



S.USA LIFE INSURANCE COMPANY, INC.

NEW BUSINESS CHECKLIST

P.O. Box 1050, Newark, NJ 07101-1050 Toll Free: 1-866-SUSA-123 / 1-866-787-2123

website: www.susa.com

Graded Benefit Term - California

*****Important Information:** *If a meeting to discuss life insurance will take place in the home of a senior (age 65 and older), you must provide the Notice to Seniors Regarding Insurance Sales Meeting, Form No. U-NOTSENECA17, to the senior at least 24 hours before the meeting is to take place. If you have an existing relationship with the applicant, and the applicant requests a meeting in his or her home on the same day, the notice must be delivered prior to the meeting.****

Is the applicant age 65 or older?

- No - Follow steps 1 - 8 below**
 Yes - Follow steps 1 - 9 below

1. Submit completed application Form No. U-APPGBTECA17.
2. Submit completed HIPAA Authorization Form No. HIPAA GES 14.
3. Leave the applicant the Notice of Disclosure of Information, page 9 of the application.
4. Leave the Customer Identification Program Notice Form No. CIP-GES with the applicant.
5. Submit completed Premium Payment Authorization Form No. C-PMTGENECW17.
6. Leave the Life Insurance Buyers Guide Form No. U-LBG16-Base with the applicant.
7. If a replacement is occurring, complete Replacement Form RN-CA. Leave a signed copy with the applicant and submit one with the application.
8. If initial premium is being submitted with the application, submit a personal check from the applicant made payable to S.USA Life Insurance Company, Inc. and provide a signed copy of the Conditional Receipt, which is page 7 of the application. The company will not accept an Agency or Agent's personal check. Do not provide a Conditional Receipt unless payment is taken with the application.
9. If the applicant is age 65 or older:
 - o If the sales visit will occur in a senior's home, provide completed Form No. U-NOTSENECA17 in advance of the visit in accordance with the Important Information notice above. Submit a copy with the application.
 - o Provide the applicant with the Financial Products Disclosure Form No. U-DISFPDECA17. Leave a signed copy with the applicant and submit one with the application.
 - o If you discuss Medi-Cal eligibility in connection with the sale, provide the applicant with the Notice Regarding Standards for Medi-Cal Eligibility, Form No. U-NOTMEDECA17. Leave a signed copy with the applicant and submit one with the application.



S.USA LIFE INSURANCE COMPANY, INC.

APPLICATION FOR INDIVIDUAL TERM LIFE INSURANCE

P.O. Box 1050, Newark, NJ 07101-1050

Toll Free: 1-866-SUSA-123 / 1-866-787-2123

website: www.susa.com

1. PROPOSED INSURED INFORMATION

Last Name		First Name		MI	Phone Number for Contact Day: Evening: Best Time To Call
Social Security Number	Sex	Date of Birth	State of Birth	Country of Birth	
Mailing Address (Number, Street, Apt. #)			City	State	
Driver's License State and Number		E-Mail Address		Are you a United States citizen or legal permanent resident? <input type="checkbox"/> Yes <input type="checkbox"/> No	

2. BENEFICIARY INFORMATION

Beneficiary <input type="checkbox"/> Primary <input type="checkbox"/> Contingent				Social Security # or Tax ID #	
Address (Number, Street, Apt. #)			City	State	Zip Code
Date of Birth	Relationship	Percent of Proceeds	Telephone Number		
Beneficiary <input type="checkbox"/> Primary <input type="checkbox"/> Contingent				Social Security # or Tax ID #	
Address (Number, Street, Apt. #)			City	State	Zip Code
Date of Birth	Relationship	Percent of Proceeds	Telephone Number		

Please attach another page for additional beneficiary information. The Percent of Proceeds for each type of beneficiary must equal 100%.

3. OWNER INFORMATION (if other than Proposed Insured)

Last Name		First Name		MI	Social Security # or Tax ID #
Address (Number, Street, Apt. #)			City	State	Zip Code
Date of Birth	Relationship	Telephone Number			

4. SECONDARY ADDRESSEE

You have the right to designate a secondary addressee to receive copies of notices of lapse or termination of your policy for nonpayment of premium or excess policy loan notices by completing the section below now or by sending the Company a written notice containing the name and address of the secondary addressee at any time the policy is in force.

Last Name		First Name		MI	
Address (Number, Street, Apt. #)			City	State	Zip Code

4. REPLACEMENT INFORMATION

1. Is there any life insurance, long term care insurance or annuity contract in force on the Proposed Insured with this or any other company? Yes No
2. Is the insurance applied for intended to replace or change any life insurance, long term care insurance or annuity contract in force with this or any other company? Yes No
3. Are any other life insurance, long term care insurance or annuity applications pending with this or any other company? Yes No

List all current or pending life insurance, long term care insurance or annuity coverage below.

Insured's Name	Company	Owner	Replacement	Face Amount	Accidental Death Benefit	Year Issued
			<input type="checkbox"/> Yes <input type="checkbox"/> No			
			<input type="checkbox"/> Yes <input type="checkbox"/> No			
			<input type="checkbox"/> Yes <input type="checkbox"/> No			
			<input type="checkbox"/> Yes <input type="checkbox"/> No			
			<input type="checkbox"/> Yes <input type="checkbox"/> No			

5. HEALTH INFORMATION

SINCE THIS POLICY IS ISSUED WITH MINIMAL OR NO MEDICAL UNDERWRITING, THE PREMIUM RATE CHARGED INCLUDES AN EXTRA MORTALITY RISK CHARGE. IF YOU ARE HEALTHY ENOUGH TO QUALIFY AS A "STANDARD" RISK, PREMIUMS WOULD LIKELY HAVE BEEN LOWER IF YOU HAD APPLIED FOR A FULLY UNDERWRITTEN POLICY.

1. Within the past two (2) years have you been confined to or been advised by a licensed medical professional to be admitted to a nursing home, hospice, extended care, special treatment facility, required the use of oxygen equipment to assist in breathing, or do you need ongoing personal assistance performing your Activities of Daily living (ADL's) eating, bathing, dressing, toileting, transferring (walking) and continence? Yes No
2. Within the past two (2) years have you been diagnosed by a member of the medical profession with any cancer (excluding Basal or Squamous cell skin cancer), heart attack (myocardial infarction), heart surgery, cardiomyopathy, congestive heart failure, stroke, Alzheimer's disease or dementia, or have undergone major organ transplant surgery? Yes No
3. Have you been advised by a licensed medical professional that your life expectancy is less than 24 months? Yes No

6. INSURANCE APPLIED FOR

Face Amount \$ _____

7. RIDERS APPLIED FOR

- Accidental Death Benefit Rider 1X Amount of Insurance

8. PREMIUM AND BILLING INFORMATION

1. Premium Information:

- a. Premium \$ _____
- b. Billing Type EFT (complete Payment Form) Direct Bill Other (complete Payment Form)
- c. Premium Mode

NOTE: If you choose to pay your policy premium in semi-annual, quarterly or monthly payments, you will pay more over the year than if you choose to pay your premium in one annual premium payment.

- Monthly (Not available for direct bill) Quarterly Semi-Annual Annual

2. Payment with Application \$ _____

3. Premium notices sent to: Proposed Insured
 Owner Other (*indicate below*)

Name	Relationship to Insured	Social Security # or Tax ID #
------	-------------------------	-------------------------------

Address	City	State	Zip Code
---------	------	-------	----------

4. Automatic Premium Loan Yes No
I understand that by selecting this option a loan may be made against the cash value of my policy to pay premiums due.

9. HOME OFFICE ENDORSEMENTS

SPECIAL REQUESTS

--	--

10. DECLARATIONS AND AUTHORIZATIONS

I understand and agree that the statements and answers in this application are complete and true to the best of my knowledge and belief and shall be attached to and form a part of the contract of insurance. I also understand and agree that the insurance applied for, if issued, shall be subject to such statements and answers and take effect on the effective date stated in the Policy Data page provided the applicable first premium has been paid.

I understand that the statements and answers in the application are the basis for any policy issued by the Company and that no information about the Proposed Insured will be considered to have been given to the Company unless it is stated in the application, and the Proposed Insured will notify the Company of any changes in the statements or answers given in the application between the time of application and delivery of the policy.

I understand that a sales representative does not have the Company's authorization to accept risk, pass on insurability, or make, void, waive or change any conditions or provisions of the application, policy or receipt, as applicable.

I understand that the amount applied for may be reduced or denied if other simplified issue policies from the company or its affiliates are in-force or pending on the life of the Proposed Insured.

I have received the Notice of Disclosure of Information.

AUTHORIZATION: I, the Proposed Insured, authorize any physician, medical professional, hospital, clinic, pharmacy, pharmacy benefit manager, laboratory, medical care facility, insurer, reinsurer, MIB, Inc., or any other similar organization or person having knowledge of me or my health to release information about me to S.USA Life Insurance Company, Inc. (the "Company"), its Medical Director, or its reinsurers for underwriting or claims purposes. The information collected may relate to the symptoms, examination, diagnosis, treatment or prognosis of any physical or mental condition, including drug and alcohol abuse, but excludes psychotherapy notes. If we need those records, we will ask for them on a separate authorization form. This authorization also includes information about prescription drug records. To facilitate rapid submission of such information, I authorize all said sources, except MIB, Inc., to give such records or knowledge to any agency employed by the Company to collect and transmit such information. I understand a telephone interview may be necessary to verify information given to the Company on this application. This interview may be from the Company or from a consumer-reporting agency by a trained interviewer acting on the Company's behalf. I, the Proposed Insured, also authorize the Company to obtain an investigative consumer report as described in the Company's NOTIFICATION IN ACCORDANCE WITH FEDERAL AND STATE LAW.

I, the Proposed Insured, authorize the Company or its reinsurers to make a brief report of my personal health information to MIB, Inc.

This Authorization is for the purpose of underwriting the life insurance. It is in effect for 24 months from the latest date shown below or for the maximum time allowed by the law of the state where the policy is delivered or issued for delivery if shorter than 24 months. A photocopy may be accepted as valid. The authorization will survive the Insured's death if it occurs while the Authorization is in effect.

I understand that this Authorization may be revoked by contacting us at the address listed at the top of this application; however, the Company retains the right to use any information obtained under my authorization prior to my revocation. I also understand that I, or my authorized representative, are entitled to receive a copy of this Authorization;

Caution: If your answers on this application are misstated or untrue and were made with the actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer, the insurer may have the right to deny benefits.

By my signature below, I certify under penalties of perjury that my Social Security Number (Taxpayer Identification Number) above is correct and I am not subject to back-up withholding.

Signed by the Proposed Insured at _____ on _____ .
City, State Date

X _____
Signature of **Proposed Insured**

Signed by the Owner at _____ on _____ .
City, State Date

X _____
Signature of **Owner**, if other than Proposed Insured

11. AGENT CERTIFICATION

- 1. To the best of your knowledge and belief, is there an existing life insurance, long term care insurance policy or annuity contract insuring the proposed insured's life? Yes No
- 2. To the best of your knowledge and belief, replacement is or may be involved in this transaction. Yes No

If "Yes" to either of these questions, complete any required replacement forms.

I certify that the above statements and responses are true and accurate.

_____ Agent Number

_____ Email Address of Agent

_____ Print Agent's Name

X _____ Agent's Signature

_____ Agency Name

_____ Agency Number

_____ Telephone Number of Agent

_____ Date

Conditional Receipt provided? Yes No

FOR S.USA USE ONLY

MK Code _____

Sales Number _____

GA Agency Name _____

GA Agency Number _____



LIFE INSURANCE SINCE 1939



S.USA LIFE INSURANCE COMPANY, INC. CONDITIONAL RECEIPT AGREEMENT

P.O. Box 1050, Newark, NJ 07101-1050

Toll Free: 1-866-SUSA-123 / 1-866-787-2123

website: www.susa.com

(Detach and leave with applicant only if payment is accepted with application. Retain a copy.)

If any question in Section 5 of the application is answered YES, no payment may be accepted.

This agreement provides a limited amount of insurance coverage for a limited period of time, subject to the terms and conditions stated below. NO INSURANCE COVERAGE WILL BECOME EFFECTIVE BEFORE DELIVERY OF THE POLICY APPLIED FOR UNLESS ALL OF THE CONDITIONS SPECIFIED BELOW ARE MET. COVERAGE IS SUBJECT TO THE MAXIMUM AMOUNT STATED BELOW AND MAY BE LESS THAN THE AMOUNT OF INSURANCE APPLIED FOR. No Agent can determine insurability or alter or waive any of the terms or conditions of this agreement.

CONDITIONS UNDER WHICH INSURANCE MAY BECOME EFFECTIVE PRIOR TO POLICY DELIVERY.

No coverage will become effective prior to policy delivery unless ALL of the following conditions are met:

- a) The amount paid with the application and shown below is equal to the first full modal premium for the coverage applied for and is honored for payment when first presented.
- b) All required medical or paramedical tests and examinations are completed.
- c) As of the Effective Date, all statements and answers given in the application as to health and insurability of the Proposed Insured (Parts I and II, if applicable) are true and complete.

EFFECTIVE DATE

Subject to satisfactory completion of all of the above conditions, coverage under this agreement will take effect on the latest of: (a) the date the application is signed, (b) the date requested in the application; or (c) the date all medical or paramedical tests and examinations are completed, if any are required under our underwriting rules.

MAXIMUM DEATH BENEFIT AMOUNT UNDER THIS AGREEMENT

If the Proposed Insured dies prior to delivery of the policy, the maximum death benefit under this agreement will be the lesser of: a) the total death benefit payable under the policy applied for in the application, or b) \$150,000 in total with respect to all conditional receipts issued by us on all applications pending at the time of death. No amount shall be paid under any Accidental Death Benefit rider or other rider. **If any of the conditions of this agreement has not been met exactly or if a Proposed Insured dies by suicide, while sane or insane, the Company's only liability will be to refund the premium payment.**

END DATE

This agreement and any coverage provided by it will end on the earliest of the following dates: a) the date the policy is delivered to the Owner or Agent and delivery requirements have been completed, b) the date we mail or otherwise provide notice to the Proposed Owner or Agent that a policy cannot be issued as applied for, c) the date we mail or otherwise provide a refund of the premium to the Proposed Owner or Agent, or d) 60 days from the date the application is signed. In no event will coverage under this agreement be in force after 60 days from the date of the application.

Received \$ _____ from _____
for an application on the life of _____ dated this
_____ day of _____, 20_____.

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO S.USA LIFE INSURANCE COMPANY, INC. NO PREMIUM CHECKS SHOULD BE PAYABLE TO ANY AGENT OR A BLANK PAYEE.

X _____
Signature of **Agent**

I acknowledge that I have read the terms and conditions of this agreement, have had them explained to me by the Agent, and I understand them. I also understand that except as provided in this agreement, no coverage under the policy applied for will become effective unless and until a policy is delivered to me and all other conditions for coverage have been met.

X _____
Signature of **Proposed Insured**



LIFE INSURANCE SINCE 1939



S.USA LIFE INSURANCE COMPANY, INC.

NOTICE OF DISCLOSURE OF INFORMATION

P.O. Box 1050, Newark, NJ 07101-1050

Toll Free: 1-866-SUSA-123 / 1-866-787-2123

website: www.susa.com

(Please detach and provide to applicant.)

IMPORTANT: Read The Information Below Before Completing Application.

NOTIFICATION IN ACCORDANCE WITH FEDERAL AND STATE LAW

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. The inquiry includes information as to your character, general reputation, personal characteristics and mode of living. You have the right upon written request to be informed whether an investigative consumer report was requested, and if so, the name and address of the consumer reporting agency to whom the request was made. You may inspect and receive a copy of your investigative consumer report from the reporting agency. You may also request to be interviewed in connection with the preparation of the report.

NOTIFICATION IN ACCORDANCE WITH MIB, INC.

Information regarding your insurability will be treated as confidential. The Company or its reinsurers may, however, make a brief report thereon to MIB, Inc., a not for profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

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

The Company or its reinsurers may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

NOTICE OF INSURANCE INFORMATION PRACTICES

To issue an insurance policy, we need to obtain information about the proposed insured. Some of that information will come from the proposed insured, and some may be collected from other sources. Such information may in certain circumstances be disclosed to third parties without your specific authorization as permitted or required by law. You have the right to access and correct this information, except information that relates to a claim or civil or criminal proceeding. A more detailed written notice describing our information practices will be furnished to you upon request.



LIFE INSURANCE SINCE 1939



S.USA LIFE INSURANCE COMPANY, INC.

AMENDMENT TO APPLICATION

(Please Execute in Duplicate)

P.O. Box 1050, Newark NJ 07101

Toll Free: 1-866-SUSA-123 / 1-866-787-2123

Website: www.susa.com

Having made application on _____ for S.USA Life Insurance on the life of _____
(Date) (Name of Proposed Insured)

(Policy Number)

I make the following new answers to be substituted for my previous answers to corresponding questions in application form # _____.

Question(s) #:

I agree that all representations made in the form are true and complete to the best of my knowledge and belief.

I (We) agree that this amendment shall form a part of the aforesaid application.

X _____ Date ____/____/____ X _____ Date ____/____/____
Signature of Proposed Insured Signature of Owner (if other than Proposed Insured)

Printed Name of Proposed Insured

Printed Name of Owner

This Area for Company and Agency Use Only

Sales Number

AUTHORIZATION FOR RELEASE OF HEALTH-RELATED INFORMATION

THIS AUTHORIZATION COMPLIES WITH THE HIPAA PRIVACY RULE

Print Name of Proposed Insured/Patient _____

Date of Birth _____

I **authorize** any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("my providers") to disclose my entire medical record, prescription history, medications prescribed and any other health information concerning me ("protected health information") to **SUSA Life Insurance Company, Inc.** ("the Company"). I also authorize any insurance company or agent from which I have applied for or obtained insurance, any consumer reporting agency such as MIB, Inc., and any other entity or person having protected health information about me, to disclose it to the Company. Protected health information includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. Protected health information also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

Further, protected health information includes genetic information and genetic test results, and I specifically authorize my providers to disclose such information and results to the Company, subject to the terms and conditions of this Authorization.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this Authorization and I instruct my providers and other entities or persons referred to above to release and disclose my entire medical record without restriction.

I further authorize the disclosure of protected health information by the Company to its affiliates, service providers, reinsurers, agents and representatives, and to any consumer reporting agency such as MIB, Inc.

This protected health information is to be used or disclosed under this Authorization so that the Company may: 1) underwrite my application for insurance, make eligibility, risk rating, and policy issuance determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Company.

This Authorization shall remain in force for 24 months following the date of my signature below, and a copy of this Authorization is as valid as the original. I understand that I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to the Company at the address below, Attention: Underwriting Department. I understand that a revocation is not effective to the extent that any person or entity has already relied on this Authorization to disclose or use information about me or to the extent that the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that if any of my protected health information is re-disclosed, it may no longer be protected by federal rules governing privacy and confidentiality of health information.

I understand that my providers may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization. I further understand that if I refuse to sign this Authorization to release my complete medical record, the Company may not be able to process my application, or if coverage has been issued, may not be able to make any benefit payments. I understand and acknowledge that I or any authorized representative will receive or have received a copy of this Authorization.

Printed Name of the Proposed Insured/Patient or Personal Representative _____

Description of Personal Representative's Authority or Relationship to Proposed Insured/Patient (if applicable) _____

Signature of Proposed Insured/Patient or Personal Representative _____

Date (required) _____

S.USA Life Insurance Co., Inc.

Customer Identification Program Notice

Important Information You Need to Know About Buying a Life Insurance Policy or Annuity

To help the government fight the funding of terrorism and money laundering activities, federal law requires financial institutions to obtain, verify, and record information that identifies each person who buys a life insurance policy or annuity.

This notice answers some questions about our Customer Identification Program.

What products are covered by this notice?

- A permanent life insurance policy, other than a group life insurance policy;
- An Annuity contract, other than a group annuity contract
- Any other insurance product with features of cash value or investment.

What types of information will I need to provide?

When you buy a life insurance policy or annuity, we are required to collect information such as the following from you:

- Your name
- Date of birth
- Address
- Identification number:
 - U.S. Citizen: taxpayer identification number (social security number or employer identification number)
 - Non-U.S. Citizen: taxpayer identification number, passport number, and country of issuance, alien identification card number, or government-issued identification showing nationality, residence and a photograph of you.

You may also need to show your driver's license or other identifying documents.

A corporation, partnership, trust or other legal entity may need to provide other information, such as its principal place of business, local office, employer identification number, certified articles of incorporation, government-issued business license, a partnership agreement, or trust agreement.

The U.S. Department of the Treasury already requires you to provide most of this information. We may also require you to provide additional information such as your net worth, annual income, occupation, and employment information.

What happens if I don't provide the information requested or my identity can't be verified?

We may not be able to issue a policy or annuity or carry out transactions for you. If you already have a policy or annuity, we may have to suspend transactions.

We thank you for your patience and hope that you will support the financial industry's efforts to deny terrorists and money launderers access to America's financial system.

PREMIUM PAYMENT AUTHORIZATION FORM

COMPLETE SECTION A OR B BELOW DEPENDING ON THE PAYMENT METHOD SELECTED

Insured Name: _____ Insurance Policy Number: _____

Mode of Payment: Annual Semi-Annual Quarterly Monthly

SECTION A: PAY BY ELECTRONIC FUNDS TRANSFER (EFT)

I request and authorize the Company to make withdrawals from my account for the purpose of paying insurance premium on the policy listed on this form. The presentation of withdrawal request forms shall constitute due notice of premiums due on the policy. The privilege of paying premiums under this plan may be revoked by the Company if any withdrawal request is not paid upon presentation. I understand that if any premiums are not paid within the time stipulated in the policy, coverage may lapse or be terminated. **Notification to discontinue OR make a change to an EFT withdrawal must be received by the Company at least seven (7) days prior to the next withdrawal date.**

- Checking** (*Please attach a voided check or enter bank information below.*)
- Savings** (*Not all Financial Institutions will acknowledge an EFT debit to a savings account. Please verify that this EFT will be accepted and that the information provided is correct.*)

Branch/Bank Name: _____

Routing Number: _____ Account Number: _____

Accountholder Name: _____

Relationship to Insured: _____

Address/City/State/Zip: _____

Please sign and date.

Accountholder Signature: _____ Date: _____

SECTION B: PAY BY CREDIT CARD

I request and authorize the Company to charge my credit card account identified below for the payment to the Company for: an amount equal to the premium for the proposed policy and amount of life insurance applied for on the application to which this authorization is attached; and/or premiums due under the policy identified on this form. The Company agrees to accept this authorization as it would a check or draft, provided it is honored when presented for payment. The privilege of paying premiums by credit card may be revoked by the Company if any charge to my account listed below is not honored upon presentation by the Company. I understand that if any premiums are not paid within the time stipulated in the policy, coverage may lapse or be terminated. **Notification to discontinue OR make a change to this plan must be received by the Company at least seven (7) days prior to the next scheduled payment date.**

Credit Card type: Visa MasterCard

Card Number: _____ Expiration Mo/Yr: _____

Name as it appears on card: _____

Relationship to Insured: _____

Billing Address/City/State/Zip: _____

Please sign and date.

Cardholder Signature: _____ Date: _____

[†] Only SBLI USA Life Insurance Company, Inc. is licensed in New York.



SBLI USA Life Insurance Company, Inc.
 100 W. 33rd Street, Suite 1007, New York, NY 10001-2914
 S.USA Life Insurance Company, Inc. (not licensed in NY)
 P.O. Box 1050, Newark, NJ 07101-1050
 (Each the "Company")
 Members of the Prosperity Life Group

SOCIAL SECURITY BENEFIT BILLING AUTHORIZATION FORM

Policy Number: _____

SOCIAL SECURITY BENEFIT PAYMENT PAID ON:	
BOX A – Required	
Payor's Date of Birth	Benefits Paid On
1 st to the 10 th	Second Wednesday of the month
11 th to the 20 th	Third Wednesday of the month
21 st to the 31 st	Fourth Wednesday of the month
Initial Draft Month _____ (Cannot exceed one benefit payment cycle past application date. Draft date will coincide with the Benefits Paid On date reflected above.)	

INITIAL AND RECURRING PREMIUM PAYMENTS for Social Security Benefit Billing options: (Complete Box B or Box C)	
BOX B – Bank Withdrawal Account (Electronic Funds Transfer)	
Insured Name: _____	Birthdate of Insured: _____
Payor Name if different than Insured: _____	Birthdate of Payor: _____
Financial Institution Name, Office or Branch _____	Financial Institution Address City, State, Zip _____
List All Authorized Account Holders _____	Check One: <input type="checkbox"/> Checking <input type="checkbox"/> Savings \$ _____ Premium amount
Transit Routing Number _____	Account Number _____
	Account Holder Signature _____

BOX C – Direct Express MasterCard	
Insured Name: _____	Birthdate of Insured: _____
Payor Name if different than Insured: _____	Birthdate of Payor: _____
5332 48 _____ Direct Express MasterCard Account Number	
Cardholder Name (Please Print) _____	Card Expiration Date _____ Mo/Yr
Cardholder Signature _____	\$ _____ Premium amount
	Date _____

I, the undersigned Cardholder or Accountholder, hereby authorize any of the Companies named above to make charges from my card or withdrawals from my account with the financial institution named above for: premiums becoming due and/or such other payments as I may authorize the Companies to make. I request the charges or withdrawals be on or before the day(s) when payments fall due. I request that this authorization, unless previously revoked, continue to apply to any conversion, renewal or change later made to the policy(ies). I understand that if a charge or withdrawal is not honored for payment, with or without cause and whether intentionally or inadvertently, and the premiums are not otherwise paid within the grace period allowed by a policy, the policy may terminate.

As a convenience to me, I hereby request MasterCard and the financial institution named above (and its successors and assigns) to accept and honor the charges or withdrawals made by the Companies from my card or account. I agree MasterCard and the financial institution shall be fully protected in honoring such charges or withdrawals.

This authorization shall take effect when recorded and processed by the Companies and financial institution and will remain in effect until I provide the Companies or the financial institutions written notification of the termination or change at least seven (7) days prior to the next scheduled payment date. I hereby terminate any prior authorization of the Companies to initiate charges to my card or withdrawals from this account for the above policy(ies) effective the date on which the initial charge or withdrawal is made under this authorization. I also understand and agree that if a charge or withdrawal is not honored by the financial institution for any reason, the Companies may cease attempting to make charges or withdrawals through the use of this authorization.

Signature of Authorized Account Holder _____ Date _____



S.USA LIFE INSURANCE COMPANY, INC.

P.O. Box 1050, Newark NJ 07101-1050

Toll Free: 1-866-SUSA-123 / 1-877-787-2123

website: www.susa.com

LIFE INSURANCE BUYER'S GUIDE

This guide can help you when you shop for life insurance. It discusses how to:

- Find a Policy That Meets Your Needs and Fits Your Budget
- Decide How Much Insurance You Need
- Make Informed Decisions When You Buy a Policy

Prepared by the

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

The National Association of Insurance Commissioners is an association of state insurance regulatory officials. This association helps the various insurance departments to coordinate insurance laws for the benefit of all consumers.

This guide does not endorse any company or policy.

Reprinted by

S.USA LIFE INSURANCE COMPANY

IMPORTANT THINGS TO CONSIDER

1. Review your own insurance needs and circumstances. Choose the kind of policy that has benefits that most closely fit your needs. Ask an agent or company to help you.
2. Be sure that you can handle premium payments. Can you afford the initial premium? If the premium increases later and you still need insurance, can you still afford it?
3. Don't sign an insurance application until you review it carefully to be sure all the answers are complete and accurate.
4. Don't buy life insurance unless you intend to stick with your plan. It may be very costly if you quit during the early years of the policy.
5. Don't drop one policy and buy another without a thorough study of the new policy and the one you have now. Replacing your insurance **may be costly**.
6. Read your policy carefully. Ask your agent or company about anything that is not clear to you.
7. Review your life insurance program with your agent or company every few years to keep up with changes in your income and your needs.

BUYING LIFE INSURANCE

When you buy life insurance, you want coverage that fits your needs.

First, decide how much you need - and for how long - and what you can afford to pay. Keep in mind the major reason you buy life insurance is to cover the financial effects of unexpected or untimely death. Life insurance can also be one of many ways you plan for the future.

Next, learn what kinds of policies will meet your needs and pick the one that best suits you.

Then, choose the combination of policy premium and benefits that emphasizes protection in case of early death, or benefits in case of long life, or a combination of both.

It makes good sense to ask a life insurance agent or company to help you. An agent can help you review your insurance needs and give you information about the available policies. If one kind of policy doesn't seem to fit your needs, ask about others.

This guide provides only basic information. You can get more facts from a life insurance agent or company or from your public library.

WHAT ABOUT THE POLICY YOU HAVE NOW?

If you are thinking about dropping a life insurance policy, here are some things you should consider:

- If you decide to replace your policy, don't cancel your old policy until you have received the new one. You then have a minimum period to review your new policy and decide if it is what you wanted.
- It may be costly to replace a policy. Much of what you paid in the early years of the policy you have now, paid for the company's cost of selling and issuing the policy. You may pay this type of cost again if you buy a new policy.
- Ask your tax advisor if dropping your policy could affect your income taxes.
- If you are older or your health has changed, premiums for the new policy will often be higher. You will not be able to buy a new policy if you are not insurable.
- You may have valuable rights and benefits in the policy you now have that are not in the new one.
- If the policy you have now no longer meets your needs, you may not have to replace it. You might be able to change your policy or add to it to get the coverage or benefits you now want.
- At least in the beginning, a policy may pay no benefits for some causes of death covered in the policy you have now.

In all cases, if you are thinking of buying a new policy, check with the agent or company that issued you the one you have now. When you bought your old policy, you may have seen an illustration of the benefits of your policy. Before replacing your policy, ask your agent or company for an updated illustration. Check to see how the policy has performed and what you might expect in the future, based on the amounts the company is paying now.

HOW MUCH DO YOU NEED?

Here are some questions to ask yourself:

- How much of the family income do I provide? If I were to die early, how would my survivors, especially my children, get by? Does anyone else depend on me financially, such as a parent, grandparent, brother or sister?
- Do I have children for whom I'd like to set aside money to finish their education in the event of my death?
- How will my family pay final expenses and repay debts after my death?
- Do I have family members or organizations to whom I would like to leave money?
- Will there be estate taxes to pay after my death?
- How will inflation affect future needs?

As you figure out what you have to meet these needs, count the life insurance you have now, including any group insurance where you work or veteran's insurance. Don't forget Social Security and pension plan survivor's benefits. Add other assets you have: savings, investments, real estate and personal property. Which assets would your family sell or cash in to pay expenses after your death?

WHAT IS THE RIGHT KIND OF LIFE INSURANCE?

All policies are not the same. Some give coverage for your lifetime and others cover you for a specific number of years. Some build up cash values and others do not. Some policies combine different kinds of insurance, and others let you change from one kind of insurance to another. Some policies may offer other benefits while you are still living. Your choice should be based on your needs and what you can afford.

There are two basic types of life insurance: **term insurance** and **cash value insurance**. Term insurance generally has lower premiums in the early years, but does not build up cash values that you can use in the future. You may combine cash value life insurance with term insurance for the period of your greatest need for life insurance to replace income.

Term Insurance covers you for a term of one or more years. It pays a death benefit only if you die in that term. Term insurance generally offers the largest insurance protection for your premium dollar. It generally does not build up cash value.

You can renew most term insurance policies for one or more terms even if your health has changed. Each time you renew the policy for a new term, premiums may be higher. Ask what the premiums will be if you continue to renew the policy. Also ask if you will lose the right to renew the policy at some age. For a higher premium, some companies will give you the right to keep the policy in force for a guaranteed period at the same price each year. At the end of that time you may need to pass a physical examination to continue coverage, and premiums may increase.

You may be able to trade many term insurance policies for a cash value policy during a conversion period - even if you are not in good health. Premiums for the new policy will be higher than you have been paying for the term insurance.

Cash Value Life Insurance is a type of insurance where the premiums charged are higher at the beginning than they would be for the same amount of term insurance. The part of the premium that is not used for the cost of insurance is invested by the company and builds up a cash value that may be used in a variety of ways. You may borrow against a policy's cash value by taking a policy loan. If you don't pay back the loan and the interest on it, the amount you owe will be subtracted from the benefits when you die, or from the cash value if you stop paying premiums and take out the remaining cash value. You can also use your cash value to keep insurance protection for a limited time or to buy a reduced amount without having to pay more premiums. You also can use the cash value to increase your income in retirement or to help pay for needs such as a child's tuition without canceling the policy. However, to build up this cash value, you must pay higher premiums in the earlier years of the policy. Cash value life insurance may be one of several types; whole life, universal life and variable life are all types of cash value insurance.

Whole Life Insurance covers you for as long as you live if your premiums are paid. You generally pay the same amount in premiums for as long as you live. When you first take out the policy, premiums can be several times higher than you would pay initially for the same amount of term insurance. But they are smaller than the premiums you would eventually pay if you were to keep renewing a term policy until your later years.

Some whole life policies let you pay premiums for a shorter period such as 20 years, or until age 65. Premiums for these policies are higher since the premium payments are made during a shorter period.

Universal Life Insurance is a kind of flexible policy that lets you vary your premium payments. You can also adjust the face amount of your coverage. Increases may require proof that you qualify for the new death benefit. The premiums you pay (less expense charges) go into a policy account that earns interest. Charges are deducted from the account. If your yearly premium payment plus the interest your account earns is less than the charges, your account value will become lower. If it keeps dropping, eventually your coverage will end. To prevent that, you may need to start making premium payments, or increase your premium payments, or lower your death benefits. Even if there is enough in your account to pay the premiums, continuing to pay premiums yourself means that you build up more cash value.

Variable Life Insurance is a kind of insurance where the death benefits and cash values depend on the investment performance of one or more separate accounts, which may be invested in mutual funds or other investments allowed under the policy. Be sure to get the prospectus from the company when buying this kind of policy and **STUDY IT CAREFULLY**. You will have higher death benefits and cash value if the underlying investments do well. Your benefits and cash value will be lower or may disappear if the investments you chose didn't do as well as you expected. You may pay an extra premium for a guaranteed death benefit.

LIFE INSURANCE ILLUSTRATIONS

You may be thinking of buying a policy where cash values, death benefits, dividends or premiums may vary based on events or situations the company does not guarantee (such as interest rates). If so, you may get an illustration from the agent or company that helps explain how the policy works. The illustration will show how the benefits that are not guaranteed will change as interest rates and other factors change. The illustration will show you what the company guarantees. It will also show you what *could* happen in the future. Remember that nobody knows what will happen in the future. You should be ready to adjust your financial plans if the cash value doesn't increase as quickly as shown in the illustration. You will be asked to sign a statement that says you understand that some of the numbers in the illustration are not guaranteed.

FINDING A GOOD VALUE IN LIFE INSURANCE

After you have decided which kind of life insurance is best for you, compare similar policies from different companies to find which one is likely to give you the best value for your money. A simple comparison of the premiums is not enough. There are other things to consider. For example:

- Do premiums or benefits vary from year to year?
- How much do the benefits build up in the policy?
- What part of the premiums or benefits is not guaranteed?
- What is the effect of interest on money paid and received at different times on the policy?

Remember that no one company offers the lowest cost at **all** ages for **all** kinds and amounts of insurance. You should also consider other factors:

- How quickly does the cash value grow? Some policies have low cash values in the early years that build quickly later on. Other policies have a more level cash value build-up. A year-by-year display of values and benefits can be very helpful. (The agent or company will give you a policy summary or an illustration that will show benefits and premiums for selected years.)
- Are there special policy features that particularly suit your needs?
- How are nonguaranteed values calculated? For example, interest rates are important in determining policy returns. In some companies increases reflect the average interest earnings on all of that company's policies regardless of when issued. In others, the return for policies issued in a recent year, or a group of years, reflects the interest earnings on that group of policies; in this case, amounts paid are likely to change more rapidly when interest rates change.



S.USA LIFE INSURANCE COMPANY, INC.
FINANCIAL PRODUCTS DISCLOSURE

P.O. Box 1050, Newark, NJ 07101-1050 Toll Free: 1-866-SUSA-123 / 1-866-787-2123

website: www.susa.com

TO BE PROVIDED TO ANY CALIFORNIA RESIDENT 65 YEARS OF AGE OR OLDER.

In the process of evaluating the purchase of any life insurance or annuity product, you should understand that the sale or liquidation of any stock, bond, IRA, certificate of deposit, mutual fund, annuity, or other asset to fund the purchase of this product may have tax consequences, early withdrawal penalties or other cost or penalties as a result of their sale or liquidation.

Prior to purchasing the new life insurance or annuity product, you or your representative may wish to consult independent legal or financial advice before selling or liquidating any assets.

I/We have read the above disclosure and have received a copy.

Dated

Agent's Name (Please print)

X

Agent's Signature

Owner's Name (Please print)

X

Owner's Signature

Joint Owner's Name, *if any* (Please print)

X

Joint Owner's Signature, *if any*



S.USA LIFE INSURANCE COMPANY, INC.

FINANCIAL PRODUCTS DISCLOSURE

P.O. Box 1050, Newark, NJ 07101-1050 Toll Free: 1-866-SUSA-123 / 1-866-787-2123

website: www.susa.com

TO BE PROVIDED TO ANY CALIFORNIA RESIDENT 65 YEARS OF AGE OR OLDER.

In the process of evaluating the purchase of any life insurance or annuity product, you should understand that the sale or liquidation of any stock, bond, IRA, certificate of deposit, mutual fund, annuity, or other asset to fund the purchase of this product may have tax consequences, early withdrawal penalties or other cost or penalties as a result of their sale or liquidation.

Prior to purchasing the new life insurance or annuity product, you or your representative may wish to consult independent legal or financial advice before selling or liquidating any assets.

I/We have read the above disclosure and have received a copy.

Dated

Agent's Name (Please print)

X

Agent's Signature

Owner's Name (Please print)

X

Owner's Signature

Joint Owner's Name, *if any* (Please print)

X

Joint Owner's Signature, *if any*



S.USA LIFE INSURANCE COMPANY, INC.

NOTICE REGARDING STANDARDS FOR MEDI-CAL ELIGIBILITY AND RECOVERY

P.O. Box 1050, Newark, NJ 07101-1050 Toll Free: 1-866-SUSA-123 / 1-866-787-2123

website: www.susa.com

If you or your spouse are considering purchasing a financial product based on its treatment under the Medi-Cal program, read this important message!

You or your spouse do not have to use up all of your savings before applying for Medi-Cal.

An annuity purchased on or after September 1, 2004, shall be subject to recovery by the state upon the annuitant's death under the regulations of the Medi-Cal Recovery Program. Income derived from the annuity must be used to meet the annuitant's share of costs and, if the annuitant is married, the income derived from the annuity may impact the minimum monthly maintenance needs of the annuitant's community spouse. An annuity purchased by a community spouse on or after September 1, 2004, may also be subject to recovery if that spouse is the recipient of past or future Medi-Cal benefits.

Unmarried Resident

An unmarried resident may be eligible for Medi-Cal benefits if he or she has less than \$2,000 in countable resources.

The Medi-Cal recipient is allowed to keep from his or her monthly income a personal allowance of \$35 plus the amount of any health insurance premiums paid. The remainder of the monthly income is paid to the nursing facility as a monthly share of cost.

Married Resident

Community Spouse Resource Allowance: If one spouse lives in a nursing facility, and the other spouse does not live in a facility, the Medi-Cal will pay some or all of the nursing facility costs as long as the couple together does not have more than \$120,900.

Minimum Monthly Maintenance Needs Allowance: If a spouse is eligible for Medi-Cal payment of nursing facility costs, the spouse living at home is allowed to keep a monthly income of at least his or her individual monthly income or \$3,023, whichever is greater.

Fair Hearings and Court Orders

Under certain circumstances, an at-home spouse can obtain an order from an administrative law judge or court that will allow the at-home spouse to retain additional resources or income. The order may allow the couple to retain more than \$120,900 in countable resources. The order also may allow the at-home spouse to retain more than \$3,023 in monthly income.

Real and Personal Property Exemptions

Many of your assets may already be exempt. Exempt means that the assets are not counted when determining eligibility for Medi-Cal.

Real Property Exemptions

One Principal Residence: One property used as a home is exempt. The home will remain exempt in determining eligibility if the applicant intends to return home someday.

The home also remains to be exempt if the applicant’s spouse or dependent relative continues to live in it.

Money received from the sale of a home can be exempt for up to six months if the money is going to be used for the purchase of another home.

Real Property Used in a Business or Trade: Real estate used in a trade or business is exempt regardless of its equity value and whether it produces income.

Personal Property and Other Exempt Assets

IRAs, Keoghs, and Other Work-Related Pension Plans: These funds are exempt if the family member whose name it is in does not want Medi-Cal. If held in the name of a person who wants Medi-Cal and payments of principal and interest are being received, the balance is considered unavailable and is not counted. It is not necessary to annuitize, covert to an annuity, or otherwise change the form of the assets in order for them to be unavailable.

Personal Property Used in a Trade of Business

One Motor Vehicle

Irrevocable Burial Trusts or Irrevocable Prepaid Burial Contracts

There may Be Other Assets That May Be Exempt

This is only a brief description of the Medi-Cal eligibility rules, for more detailed information, you should call your county welfare department. Also, you are advised to contact a legal services program for seniors or an attorney that is not connected with the sale of this product.

I/We have read the above notice and have received a copy (Copies to be provided to: Client, Agency, Agent, and Home Office.)

Dated

Owner’s Name (Please print)

X _____
Owner’s Signature

Owner’s Spouse Name (Please print)

X _____
Spouse’s Signature

Joint Owner’s Name, if any (Please print)

X _____
Joint Owner’s Signature, if any

Joint Owner’s Spouse Name, if any (Please print)

X _____
Joint Owner’s Spouse Signature, if any

Agent’s Name (Please print)

X _____
Agent’s Signature



S.USA LIFE INSURANCE COMPANY, INC.

NOTICE REGARDING STANDARDS FOR MEDI-CAL ELIGIBILITY AND RECOVERY

P.O. Box 1050, Newark, NJ 07101-1050 Toll Free: 1-866-SUSA-123 / 1-866-787-2123

website: www.susa.com

If you or your spouse are considering purchasing a financial product based on its treatment under the Medi-Cal program, read this important message!

You or your spouse do not have to use up all of your savings before applying for Medi-Cal.

An annuity purchased on or after September 1, 2004, shall be subject to recovery by the state upon the annuitant's death under the regulations of the Medi-Cal Recovery Program. Income derived from the annuity must be used to meet the annuitant's share of costs and, if the annuitant is married, the income derived from the annuity may impact the minimum monthly maintenance needs of the annuitant's community spouse. An annuity purchased by a community spouse on or after September 1, 2004, may also be subject to recovery if that spouse is the recipient of past or future Medi-Cal benefits.

Unmarried Resident

An unmarried resident may be eligible for Medi-Cal benefits if he or she has less than \$2,000 in countable resources.

The Medi-Cal recipient is allowed to keep from his or her monthly income a personal allowance of \$35 plus the amount of any health insurance premiums paid. The remainder of the monthly income is paid to the nursing facility as a monthly share of cost.

Married Resident

Community Spouse Resource Allowance: If one spouse lives in a nursing facility, and the other spouse does not live in a facility, the Medi-Cal will pay some or all of the nursing facility costs as long as the couple together does not have more than \$120,900.

Minimum Monthly Maintenance Needs Allowance: If a spouse is eligible for Medi-Cal payment of nursing facility costs, the spouse living at home is allowed to keep a monthly income of at least his or her individual monthly income or \$3,023, whichever is greater.

Fair Hearings and Court Orders

Under certain circumstances, an at-home spouse can obtain an order from an administrative law judge or court that will allow the at-home spouse to retain additional resources or income. The order may allow the couple to retain more than \$120,900 in countable resources. The order also may allow the at-home spouse to retain more than \$3,023 in monthly income.

Real and Personal Property Exemptions

Many of your assets may already be exempt. Exempt means that the assets are not counted when determining eligibility for Medi-Cal.

Real Property Exemptions

One Principal Residence: One property used as a home is exempt. The home will remain exempt in determining eligibility if the applicant intends to return home someday.

The home also remains to be exempt if the applicant’s spouse or dependent relative continues to live in it.

Money received from the sale of a home can be exempt for up to six months if the money is going to be used for the purchase of another home.

Real Property Used in a Business or Trade: Real estate used in a trade or business is exempt regardless of its equity value and whether it produces income.

Personal Property and Other Exempt Assets

IRAs, Keoghs, and Other Work-Related Pension Plans: These funds are exempt if the family member whose name it is in does not want Medi-Cal. If held in the name of a person who wants Medi-Cal and payments of principal and interest are being received, the balance is considered unavailable and is not counted. It is not necessary to annuitize, covert to an annuity, or otherwise change the form of the assets in order for them to be unavailable.

Personal Property Used in a Trade of Business

One Motor Vehicle

Irrevocable Burial Trusts or Irrevocable Prepaid Burial Contracts

There may Be Other Assets That May Be Exempt

This is only a brief description of the Medi-Cal eligibility rules, for more detailed information, you should call your county welfare department. Also, you are advised to contact a legal services program for seniors or an attorney that is not connected with the sale of this product.

I/We have read the above notice and have received a copy (Copies to be provided to: Client, Agency, Agent, and Home Office.)

Dated	
_____	X
Owner’s Name (Please print)	_____
	Owner’s Signature
_____	X
Owner’s Spouse Name (Please print)	_____
	Spouse’s Signature
_____	X
Joint Owner’s Name, <i>if any</i> (Please print)	_____
	Joint Owner’s Signature, <i>if any</i>
_____	X
Joint Owner’s Spouse Name, <i>if any</i> (Please print)	_____
	Joint Owner’s Spouse Signature, <i>if any</i>
_____	X
Agent’s Name (Please print)	_____
	Agent’s Signature



S.USA LIFE INSURANCE COMPANY, INC.

P.O. Box 1050, Newark, NJ 07101-1050 Toll Free: 1-866-SUSA-123 / 1-866-787-2123

website: www.susa.com

NOTICE TO SENIORS REGARDING INSURANCE SALES MEETING AGENT INFORMATION:

Full name as it appears on his or her California insurance license

License number

Mailing address and telephone number listed on his or her California insurance license.

I am a licensed insurance agent. My purpose for coming to your home is to sell, discuss, and/or deliver one of the following (indicate all that apply):

Life Insurance, including annuities.

Other insurance products (specify): _____

I wanted to make you aware of certain rights you have at this visit:

- (1) You have the right to have other persons present at the meeting, including family members, financial advisors or attorneys.
- (2) You have the right to end the meeting at any time.
- (3) You have the right to contact the California Department of Insurance for information, or to file a complaint.

The consumer assistance telephone numbers at the department are 1-800-927-4357 or 213-897-8921.

The following individuals will be coming to your home:

Agent/Attendee Name	California Insurance License Number
_____	_____
_____	_____
_____	_____



S.USA LIFE INSURANCE COMPANY, INC.

P.O. Box 1050, Newark, NJ 07101-1050 Toll Free: 1-866-SUSA-123 / 1-866-787-2123

website: www.susa.com

NOTICE TO SENIORS REGARDING INSURANCE SALES MEETING AGENT INFORMATION:

Full name as it appears on his or her California insurance license

License number

Mailing address and telephone number listed on his or her California insurance license.

I am a licensed insurance agent. My purpose for coming to your home is to sell, discuss, and/or deliver one of the following (indicate all that apply):

Life Insurance, including annuities.

Other insurance products (specify): _____

I wanted to make you aware of certain rights you have at this visit:

- (1) You have the right to have other persons present at the meeting, including family members, financial advisors or attorneys.
- (2) You have the right to end the meeting at any time.
- (3) You have the right to contact the California Department of Insurance for information, or to file a complaint.

The consumer assistance telephone numbers at the department are 1-800-927-4357 or 213-897-8921.

The following individuals will be coming to your home:

Agent/Attendee Name

California Insurance License Number



S.USA LIFE INSURANCE COMPANY, INC.

NOTICE REGARDING REPLACEMENT OF LIFE INSURANCE AND ANNUITY CONTRACTS

P.O. Box 1050, Newark, NJ 07101-1050

Toll Free: 1-866-SUSA-123 / 1-866-787-2123

website: www.susa.com

MUST BE PRESENTED TO, SIGNED AND DATED BY THE OWNER AND PRODUCER AT THE TIME OF APPLICATION

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

Make sure you understand the facts. You should ask for the advice of the company or agent that sold you your existing policy to give you information about it.

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

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

The following policy(ies) may be replaced as a result of this transaction.

Policy #1

Name of Insured Company Name

Policy Number Policy Type Face Amount

Policy #2

Name of Insured Company Name

Policy Number Policy Type Face Amount

Policy #3

Name of Insured Company Name

Policy Number Policy Type Face Amount

Agreements and Signatures

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

X _____
Signature of Owner Date

X _____
Signature of Producer Date

Printed Name of Producer

Address of Producer (Street)

Address of Producer (City, State, Zip)



S.USA LIFE INSURANCE COMPANY, INC.

NOTICE REGARDING REPLACEMENT OF LIFE INSURANCE AND ANNUITY CONTRACTS

P.O. Box 1050, Newark, NJ 07101-1050

Toll Free: 1-866-SUSA-123 / 1-866-787-2123

website: www.susa.com

MUST BE PRESENTED TO, SIGNED AND DATED BY THE OWNER AND PRODUCER AT THE TIME OF APPLICATION

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

Make sure you understand the facts. You should ask for the advice of the company or agent that sold you your existing policy to give you information about it.

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

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

The following policy(ies) may be replaced as a result of this transaction.

Policy #1

Name of Insured Company Name

Policy Number Policy Type Face Amount

Policy #2

Name of Insured Company Name

Policy Number Policy Type Face Amount

Policy #3

Name of Insured Company Name

Policy Number Policy Type Face Amount

Agreements and Signatures

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

X _____
Signature of Owner Date

X _____
Signature of Producer Date

Printed Name of Producer

Address of Producer (Street)

Address of Producer (City, State, Zip)

