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:

Social Security Number	Sex	Date of Birth	State of Birth	Country of Birth	Evening:
					Best Time To Call

Mailing Address (Number, Street, Apt. #)	City	State	Zip Code

Driver's License State and Number	E-Mail Address	Are you a United States citizen or legal permanent resident? ❑ Yes ❑ No

2. BENEFICIARY INFORMATION

Beneficiary ❑ Primary ❑ Contingent	Social Security # or Tax ID #

Address (Number, Street, Apt. #)	City	State	Zip Code

Date of Birth	Relationship	Percent of Proceeds	Telephone Number

Beneficiary ❑ Primary ❑ 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

Secondary Addressee: You have the right to designate a secondary addressee to receive copies of Termination of Coverage Notices now, by completing the section below, or at any time the policy is in force by sending Us a written notice containing the name and address of the secondary addressee.

Last Name	First Name	MI

Address (Number, Street, Apt. #)	City	State	Zip Code

5. REPLACEMENT INFORMATION

1. Is there any life 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 or annuity contract in force with this or any other company? ..... ❑ Yes ❑ No
3. Are any other life insurance or annuity applications pending with this or any other company? ..... ❑ Yes ❑ No

List all current or pending life insurance or annuity coverage below.

Insured's Name	Company	Owner	Replacement	Face Amount	Accidental Death Benefit	Year Issued
			❑ Yes ❑ No			
			❑ Yes ❑ No			
			❑ Yes ❑ No			
			❑ Yes ❑ No			
			❑ Yes ❑ No			

6. 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

7. INSURANCE APPLIED FOR

Face Amount ..... $_____

8. RIDERS APPLIED FOR

❑ Accidental Death Benefit Rider ..... 1X Amount of Insurance

9. 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.

10. HOME OFFICE ENDORSEMENTS	SPECIAL REQUESTS

11. 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. 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.

Caution: If your answers on this application are misstated or untrue, the insurer may have the right to deny benefits.

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

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

12. AGENT CERTIFICATION

1. To the best of your knowledge and belief, is there an existing life 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	FL License ID Number
E-Mail 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 _____


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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 6 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**


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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.

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.


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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.

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

I (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

SBLI USA LIFE INSURANCE SINCE 1939

S.USA Life Insurance Company, Inc.

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 **S.USA 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)

P.O. Box 1050, Newark, NJ 07101-1050
1-866-SUSA-123 (1-866-787-2123) • www.susa.com

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.

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LIFE INSURANCE SINCE 1939

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

SUMMARY AND DISCLOSURE STATEMENT FOR ACCELERATED DEATH BENEFITS

This is a brief description of the accelerated death benefit in the policy applied for. Please consult the policy for actual contract provisions.

What it is: If the insured has a terminal illness, you may accelerate payment of a portion of the eligible proceeds, subject to stated maximum or minimum limits. The eligible proceeds are generally the death benefit at the time of acceleration. The accelerated death benefit does not and is not intended to qualify as long-term care insurance.

Amount: The amount payable as an accelerated death benefit will equal: (a) the amount of the eligible proceeds you request to accelerate adjusted by the discount factor stated in the policy, (b) minus an administrative fee, (c) minus the elected percentage applied to any outstanding policy loan and loan interest. Payment of the accelerated death benefit will be in one lump sum.

Requirements: In order to receive the benefit, you must provide us with:

a) a written request for the benefits during the lifetime of the insured and while the policy is in force;
b) written certification by a qualified physician that the insured suffers from a terminal illness; and
c) written consent of any assignee or irrevocable beneficiary.

We may require a second or third medical opinion to confirm benefit eligibility at our expense. Your policy outlines any other applicable conditions or exclusions.

Costs: There is no additional premium charged for this benefit. However, we will discount the benefit by the discount factor because it is an early payment of the death benefits and charge an administrative fee not to exceed the amount stated in the policy.

Effect of Acceleration: Upon acceleration, any policy values and the death benefit on the remaining policy will be reduced proportionately.

What follows is a hypothetical example of how an accelerated benefit payment of 50% of the eligible proceeds would affect a level premium policy with cash values, a policy loan and $100,000 face amount:

	Premium	Cash Value	Face Amount	Outstanding Loan
Before accelerated payment	$1,200.00	$16,000.00	$100,000.00	$4,000.00
After accelerated payment	$600.00	$8,000.00	$50,000.00	$2,000.00

Important Disclosure: Although accelerated death benefit payments are intended to qualify for favorable tax treatment, there are circumstances when receipt of the benefit payment MAY BE TAXABLE. Receipt of an accelerated death benefit payment may adversely affect the recipient's eligibility for Medicaid, Supplemental Security Income ("SSI") or other government benefits or entitlements. Consult your tax advisor and the appropriate social service agency before applying for this benefit.

Applicant's Signature

Agent's Signature

Date

Date

SBLI USA
LIFE INSURANCE SINCE 1939

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

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Requirements: In order to receive the benefit, you must provide us with:

a) a written request for the benefits during the lifetime of the insured and while the policy is in force;
b) written certification by a qualified physician that the insured suffers from a terminal illness; and
c) written consent of any assignee or irrevocable beneficiary.

We may require a second or third medical opinion to confirm benefit eligibility at our expense. Your policy outlines any other applicable conditions or exclusions.

Costs: There is no additional premium charged for this benefit. However, we will discount the benefit by the discount factor because it is an early payment of the death benefits and charge an administrative fee not to exceed the amount stated in the policy.

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Important Disclosure: Although accelerated death benefit payments are intended to qualify for favorable tax treatment, there are circumstances when receipt of the benefit payment MAY BE TAXABLE. Receipt of an accelerated death benefit payment may adversely affect the recipient's eligibility for Medicaid, Supplemental Security Income ("SSI") or other government benefits or entitlements. Consult your tax advisor and the appropriate social service agency before applying for this benefit.

Applicant's Signature

Agent's Signature

Date

Date

PROSPERITY LIFE GROUP℠

SBLI USA Life Insurance Company, Inc.
S.USA Life Insurance Company, Inc.
Shenandoah Life Insurance Company
(Each the "Company")
Members of the Prosperity Life Group†

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.*

PROSPERITY LIFE GROUP℠

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**
1st to the 10th	Second Wednesday of the month
11th to the 20th	Third Wednesday of the month
21st to the 31st	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

_____ Check One: ☐ Checking ☐ Savings $ _____

List All Authorized Account Holders 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 Date Premium amount

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.

USA Life Insurance Company, Inc.

FLORIDA NOTICE TO APPLICANT REGARDING REPLACEMENT OF LIFE INSURANCE

EXHIBIT A – (Use for Internal and External Replacements)

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

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

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

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

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

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

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

☐ Yes ☐ No

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

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

_____ _____

Applicant's Signature Date

_____ _____

Agent's Signature Date

_____ _____

Agent Name (printed or typed) Agent Company (printed or typed)

_____

Agent's Address (printed or typed)

Information on Policies which may be replaced:

Company Name	Policy Number	Name of Insured

P.O. Box 1050, Newark, NJ 07101
1-866-SUSA-123 (1-866-787-2123) • www.susa.com

USA Life Insurance Company, Inc.

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Agent's Signature Date

_____ _____

Agent Name (printed or typed) Agent Company (printed or typed)

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Agent's Address (printed or typed)

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USA Life Insurance Company, Inc.

NOTICE TO OWNER REGARDING REPLACEMENT OF LIFE INSURANCE

To be used when the existing and proposed policies are written by the same company. (Form D14-1180)

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

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

Part A – Current Policy Information

☐ Life ☐ Annuity

Policyowner Name: _____ Policy Number: _____

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

Cash Surrender Value: $_____ Paid-up Addition Value: $_____ Dividend Value: $_____

(The BENEFIT and VALUES stated above will be reduced as funds are used to purchase the policy proposed in Part B, below.)

Part B – Proposed Policy Information

☐ Life ☐ Annuity

Initial Death Benefit: $_____ Proposed Premium Amount: $_____ Mode of Payment: _____

Proposed Effective Date: _____ Premium payable to age_____ or for _____ years.

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

Part C – Source of Funding for the Proposed Policy

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

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

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

Part D – Your Current Policy Could Terminate

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

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

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

Signatures

_____ _____

Signature of Owner Date

_____ _____

Signature of Producer or Company Officer Date

_____

Florida Licensed Producer ID No. or Corporate Title

(See reverse side for instructions.)
(A signed and dated copy of this notice must accompany the application.)

P.O. Box 1050, Newark, NJ 07101
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Policy Disclosure Form

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

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

PART A

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

PART B

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

PART C

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

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

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

PART D

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

SIGNATURES

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

USA Life Insurance Company, Inc.

NOTICE TO OWNER REGARDING REPLACEMENT OF LIFE INSURANCE

To be used when the existing and proposed policies are written by the same company. (Form D14-1180)

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

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☐ Life ☐ Annuity

Policyowner Name: _____ Policy Number: _____

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

Cash Surrender Value: $_____ Paid-up Addition Value: $_____ Dividend Value: $_____

(The BENEFIT and VALUES stated above will be reduced as funds are used to purchase the policy proposed in Part B, below.)

Part B – Proposed Policy Information

☐ Life ☐ Annuity

Initial Death Benefit: $_____ Proposed Premium Amount: $_____ Mode of Payment: _____

Proposed Effective Date: _____ Premium payable to age_____ or for _____ years.

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

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

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Signature of Owner Date

_____ _____

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Florida Licensed Producer ID No. or Corporate Title

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ANY REQUIRED REPLACEMENT AND SALES FORMS MUST ALSO BE COMPLETED
ONE COPY IS DELIVERED TO THE POLICYOWNER AND ONE COPY MAINTAINED BY THE INSURED

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PART B

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

PART C

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

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

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

PART D

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

SIGNATURES

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