then the Policy will terminate with no further value.

OCCIDENTAL LIFE INSURANCE COMPANY OF NORTH CAROLINA
WACO, TEXAS

DISCLOSURE STATEMENT

ACCELERATED BENEFITS RIDER - CONFINED CARE

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 THE OWNER IS ELIGIBLE MAY BE AFFECTED BY PAYMENTS RECEIVED UNDER THIS RIDER.

The Rider provides early (pre-death) payments of life insurance proceeds if the Insured is receiving Confined Care as defined in the Accelerated Benefits Rider - Confined Care. Benefits are only paid at the Owner's option and request. The terms and conditions are detailed in the Rider. **THE RIDER IS NOT INTENDED TO PROVIDE HEALTH INSURANCE, NURSING HOME INSURANCE OR LONG TERM CARE INSURANCE. IT MAY NOT COVER ALL NURSING HOME EXPENSES. IT DOES NOT COVER HOME CARE OR ADULT DAY CARE SERVICES.**

Cash Value, if any, and the Face Amount are reduced if Accelerated Benefits are paid.

OCCIDENTAL LIFE INSURANCE COMPANY OF NORTH CAROLINA
WACO, TEXAS

DISCLOSURE FOR CHRONIC ILLNESS ACCELERATED DEATH BENEFIT RIDER

This summary of coverage briefly highlights some of the major provisions of the Chronic Illness Accelerated Death Benefit Rider. The details of the rights and obligations of all parties under the Rider as well as any limitations or restrictions are set forth in the Rider document.

TAX IMPLICATIONS. The acceleration-of-life-insurance benefits offered under this Rider are not intended to qualify for favorable tax treatment. Tax laws relating to acceleration-of-life-insurance benefits are complex. You are advised to consult with a qualified tax advisor. The acceleration-of-life-insurance benefits do not, and are not intended to, qualify as long-term care insurance.

Receipt of acceleration-of-life-insurance benefits may affect your, your spouse or your family's eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children (AFDC), supplementary social security income (SSI), and drug assistance programs. You are advised to consult with a qualified tax advisor and with social service agencies concerning how receipt of such a payment will affect you, your spouse and your family's eligibility for public assistance.

READ YOUR RIDER CAREFULLY

Rider Description: The request for the benefit under the Rider must be in writing signed by the Owner. The Owner may make one (1) claim per calendar year. If the Rider is exercised, this may impact the later ability to exercise another Accelerated Death Benefit rider. The Accelerated Death Benefit Payment will be paid in a lump sum.

The Rider allows the Owner to receive payment of a portion of the death benefit under the Policy upon chronic illness of the Insured. The Owner must provide written evidence from a licensed Physician that the Insured has been certified as;

- 1) Being unable to perform at least two activities of daily living for at least 90 days, as defined in the Rider; or
- 2) Requiring substantial supervision due to severe cognitive impairment for at least 90 days, as defined in the Rider.

Premium Charge: There is no separate premium charge for the Accelerated Death Benefit Rider.

Administrative Charge: There is an administrative charge of \$150 for the exercise of the Rider. This is due at the time of benefit payment.

Amount of Accelerated Death Benefit Payment: The request for a benefit under the Rider must specify the amount of the Policy Death Benefit to be accelerated, subject to the terms in the Rider. The Maximum Acceleration Percentage is 95%. The actual payment will be a discounted value of the accelerated death benefit minus administrative charge. The discounted value, calculated at the time of claim, will take into account the medical condition of the Insured, required future premiums under the base policy, and the applicable interest rate at the time of claim. If future premiums are expected to increase significantly, this could further lower the actual payment.

Additional Information:

- Accelerated Death Benefits are paid as a lump sum.
- In the event that the Insured dies after a written request for an Accelerated Death Benefit is submitted but before payment is made and we receive written notice at our home office of this death, the request for an Accelerated Death Benefit will be considered void and no benefit will be paid under the Rider.
- Once an Accelerated Death Benefit has been paid, the election to request such Accelerated Death Benefit cannot be revoked.
- Consent of an assignee or irrevocable policy beneficiary may be required.

Effect on Policy: After payment of an Accelerated Death Benefit, the Policy Face Amount, Cash Value, and the amount available for loans will be reduced on a proportional basis. Base policy premiums payable will also be reduced accordingly. There will be no reduction in the annual policy fee.

Government Benefit Eligibility: You should note that the actual or constructive receipt of payment under the rider may adversely affect your eligibility for Medicaid, Supplemental Security Income, or other government benefits or entitlements. Exercising the option to accelerate benefits and receiving those benefits before application for these programs, or while benefits are being received, may affect initial or continued eligibility; an elder law or elder care advisor should be consulted.