Life Insurance Application

AccordiaLife
www.accordia.com

Accordia Life and Annuity Company
P.O. Box 305030
Nashville, TN 37230-5030
Customer Contact Center – Tel: 877 462 8992 Fax: 800 262 6976

AGENT/PRODUCER CODE & NAME:

This Application can be used for all products except the Survivorship Builder product.

Checklist for Submitting New Application

- ☐ State specific **Life Insurance Application**
- ☐ Signed **Authorization and Acknowledgement**
- ☐ Signed **Terminal Illness Accelerated Death Benefit Disclosure** (Form 19320)
- ☐ **Supplemental Applications** for child or additional insured
- ☐ **Financial Supplement,** if required by age and amount
- ☐ **Trust Verification Form** (Form 16541) if beneficiary or owner is a Trust
  - ☐ Full copy of the **Trust**, if trust date is within **two years** of application and client is **age 65+**
- ☐ **Indexed Products -** If the application is completed for an indexed product in Connecticut, the Applicant must sign the Indexed Signatures section

Verify the following:

- ☐ **Product or Plan** is indicated
- ☐ **Face Amount** is listed

Supporting Documents

- ☐ State specific **Agent/Producer's Report for Application for Life Insurance**
- ☐ **Signed Illustration or Policy Illustration Certificate**
  - ☐ If this application is completed for an indexed product in the states listed, you must provide a signed illustration with the application. A certification of non-illustration or electronic illustration only is not allowed: Arkansas, Connecticut, Michigan North Dakota, Oklahoma, South Dakota, Wyoming.
- ☐ **Signed Strategy Allocation Form**
- ☐ State specific Replacement Form, if applicable, must be dated on or before the application date.
- ☐ If applicable, **1035 Absolute Assignment** (Form 11959) for each exchanged policy; and return the old policy or complete a **Lost Policy Statement** (Form 14101)
- ☐ **EFT/PAC Form** required if premiums will be paid by **Monthly Bank Draft**
- ☐ If **Employer Owned**, complete form 15996

Conditional Life Insurance Agreement

- ☐ Explain the terms of the company's Conditional Life Insurance Agreement prior to accepting any money with this application.
- ☐ Leave one copy of the completed Conditional Life Insurance Agreement with the applicant if money is taken.

Submission of Application

- ☐ Review the application prior to mailing to the Company to make certain it is complete and accurate. Include a cover memo or Transmittal Form 15743 with special instructions if needed.
- ☐ Leave the Disclosure Notice to Proposed Insured with the Proposed Insured (Form 15740).
- ☐ If the application is completed for a product in the states listed, you must leave the Buyers Guide with the applicant: Georgia, Illinois, Maine, New Hampshire, Washington, Wisconsin.

Life Insurance Application

AccordiaLife
www.accordia.com

Accordia Life and Annuity Company
P.O. Box 305030
Nashville, TN 37230-5030
Customer Contact Center – Tel: 877 462 8992 Fax: 800 262 6976

AGENT/PRODUCER CODE & NAME:

A. INFORMATION ABOUT THE PROPOSED INSURED

First Name	M. I.	Last Name	Suffix	Is Proposed Insured also the Owner? ☐ Yes ☐ No

Mailing Address*	City	State	Zip	Country
Street Address: (Required if mailing address is a PO Box)	City	State	Zip	Country

Social Security Number	Date of Birth (MM/DD/YY) / /	Birth State
Personal Phone ( ) -	Business Phone ( ) -	E-Mail

Gender ☐ M ☐ F	Marital Status: ☐ Married ☐ Single ☐ Divorced or Separated ☐ Widow or Widower	Maiden Name

U.S. Citizen ☐ Yes ☐ No	Permanent Resident ☐ Yes ☐ No	Are you a resident or citizen of a country other than the U.S.? ☐ Yes ☐ No (If yes, please complete the next line)

Country of Birth	Country of Residency	Length of time in the U.S.	Type of Visa

Proposed Insured's Driver's License or other government issued photo ID:

Document Type	Document Number	Where Issued	Issue Date / /	Expiration Date / /

Employer Name	Employer Address, City, State, Zip

Occupation/Duties	Length of time at current employer	Phone ( ) -

Annual earned income $	Annual unearned income $	Net worth $	Income and net worth: ☐ Personal ☐ Joint

B. INFORMATION ABOUT THE OWNER (If different from Proposed Insured)

Individual, Trustee or Company Name	Relationship to Proposed Insured ☐ Spouse ☐ Trustee ☐ Other:

If Trust, list Trust Name and Trust Date

Mailing Address*	City	State	Zip	Country
Street Address: (Required if mailing address is a PO Box)	City	State	Zip	Country

Social Security or Tax ID Number	Date of Birth (MM/DD/YY) / /	E-Mail	Personal Phone ( ) -

Gender ☐ M ☐ F	Marital Status: ☐ Married ☐ Single ☐ Divorced or Separated ☐ Widow or Widower	U.S. Citizen ☐ Yes ☐ No	Permanent Resident ☐ Yes ☐ No

Owner's or Trustee's personal Driver's License or other government issued photo ID, or corporate license:

Document Type	Document Number	Where Issued	Issue Date / /	Expiration Date / /

B. **INFORMATION ABOUT THE OWNER** (continued)

Contingent Owner (If none specified, policy provisions will apply)

Individual, Trustee or Company Name			Relationship to Proposed Insured ☐ Spouse ☐ Trustee ☐ Other:	
If Trust, list Trust Name and Trust Date				
Mailing Address*	City	State	Zip	Country
Street Address: (Required if mailing address is a PO Box)	City	State	Zip	Country

Social Security or Tax ID Number	Date of Birth (MM/DD/YY) / /	E-Mail	Personal Phone ( ) -

Gender ☐ M ☐ F	Marital Status: ☐ Married ☐ Single ☐ Divorced or Separated ☐ Widow or Widower	U.S. Citizen ☐ Yes ☐ No	Permanent Resident ☐ Yes ☐ No

Contingent Owner's or Trustee's personal Driver's License or other government issued photo ID, or corporate license:

Document Type	Document Number	Where Issued	Issue Date / /	Expiration Date / /

*__Mail notices to:__ ☐ Insured ☐ Owner ☐ Other			Name and relationship to Owner	
Other Notice Mailing Address	City	State	Zip	Personal Phone ( ) -
Past Due Premium/Lapse Notification: You may select an additional person to receive past due premium & possible lapse in coverage notifications.			Name and relationship to Owner	
Notice Mailing Address	City	State	Zip	Personal Phone ( ) -

C. **BENEFICIARY DESIGNATION** (Attach separate sheet if necessary, signed and dated by the Owner)

Individual, Trust or Company Name		Relationship to Insured	☐ Primary ☐ Contingent	Percentage %
Address	City	State	Zip	Country
Social Security or Tax ID Number	Date of Birth (MM/DD/YY) / /	Birth State		
Personal Phone ( ) -	Business Phone ( ) -	E-Mail		

Individual, Trust or Company Name		Relationship to Insured	☐ Primary ☐ Contingent	Percentage %
Address	City	State	Zip	Country
Social Security or Tax ID Number	Date of Birth (MM/DD/YY) / /	Birth State		
Personal Phone ( ) -	Business Phone ( ) -	E-Mail		

C. BENEFICIARY DESIGNATION (Attach separate sheet if necessary, signed and dated by the Owner) (continued)

Individual, Trust or Company Name	Relationship to Insured	☐ Primary ☐ Contingent	Percentage %

Address	City	State	Zip	Country

Social Security or Tax ID Number	Date of Birth (MM/DD/YY) / /	Birth State
Personal Phone ( ) -	Business Phone ( ) -	E-Mail

D. POLICY INFORMATION

Proposed Insured: ☐ Tobacco ☐ Non-Tobacco

Base Plan	Amount of Insurance $
Optional Coverage Riders: Primary Insured Rider, Additional Insured Rider or Childrens Insurance Rider	
Additional Coverage	Amount of Insurance $
Additional Coverage	Amount of Insurance $

Riders That May Be Available on Universal Life Insurance	
☐ Overloan Protection	☐ Accidental Death Benefit: Amount of Insurance: $
☐ Waiver of Monthly Deductions	☐ Guaranteed Purchase Option: Option Amount: $
☐ Wellness for Life	☐ Waiver of Specified Premium: Waiver Amount: $
	☐ Other - Details:
	☐ Other - Details:
Riders That May Be Available on Term Life Insurance	
☐ Waiver of Premium	☐ Accidental Death Benefit: Amount of Insurance: $
☐ Waiver of Premium Plus	☐ Other - Details:
The Terminal Illness Accelerated Death Benefit Rider will automatically be included on a Universal Life or Term Life Policy	
Universal Life Death Benefit Option	
☐ DBO 1: Level ☐ DBO 2: Increasing ☐ DBO 3: Death Benefit Return of Premium Rider	

Levelized Strategy Transfer: ☐ Yes ☐ No

Purpose of Insurance: ☐ Business Insurance ☐ Estate Planning ☐ Income Replacement ☐ Other_____

Optional Policy Date (Backdate to save age or future date) (MM/DD/YY): / /

Death Benefit Qualification Test (If no option is selected, the default option will be Guideline Premium Test):

☐ Guideline Premium Test (GLP) ☐ Cash Value Accumulation Test (CVAT)

E. PREMIUM INFORMATION

1.

Planned Premium $	Additional Premium (Lump Sum) $

Billing Frequency: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly Electronic Funds Transfer (EFT – complete authorization)

☐ Other: Government Allotment, Group Bill, Group Bill #

Has the premium for the policy applied for been given to the Agent/Producer? ☐ Yes ☐ No Amount: $

E. **PREMIUM INFORMATION** (continued)

Source of Premium: ☐ 1035 Exchange . . . . . (approximate amount) $
☐ Income
☐ Liquidation of other assets (if yes, explain below)
☐ Other (if yes, explain below)

Explanation

2. Will any policy issued as a result of this application have any portion of the initial or future premiums paid, or otherwise provided, by anyone other than an insured, their family or employer? . . . . . ☐ Yes ☐ No
(If yes, please attach Premium Financing disclosure forms)

F. **INSURANCE HISTORY**

(If yes to questions F.1-F.3, please explain in chart below and attach separate sheet if necessary, signed and dated by Proposed Insured)

1. Are any life insurance policy(ies) or annuity contract(s) in-force? . . . . . ☐ Yes ☐ No
2. Will any life insurance policy(ies) or annuity contract(s) presently or recently in-force be replaced or changed by this policy applied for? . . . . . ☐ Yes ☐ No
3. Within the last year, has any other life, health or long term care insurance been issued or applied for, or is any to be applied for? . . . . . ☐ Yes ☐ No

In-force or Applied For	Company	Being Replaced	Death Benefit	Waiver of Premium	Personal/Business	Year Issued

G. **OTHER NON-MEDICAL INFORMATION**

1. a. Do you use any form of tobacco or nicotine based products? . . . . . ☐ Yes ☐ No
   b. If no, have you used any form of tobacco or nicotine based products in the last 5 years? . . . . . ☐ Yes ☐ No
   c. If yes, when did you last use tobacco or nicotine based products?
   Mo./Yr. Last Used: Type: Quantity:
2. Have you ever engaged or intend within the next 2 years to engage in:
   a. Any aviation activity other than as a passenger? . . . . . ☐ Yes ☐ No
   b. Ballooning, gliding, boat or vehicle racing, mountain or rock climbing, parachuting, sky diving, underwater diving or any other hazardous sport or activity? . . . . . ☐ Yes ☐ No
3. In the last 5 years, have you had a personal or business bankruptcy; or do you currently have any civil lawsuits or judgments pending against you? . . . . . ☐ Yes ☐ No
4. Have you ever had your driver's license suspended or revoked; or ever plead guilty to or been convicted of driving while under the influence of alcohol or drugs? . . . . . ☐ Yes ☐ No
5. In the last 5 years, have you plead guilty to or been convicted of a moving violation or been involved in an accident in which you were at fault? . . . . . ☐ Yes ☐ No
6. In the last 10 years, have you been arrested, convicted, or imprisoned for any crime; or do you currently have any criminal charges pending against you? . . . . . ☐ Yes ☐ No
7. Are you or the owner a member of the Armed Forces or an active or reserve military unit or have either of you entered into a written agreement to become a member of the Armed Forces? . . . . . ☐ Yes ☐ No
8. Do you intend to travel within the next 2 years outside the United States or Canada? . . . . . ☐ Yes ☐ No
9. Have you or the owner established a residence outside the U.S. or Canada within the last 2 years or intend to establish a residence outside the U.S. or Canada within the next 2 years? . . . . . ☐ Yes ☐ No

G. **OTHER NON-MEDICAL INFORMATION** (continued)

10. In the last 5 years, have you been the insured or annuitant on a life insurance policy or annuity contract that was sold to a life settlement/viatical company, secondary market purchaser or an investor? ☐ Yes ☐ No
11. Will any person or entity, other than a life insurance company, evaluate you in order to provide any form of life expectancy evaluation? ☐ Yes ☐ No
12. Have you, the owner, the beneficiary or anyone on your behalf discussed or arranged for the sale or assignment of this policy or any beneficial interest in an entity that owns this policy? ☐ Yes ☐ No
13. Will you, the owner or beneficiary receive a fee, rebate or any form of compensation if this policy is issued? ☐ Yes ☐ No

Provide complete details of any yes answers to questions G.1 through G.13. (Attach separate sheet if necessary, signed and dated by Proposed Insured)

Question #	Details

H. **MEDICAL PROFESSIONAL CONTACT INFORMATION**

(Attach separate sheet if necessary, signed and dated by Proposed Insured)

1. Contact information for your medical professional(s) or health care provider(s):

Name and Title	Address	Phone Number

2. When did you last consult a medical professional? What was the diagnosis and follow-up treatment?

3. Are you currently taking prescribed or over-the-counter medications? If yes, please list below. ☐ Yes ☐ No

I. **MEDICAL INFORMATION**

For Proposed Insured, this section does not need to be completed if an Accordia Life company medical exam is required. Please skip to Section J if it is not necessary to complete Section I.

1. Height in shoes ft. in. | Weight in clothes lbs.
2. Have you gained or lost more than 10 pounds in the last year? ☐ Yes ☐ No
3. Are you now under observation or treatment by a medical professional? ☐ Yes ☐ No
4. Have you ever been diagnosed by a medical professional as having or been treated for AIDS or ARC (AIDS-related complex)? ☐ Yes ☐ No
5. Have you ever tested positive for HIV antibodies as part of a test for obtaining insurance? ☐ Yes ☐ No
6. In the past 10 years have you been diagnosed, tested positive for, been treated for, or been given medical advice by a member of the medical profession for a disease or disorder such as:
   a. Disease of the heart or circulatory system, including high blood pressure, heart attack, coronary artery disease, or chest pain? ☐ Yes ☐ No
   b. Heart murmur, rhythm abnormality, heart catheterization, echocardiogram or an exercise treadmill test? ☐ Yes ☐ No
   c. Cancer, tumors, lymphoma, leukemia, or any growths, lesions, polyps? ☐ Yes ☐ No
   d. Diabetes, thyroid, glandular or endocrinal disorder? ☐ Yes ☐ No

I. **MEDICAL INFORMATION** (continued)

e. Respiratory disorders including asthma, chronic bronchitis, emphysema, pneumonia, shortness of breath, or abnormal chest x-ray? ☐ Yes ☐ No

f. Disorder of the stomach, liver, pancreas or intestinal tract, including ulcerative colitis, Crohn's disease or cirrhosis? ☐ Yes ☐ No

g. Disorder of the kidneys, prostate, bladder, reproductive organs, sexually transmitted diseases, sugar, albumin or blood in urine? ☐ Yes ☐ No

h. Stroke, transient ischemic attack (TIA), Parkinson's, multiple sclerosis, seizures, epilepsy, chronic headaches, memory changes or fainting? ☐ Yes ☐ No

i. Anxiety, depression, attempted suicide, attention deficit disorder or psychosis, mental or nervous system disorder? ☐ Yes ☐ No

j. Anemia, hepatitis, or any blood disorder (except HIV status)? ☐ Yes ☐ No

k. Chronic back pain, arthritis, loss of limb, paralysis, muscle weakness or disease? ☐ Yes ☐ No

7. Within the last 5 years, have you ever requested or received a benefit, military deferment, discharge or rejection, payment or pension because of a disability, injury, or sickness? ☐ Yes ☐ No

8. Within the last 5 years, other than noted in previous questions, have you:

a. Seen a doctor, health care provider, counselor, therapist, or had any illness, injury, surgery, diagnostic test or treatment, or been advised to have any diagnostic test, surgery or treatment not yet completed? ☐ Yes ☐ No

b. Been a patient of a clinic or hospital emergency room, or had any diagnostic test that was not normal? ☐ Yes ☐ No

c. Used any drug, narcotic or controlled substance not prescribed by a physician, or been arrested, counseled, treated, or participated in a support group because of alcohol, controlled substance or drug use? ☐ Yes ☐ No

9. Within the last 5 years, have you been unable to work, attend school, or perform the normal activities of like age and gender or been confined at home, or in a care facility? ☐ Yes ☐ No

10. Do you currently use alcoholic beverages? ☐ Yes ☐ No

If yes, what is the average number of drinks per day? _____

11. Are you pregnant? ☐ Yes ☐ No If yes, please provide delivery date: ___/___/___

12. Is there a family history of diabetes, cancer, heart disease, mental illness, or any hereditary disorders? ☐ Yes ☐ No

13. Family information (biological parents, siblings):

Family Member	Gender	Age if Living	Age at Death	Cause of Death Details
Father				
Mother				
Sibling(s)				

Provide complete details of any yes answers to questions I.2 through I.12. (Attach separate sheet if necessary, signed and dated by Proposed Insured)

Question Number	Date	Details, Include Diagnosis, Treatment, Duration, Result	Name, Address and Phone Number of Medical Professional

J. TAXPAYER IDENTIFICATION

Backup Withholding - You are subject to backup withholding if:

(1) You fail to furnish your taxpayer identification number to Accordia Life and Annuity Company (the "Company"); OR

(2) The Internal Revenue Service (IRS) notifies the Company that you furnished an incorrect taxpayer identification number; OR

(3) You are notified that you are subject to backup withholding under 26 U.S.C. § 3406(a)(1)(C); OR

(4) You fail to certify to the Company that you are not subject to backup withholding under (3) above, or fail to certify your taxpayer identification number.

To Prevent Backup Withholding

To prevent backup withholding on payments under the policy, provide taxpayer identification numbers where requested in this application. The taxpayer identification number for an individual is their social security number. The taxpayer identification number for a corporation is their employer identification number. In addition to providing taxpayer identification numbers, you must certify that you are not subject to backup withholding. To certify that the Proposed Insured and/or the Owner is not subject to backup withholding, read the certification under the Agreements and Representations section below and sign this application.

K. AGREEMENTS AND REPRESENTATIONS

It is hereby represented that I have read the application(s) and all the answers and statements provided in the application(s) and any documents providing supplemental information (the "Supplements"), and the answers and statements on the application(s) and any Supplements are complete, true and correctly recorded. Information not recorded on the application(s) and any Supplements will not be treated as known to the Company. A copy of the application(s) and any Supplements shall be a part of the policy, and it is agreed that the policy and copy of the application(s) and any Supplements constitute the entire contract. No changes will be made unless the Owner agrees and the change is authorized in writing by an officer of the Company.

If a Conditional Life Insurance Agreement was delivered in consideration of the payment of the first premium and is in effect, its terms will apply. Otherwise, the policy will take effect and coverage will begin on the issue date specified in the policy if the full first premium is paid, the Proposed Insured(s) is/are living, and the answers and statements in the application(s) and any Supplements continue to be complete and true at the time of delivery of the policy.

Under penalties of perjury, I certify that (1) the social security or federal tax identification number shown on page 1 of this application for me as the Owner of this policy is my correct taxpayer identification number, AND (2) I am a U.S. person (including a U.S. resident alien), AND (3) I am not subject to backup withholding because (a) I am exempt from backup withholding, or (b) I have not been notified by the IRS that I am subject to backup withholding as a result of failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding. NOTE: You must cross out item 3 in this certification if you have been notified by the IRS that you are currently subject to backup withholding. The IRS does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

L. IMPORTANT INFORMATION ABOUT THE USA PATRIOT ACT

To help fight the funding of terrorism and money-laundering activities, the U.S. government has passed the USA PATRIOT ACT, which requires financial institutions to obtain, verify and record information that identifies persons who engage in certain transactions with or through a financial institution, including insurance companies. This means that the Company will need to verify the **name, residential or street address (no P.O. Boxes), date of birth and social security number, drivers license and/or other identification information of all Owners as may be required by law.**

M. **SIGNATURES**

I have reviewed and understand the information contained above in the "Taxpayer Identification", "Agreements and Representations", including reviewing the answers and statements on the application(s) and any Supplements for accuracy, and "Important Information About the USA Patriot Act" sections, and further acknowledge receipt of the Disclosure Notice to Proposed Insured and the Authorization and Acknowledgement.

I understand, acknowledge and agree that the Agent/Producer has no authority to make any promise, representation or waiver regarding coverage or the terms of the policy. I also understand, acknowledge and agree that the Agent/Producer has no authority to provide any legal or tax advice on behalf of the Company. If any such legal or tax advice has been given, I understand, acknowledge and agree it has been done without Company authority and has not been given on behalf of the Company. I understand, acknowledge and agree that I am responsible for obtaining independent legal or tax advice with respect to any such matters. I understand, acknowledge and agree that all premium payments after the first are to be provided directly to the Company and that the Agent/Producer has no authority to receive, transmit, sign, endorse, deposit or process any subsequent payments made on the policy.

I have not been involved with and I am not aware of: (1) any planned sale or assignment of this policy to a life settlement or viatical company, secondary market purchaser or investor; (2) any planned sale or assignment of any interest in a trust or entity that shall own or have an interest in this policy; or (3) any offer of money, future payments, "free insurance" or anything of value to any Owner, Proposed Insured or Beneficiary in connection with this application or policy.

I understand the Company and its affiliates, agents and independent contractors may listen to or record telephone calls between me and its representatives without additional notice to me.

For your protection, California law requires the following statement to appear on this application. Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Signature of Proposed Insured (or signature of Insured's Personal Representative*) X		
Signed at: City	State	Date Signed / /
Signature of Owner if other than the Proposed Insured X	**Signature of Licensed Agent/Producer** X	
If Owner is a Corporation, Business firm or Trust, print name and title of individual authorized to sign		
Signature of Authorized Signer X	Title of Authorized Signer	

*If you are signing on behalf of the Proposed Insured, print your name and provide your signature below. Check the box that applies to the capacity in which you are signing. Please also provide documents verifying you are authorized to act on behalf of the Proposed Insured.

☐ Conservator ☐ Guardian ☐ Power of Attorney ☐ Assignee

Signature X	Printed Name	Date Signed / /

AccordiaLife
www.accordia.com

Accordia Life and Annuity Company
P.O. Box 305030, Nashville, TN 37230-5030
Customer Contact Center –
Tel: 877 462 8992 Fax: 800 262 6976

NOTICE AND CONSENT FOR HIV-RELATED TESTING

To evaluate your insurability, the company named above (the Company) may request that you provide a specimen for testing and analysis to determine the presence of human immunodeficiency virus (HIV) antibodies. By signing and dating this form you agree that this test may be done and that underwriting decisions will be based on the test result. A series of three tests will be performed by a licensed laboratory through a medically accepted procedure.

If an HIV Antibody Screen is performed, it will be performed only by a certified laboratory and according to the following medical protocol:

1. An initial ELISA test will be done.
   a) If the initial ELISA test is reactive or indeterminant, it will be repeated.
   b) If the initial ELISA test is nonreactive, a negative finding will be reported to the Company.
2. If the second ELISA test is also reactive or indeterminant, a Western Blot test will be performed to confirm the results of the two ELISA tests.
   a) If the second ELISA test is nonreactive, a third ELISA test will be performed. If the third ELISA test is reactive or indeterminant, a Western Blot test will be performed to confirm the previous results. If the third ELISA test is nonreactive, a negative result will be reported to the Company.
3. Only if at least two ELISA tests and a Western Blot test are all reactive or indeterminant will the result be reported as such. All other results will be reported as negative to the Company.

Meaning of Positive Test Result

The test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus. A positive test result does not mean that you have AIDS but that you are at significantly increased risk of developing problems with your immune system. The test for HIV antibodies is very sensitive. Errors are rare, but they do occur. Your private physician, a public health clinic, or an AIDS information organization in your city might provide you with further information on the medical implications of a positive test.

Positive HIV antibody test results will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged or that other policy changes may be necessary.

Confidentiality of Test Results

All test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed as required by law or to employees of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer or to other persons or organizations performing business or legal services for the Insurer. The results may

be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover results of tests for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular person.

Notification of Test Result

If your test results are negative, no routine notification will be sent to you. If your test results are reported as being reactive or indeterminant, you are entitled to that information if you so desire. Because a trained person should deliver that information so that you can understand clearly what the test result means, please list your private physician below so that the Company can have him or her tell you the test result and explain its meaning. In the event the test is other than nonreactive and you are denied coverage because of that fact and you request the reason for the denial, the insurer may require you to name a physician at that time in order to receive the information.

Consent

I have read and I understand this Notice and Consent for HIV-Related Testing. I voluntarily consent to provide a specimen, the testing of that specimen, and the disclosure of the test results as described above. I have read the information on this form about what a test result means and understand that I should contact a local AIDS service group or my private physician for further information and counseling if the test result is positive.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original. This consent shall be valid for 90 days from the date below.

Name and address of physician for reporting a possible positive test result:

_____

_____

_____

_____
Signature of Proposed Insured or Parent/Guardian

Date Signed: _____

HIV INFORMATION

What Is AIDS?

Acquired immune deficiency syndrome (AIDS) is a serious condition that affects the body's ability to fight infection. A diagnosis of AIDS is made when a person develops a life-threatening illness not usually found in a person with a normal ability to fight infection. The two diseases most often found in AIDS patients are a lung infection called Pneumocystis carinii pneumonia and a rare form of cancer called Kaposi's sarcoma. It is these diseases, not the AIDS virus itself, that can lead to death.

What Causes AIDS?

Researchers have discovered the cause of AIDS—a virus that is called either HTLV-III or LAV. This virus changes the structure of the cell it attacks. Infection with the virus can lead to AIDS or to a less severe condition known as AIDS-related complex (ARC). Some of those persons infected with the virus will develop symptoms of AIDS or ARC. Other people who carry the virus may remain in apparent good health. These carriers can transmit the virus during sexual contact, or an infected mother can transmit the virus to her infant before, during, or after birth (probably through breast milk).

What Are the Symptoms?

Most individuals infected with the AIDS virus have no symptoms and feel well. Some develop symptoms that may include:

Fever, including "night sweats."
Weight loss for no apparent reason.
Swollen lymph glands in the neck, underarm or groin area.
Fatigue or tiredness.
Diarrhea.
White spots or unusual blemishes in the mouth.

These symptoms are also symptoms of many other illnesses. They may be symptoms of AIDS only if they are unexplained by other illness.

How Is the AIDS Virus Spread?

The AIDS virus is spread by sexual contact, needle sharing, or rarely through transfused blood or its components. Multiple sexual partners, either homosexual or heterosexual, and sharing needles by drug users increase the risk of infection with the virus.

Is There a Test for AIDS?

There is an AIDS virus antibody test that detects antibodies to the AIDS virus that causes the disease. The body produces antibodies that try to get rid of bacteria, viruses, or anything else that is not supposed to be in the bloodstream. The test tells if someone has been infected with the AIDS virus. Most people with AIDS have a positive test and some people with a positive test will develop AIDS. The test does not tell who will develop AIDS.

What Does a Positive Test Mean?

It means that a person has been infected with the AIDS virus. Some of these people will develop AIDS. Others who have the virus may stay well, without any symptoms, but can transmit the virus to others.

Where Can I Get Tested?

The test is available at a variety of test sites. It is also available through private doctors and clinics. Information about where to get the test is available from state or local health departments, sexually transmitted disease clinics, doctors' offices, local American Red Cross chapters, and community blood services. Anyone planning to take the test should get advice before the test and understand what the results may indicate. It is important to have counseling after the test.

What Should I Do If I have a Positive Test?

Have a regular medical checkup and get counseling.
Do not donate blood, sperm, or organs.
Do not share drugs with others, and avoid exchanging body fluids during sexual activity (a condom should be used). Avoid oral-genital contact and intimate kissing.
Do not share toothbrushes, razors, or anything that could be contaminated with blood.
Consider postponing pregnancy.

Further information about AIDS can be obtained from your Red Cross chapter, local or state health department, other community agencies, or the Public Health Service Hotline. The Hotline number is 1-800-342-AIDS. Below are some of the counselling resources available in California:

San Francisco
AIDS Foundation
25 Van Ness Avenue
Suite 660
San Francisco, CA 94102
(415) 864-5855

Sacramento AIDS Foundation
1900 K Street
Suite 201
Sacramento, CA 95814
(916) 448-2437

Central Valley
AIDS Team
P.O. Box 4640
Fresno, CA 93744
(209) 264-2436

AIDS Project
Los Angeles
3670 Wilshire Blvd.
Suite 300
Los Angeles, CA 90010
(213) 380-2000

San Diego AIDS Project
3777 Fourth Avenue
San Diego, CA 92103
(619) 543-0300

AIDS Project—East Bay
400 40th Street
Suite 20
Oakland, CA 94609
(415) 420-8181

AIDS Project
595 Millich Drive
Suite 104
Campbell, CA 95008
(408) 370-3272

AIDS Services
Foundation of Orange County
1685-A Babcock Street
Costa Mesa, CA 92627
(714) 646-0411

Disclosure Notice to Proposed Insured

AccordiaLife
www.accordia.com

Mail or fax completed form to:
Accordia Life and Annuity Company
P.O. Box 305030, Nashville, TN 37230-5030

Contact us:
Customer Contact Center – Tel: 877 462 8992 Fax: 800 262 6976

Accordia Life and Annuity Company
215 10th Street, Suite1100, Des Moines, IA 50309

In this Disclosure, "Company" refers to the insurance company named above.
In this Disclosure, "You" and "Your" mean the Proposed Insured.

MIB, Inc.

Information regarding Your insurability will be treated as confidential. The Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc. ("MIB"), a not for profit membership organization of life insurance companies which operates an information exchange on behalf of its members. If You apply to another MIB 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 are interested in such a disclosure. If You question the accuracy of information in MIB's file, You may contact the MIB information office in writing at 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734 and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act.

The Company or its reinsurers may also release information in its file to insurance support organizations, or to other insurance companies to whom You may apply for life or health insurance or to whom a claim for benefits may be submitted. Insurance support organizations include any person or entity that assembles or collects information about individuals primarily for the purpose of providing such information to an insurance company.

INVESTIGATIVE CONSUMER REPORT

In addition to requesting a report from MIB, as a part of the Company's underwriting process the Company may request an investigative consumer information report to confirm and supplement the information on Your application about Your general health, employment and occupation, finances, smoking habits, and hazardous activities. Such a report may also cover Your mode of living, except as may be related directly or indirectly to Your sexual orientation, but including alcohol and drug use, general reputation, and driving record. Some of this information may be obtained through personal interviews with You or Your family, friends, associates, or others with whom You are acquainted. If a consumer information report is requested, You may request to be personally interviewed if You can be contacted during normal business hours. An interview is normally conducted, but You are entitled to make a specific request. You may submit a written request asking to be notified if an investigative consumer report has been prepared. You may also request information on what organization prepared such a report and how to contact that organization.

The Company keeps such information reports confidential and uses them only to evaluate and underwrite Your application. You have a right under the Fair Credit Reporting Act to make a written request to inspect and obtain a copy of a consumer information report. If the Company requests a report and the report has an adverse effect on Your insurability, the Company will notify You in writing and give You the name and address of the reporting company.

USA PATRIOT ACT

To help fight the funding of terrorism and money-laundering activities, the U.S. government has passed the USA PATRIOT Act, which requires financial institutions to obtain, verify and record information that identifies persons who engage in certain transactions with or through such financial institutions, including insurance companies.

This means that the Company will need to verify the name, residential or street address (no P.O. Boxes), date of birth and social security number or other tax identification number, and other information as deemed necessary, of all policy owners.

INFORMATION PRACTICES

Personal information the Company obtains during the underwriting process is private and confidential, and the Company will not disclose it to other persons or organizations without Your written authorization except to the extent necessary to conduct the Company's business, or as permitted or required by law. The Company reserves the right to disclose medical information to a medical professional of Your choice and the right to arrange for an insurance support organization to disclose information on the Company's behalf.

Personal information that may be collected includes mental and physical health conditions, medical history, medical treatment, and information about Your general character, habits, hobbies or avocations, finances, employment, occupation, reputation, or marital status. The information may be collected for the Company by the Company's employees, the Agent, and insurance support organizations that assemble information or prepare investigative consumer reports about You. Information may be collected from personal interviews or by telephone calls with You or Your family, neighbors, friends, business associates, and employers, also from public records, court documents, insurance support organizations and other insurance companies or insurance institutions. If there is a need to contact You by phone, a specially trained representative will call to verify or to ask for additional information relating to the underwriting of Your application.

Delaware Residents:
NOTICE TO POLICYHOLDER

On January 1, 2012, the Delaware Civil Union and Equality Act of 2011 ("the Act") takes effect. The Act, which creates a legal relationship between two persons of the same or opposite sex who form a civil union, provides that parties to a civil union are entitled to the same legal obligations, responsibilities, protections and benefits as those afforded or recognized by the laws of Delaware to spouses in a legal marriage. The Act also provides that a party to a civil union shall be included in any definition or use of the terms "marriage", "married", "spouse", "family", "immediate family", "dependent", "next of kin" or any other descriptive term for a spousal relationship when used in Delaware law including the Delaware Insurance Code.

This notice is to inform You that in compliance with the Act, effective January 1, 2012, under all Accordia Life and Annuity insurance certificates and riders covering Delaware residents, any benefit, coverage or right, governed by Delaware state law, provided to a person considered a spouse by marriage will also be provided to a party to a civil union and any benefit, coverage or right, governed by Delaware state law, provided to a child of a marriage will also be provided to a child of a civil union.

Federal law may impact how certain spousal rights and benefits within some insurance products are treated. For example, federal tax laws that afford favorable income-deferral options to an opposite-sex spouse under the internal revenue code do not currently extend such rights to a same-sex spouse (e.g., the Federal Defense of Marriage Act).

More information on the Act or how it affects insurance coverage is available by calling Accordia Life and Annuity Company at 877 462 8992.

Illinois Residents:
NOTICE

The Illinois legislature created the Religious Freedom Protection and Civil Union Act ("The Act") effective June 1, 2011. The Act creates a legal relationship between two persons of the same or opposite sex who form a civil union and the parties to a civil union are entitled to the same legal obligations, responsibilities, protections and benefits that are afforded or recognized by the laws of Illinois to spouses. This policy being applied for and the administration of it comply with the Act.

DISCLOSURE OF INFORMATION AND RIGHT OF ACCESS TO INFORMATION

The Company may disclose personal information about You without prior authorization under certain circumstances. For instance, disclosure may be made to persons or organizations to allow such persons or organizations to perform a business, professional, or insurance function for the Company, or an insurance support organization, or to provide information to determine eligibility for insurance benefits or detect fraud, misrepresentation, or material non-disclosure. The Company may give information to accounting firms performing audits, governmental agencies reviewing Company practices, or attorneys hired to protect the Company's legal interest.

Information may be disclosed to reinsurance companies or another insurance company to which You have applied for coverage or benefits. Information may be furnished to agents to aid them in providing adequate service to a policy owner. Other disclosures may be made as permitted or required by law. The Company may also disclose information to medical professionals where required by law for the purpose of informing You of a medical problem

of which You may not be aware or to persons or organizations for the purpose of conducting research including actuarial, marketing, and underwriting studies. This may include various insurance industry groups which conduct studies about risk experience or medical backgrounds of insured lives. No medical record information or personal information relating to Your character, personal habits, mode of living, or general reputation will be released to anyone who receives personal information for purposes of marketing a product or service.

Upon Your written request, the Company will inform You of all persons or entities to whom the Company, the Agent, or any insurance support organization has released Your personal information during the 2 years prior to Your request.

You have a right of access to Your personal information that the Company has collected, and a right to know from what sources it was collected. You may submit a written request to the Company that includes Your full name, address, and policy number and reasonably describes the information desired. The Company will mail the information to You or You may review such personal information in person at one of the Company's offices. The Company will inform You of the nature and substance of the information within 30 days from receipt of the request. The Company will identify sources of information such as hospitals, clinics, doctors, or insurance support organizations. The Company will not identify sources of information where such information was obtained from individuals such as friends or neighbors. The Company will not provide access to information obtained in connection with or in anticipation of a claim for policy benefits, or as part of a civil or criminal proceeding.

You may request that the Company correct, amend, or delete personal information in whole or in part by making written request to the Company. Within 30 days from receipt of the request, the Company will inform You that the Company has either changed such information or the Company will communicate the reasons for not changing such information. If the Company does not make the requested change(s), You may then submit a written statement to the Company setting forth Your opinion regarding the information and/or the reasons why You disagree with the Company's position. All written communications will become part of the policy file.

In any case, the Company will provide either the corrected personal information, or Your request and statement, to all insurance support organizations with whom the Company has shared such information during the previous 7 years. The Company will also notify any specific persons or entities that You direct the Company to inform, who may have received such information during the previous 2 years.

Alaska Residents:
DISCLOSURE TO POLICYHOLDER
Upon written request, Accordia Life and Annuity is requested to provide, within ten days, reasonable factual information regarding the benefits and provisions of this policy to you. If, for any reason, you are not satisfied with the policy, within 20 days (30 days in the case of a replacement) from the policy delivery date you may return the policy and receive a refund of all money paid.

Massachusetts Residents:
You may also request that the Company provide you with detailed information concerning your rights established under Massachusetts Insurance Code 1751:4(b) and how to exercise those rights by contacting us in writing or by telephone at the contact information at the top of page one of this Disclosure Notice.

Authorization and Acknowledgement

AccordiaLife
www.accordia.com

Mail or fax completed form to:
Accordia Life and Annuity Company
P.O. Box 305030, Nashville, TN 37230-5030

Contact us:
Customer Contact Center – Tel: 877 462 8992 Fax: 800 262 6976

Accordia Life and Annuity Company
215 10th Street, Suite1100, Des Moines, IA 50309

Any alteration of this form will not be accepted.

This authorization complies with the HIPAA Privacy Rule.

Name of Proposed Insured	Birth Date (mm/dd/yy) / /

A. AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I authorize the Accordia Life and Annuity Company (the "Company"), its reinsurers, or its authorized representatives, to obtain from MIB, Inc. or any other consumer reporting agency or employer one or more consumer reports including, but not limited to, a credit report, about me, which may include information about my physical or mental health.

I understand that an investigative consumer report may be prepared in connection with this application. I authorize the Company, its reinsurers, or its authorized representatives, to prepare or obtain from any consumer reporting agency one or more investigative consumer reports about me. **With the exception of Arizona residents,** I understand that an investigative consumer report involves personal interviews with sources such as neighbors, friends, or associates, and may include information as to my character, general reputation, personal characteristics, and mode of living. **For residents of Arizona,** I understand that an investigative consumer report involves personal interviews with sources such as neighbors, friends, or associates, and may include information as to my character and general reputation. I understand these investigative consumer reports contain information regarding income, net worth, business information, hazardous sports, avocations, driving history, occupation, credit history, or criminal history.

This authorization shall remain in force for 24 months following the date of my signature on this form.

For residents of all states, I understand that I may request to be personally interviewed if an investigative consumer report is prepared or obtained in connection with this application. I further understand that, if an investigative consumer report is prepared or obtained, I have the right to request in writing, within a reasonable time, a complete and accurate disclosure of the nature and scope of the investigation, a copy of the investigative consumer report, and a summary of my rights under the Fair Credit Reporting Act.

I authorize the Company, its reinsurers, or its authorized representatives, to release information obtained in connection with this application including, but not limited to, any consumer reports, investigative consumer reports, or personal health information to reinsurers, the MIB, Inc. or other persons or organizations performing business or legal services in connection with my application, claim, or as may be permitted or required by law, or as I may further authorize.

B. AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION

To evaluate my eligibility for insurance coverage, I authorize any licensed physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, health care provider, health plan, insurer, and/or any other entity subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that has provided treatment service, payment, or coverage to me within the past 10 years to disclose my entire medical record and any other protected health information concerning me to the Company, its agents/producers, employees, representatives, insurance support organizations, and reinsurers. Protected health information includes but is not limited to: hospital records, treatment records/office notes, consultation reports, workers' compensation information, diagnosis, prescriptions, and test results. It also includes information concerning the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection (see below for state-specific exclusions concerning disclosure of HIV-related information), sexually transmitted diseases, and information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

FOR RESIDENTS OF MAINE: This authorization excludes the disclosure of the result of a test for HIV if the applicant has tested HIV positive but has not developed symptoms of the disease AIDS. Such tests shall not be discovered or published. Nothing in this caveat will prohibit this authorization from including the fact that the applicant has AIDS.

FOR RESIDENTS OF MINNESOTA: This authorization excludes the release of information about HIV (AIDS) virus tests which were administered (1) to a criminal offender or crime victim as a result of a crime that was reported to the police; (2) to a patient who received the services of emergency medical services personnel at a hospital or medical care facility; (3) to emergency medical personnel who were tested as a result of performing emergency medical services. The term "emergency medical personnel" includes individuals employed to provide pre-hospital emergency services; licensed policeE officers, firefighters, paramedics, emergency medical services; crime lab personnel, correctional guards, including security guards at the Minnesota security hospital, who experience a significant exposure to an inmate who is transported to a facility for emergency medical care; and other persons who render emergency care or assistance at the scene of an emergency, or while an injured person is being transported to receive medical care and who would qualify for immunity under the good samaritan law.

FOR RESIDENTS OF VERMONT: This authorization EXCLUDES the release of any information relating to ANY previously administered tests for the HIV antibody, T-Cell counts, AIDS, or ARC. Further, the results from any new test requested of me by the Company will NOT be forwarded to any outside, non-affiliated company or to any entity not under specific contract with the Company to perform underwriting services.

FOR RESIDENTS OF WISCONSIN: The reporting of AIDS/HIV test results is limited only to the results of FDA-licensed tests and that the consumer need not report the results of the tests conducted at an anonymous counseling testing site, or home test kit.

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 any physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, health care provider, health plan, insurer, and/or other entity subject to HIPAA to release and disclose such information. I understand that, unless prohibited by state and/or federal law, the protected health information is to be disclosed under this authorization so that the Company may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment 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, have applied for, or may in the future apply for with the Company. I understand any information disclosed under this authorization may no longer be covered by federal rules governing privacy and confidentiality of health information and may be subject to redisclosure (**For residents of Colorado**, the Company will not redisclose information received pursuant to this authorization without my written authorization)

This authorization shall remain in force for 24 months following the date of my signature on this form (**Except for residents of Arizona**, authorization to disclose HIV-related information is valid for 180 days from the date of the signature below). If this authorization is signed and the Company is collecting information in connection with a claim for life insurance benefits, this authorization shall remain valid for no longer than the duration of the claim. A copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization at any time. The request for revocation must be in writing and sent to the attention of the Underwriting Department of the Company at the address listed above. I understand that the request for revocation may be a basis for denying an application or a claim for benefits. I also understand that a revocation is not effective to the extent that the Company has already relied on this authorization or to the extent that has a legal right to contest a claim under an insurance policy or to contest the policy itself. Such revocation shall not apply to any use or disclosure of my protected health information specifically allowed without authorization by HIPAA and no action relating to this authorization shall be construed as creating any restriction on the uses that HIPAA allows without my authorization.

I understand that failure to sign this authorization may impair the ability of a regulated insurance entity to evaluate claims or process applications and may be a basis for the Company to deny an application or claim for benefits. By signing below, I acknowledge that I have received a copy of this authorization.

Signature of Proposed Insured or Personal Representative X	Date (mm/dd/yy) / /

If you are the Personal Representative of the Proposed Insured, describe the scope and/or basis of your authority to act on the Insured's behalf:

Electronic Funds Transfer (EFT) Authorization For Direct Payments (ACH Debits)
Pre-Authorized Check (PAC) Authorization Form
Life Policies Only

AccordiaLife
www.accordia.com

Mail or fax completed form to:
PO Box 305030, Nashville, TN 37230-5030
Fax: 800 262 6976

Contact us:
Customer Contact Center – Tel: 877 462 8992

Accordia Life and Annuity Company
215 10th Street, Suite 1100, Des Moines, IA 50309

First Allmerica Financial Life Insurance Company
132 Turnpike Road, Suite 210, Southborough, MA 01772

INSTRUCTIONS

Use this form to transfer funds systematically from your bank into your life policy.

1. OWNER INFORMATION

Individual, Trustee or Company Name				
If Trust, list Trust Name and Trust Date		Email Address		
Policy Number(s)		☐ Address Change Requested*		
Mailing Address	City	State	Zip	Country
Street Address (**REQUIRED** if mailing address is a PO Box)	City	State	Zip	Country
Social Security Number (last four digits) X X X - X X -	Date of Birth (mm/dd/yy) / /	Personal Phone ( ) -		

*** For your protection, if you changed your address, confirmation of the change will be sent to both the old and new address.**

2. PREMIUM PAYOR AND BANK INFORMATION

I (we) hereby authorize the company to start debit entries as follows:

Name of Account (as it appears on the account)	Bank Name

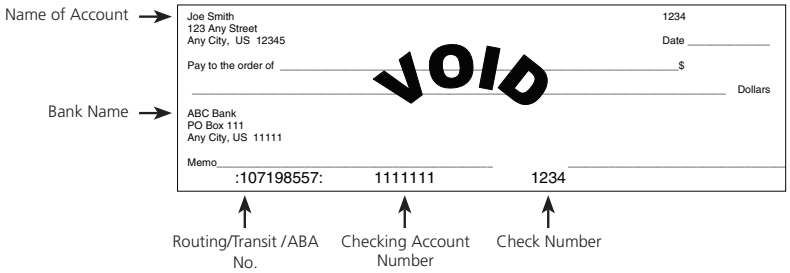
Routing Number (Bottom left of check)

Account Number (Bottom center of check)

Type of account: ☐ Checking - Please attach a voided check for the listed account.

☐ Savings - Please attach a deposit slip for the listed account.

If you are unsure about the correct way to complete the form, please reference the following sample check information.



Electronic Funds Transfer (EFT) Authorization For Direct Payments (ACH Debits)
Pre-Authorized Check (PAC) Authorization Form
Life Policies Only

3. YOUR DIRECT PAYMENT OPTIONS

Please select one option: The EFT Direct Payment (PAC) will be the same as the policy date unless otherwise indicated.

☐ First Request for EFT Direct Payments (PAC): A check with receipt of funds is needed for initial premium payments. First or initial premiums cannot be drawn automatically.

☐ Update existing bank information on additional policies: _____
(list policy numbers)

☐ Change of Bank, Account Number or Premium Payor.

☐ Premium Payment Amount: $ _____ ☐ Loan Payment Amount: $ _____

Frequency: Direct Payments are done on a monthly basis.

Please start my withdrawals on: ____ / ____ / ____ (mm/dd/yyyy) Please indicate day, 1st - 28th.

The date of withdrawal is the date the funds are removed from your bank account, not the date they are posted into your Policy. Please allow 2-3 business days for funds to transfer into your Policy. Due to the pre-note process at your bank, it may take 10-14 days to setup the first withdrawal of funds. If changes are requested, please allow 15 days for processing.

4. YOUR CONFIRMATION

I acknowledge that: 1) This request is to remain in full force and effect until the company has received notification of termination in such time and in such manner as to afford the company and the Depository a reasonable opportunity to act on the notification; 2) My financial institution shall be fully protected in honoring any such debit entry and may at any time cease its participation in and compliance with this request and authorization by giving thirty (30) days written notice to me and the company; 3) If any debit is dishonored, whether with or without cause and whether intentionally or inadvertently, the company shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance; 4) If the payment is not honored by my financial institution, this agreement and future EFT transactions may be terminated by the company, at which time repayment notices will be sent directly to my address of record; 5) I understand this form is a bank authorization only and there will be no charge to my account until and unless a policy of insurance is issued by the company; 6) I understand that completion of this form DOES NOT provide coverage under a Conditional Life Insurance Agreement.

Signature of Owner X	Date / /
Additional Signature (if account requires) X	Date / /
Signature of Premium Payor (if other than Owner) X	Date / /

If you are signing on behalf of the owner, check one of the boxes to indicate the capacity in which you are signing and provide documentation to verify your authorization to act on behalf of the owner.

☐ Conservator ☐ Guardian ☐ Power of Attorney

Signature X	Date / /
Print Name	Title

We appreciate your business and are committed to providing you with accurate and caring service. If you have any questions or need additional information, please contact your Insurance Professional or our Customer Contact Center.

Conditional Life Insurance Agreement

AccordiaLife
www.accordia.com

Accordia Life and Annuity Company
P.O. Box 305030
Nashville, TN 37230-5030
Customer Contact Center – Tel: 877 462 8992 Fax: 800 262 6976

AGENT/PRODUCER CODE:
AGENT/PRODUCER NAME:

(In this receipt, "Company" refers to the insurance company named above)

ADDITIONS, DELETIONS, OR OTHER ALTERATIONS TO THIS AGREEMENT ARE STRICTLY PROHIBITED.

Insurance applied for on the application is provided by this form from the START DATE to the STOP DATE, as defined below. However, NO INSURANCE is provided unless ALL the CONDITIONS AND LIMITATIONS of this Agreement are met. If not met, the Company's liability under this Agreement is limited to a refund of the total premium received.

DO NOT COLLECT CASH IF DEATH BENEFIT AMOUNT APPLIED FOR EXCEEDS $3,000,000.

CONDITIONS AND LIMITATIONS

1. It is a condition precedent that the proposed insured be insurable on the START DATE. This means "insurable" under our rules and limits.
2. There is no insurance before the START DATE.
3. There is no insurance after the STOP DATE.
4. There is no insurance if any material misrepresentation exists on the application or supplements.
5. This form is void if any check or draft is not valid.
6. There is no insurance if less than a full month premium is paid.
7. Life Insurance limits are the lesser of:
   a. $500,000 or the amount in Section D of the application, if the proposed insured is insurable at the rate applied for or better; or
   b. $100,000 or the amount in Section D of the application, if the proposed insured is insurable, but at a higher rate than applied for.
8. If the proposed insured dies by suicide, the Company's liability under this agreement is limited to a refund of the payment received.

START DATE

START DATE means the later of:

1. completion of all parts of the application and supplements thereto; OR
2. the date any medical exam or other required medical studies or tests are completed.

STOP DATE

STOP DATE means the earliest of:

1. the date a non-acceptance notice is mailed by the Company; OR
2. the day before the policy date; OR
3. 60 days after the START DATE.

RECEIVED from _____ Payment in the Amount of $ _____

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE COMPANY. DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE PAYEE BLANK. ALL PREMIUMS AFTER THE FIRST ARE TO BE PROVIDED DIRECTLY TO THE COMPANY.

Signature of Proposed Insured X		
Signed at: City	State	Date Signed / /
Signature of Owner if other than the Proposed Insured X	Signature of Licensed Agent/Producer X	

PLEASE RETURN ONE COPY TO HOME OFFICE WITH CHECK

Conditional Life Insurance Agreement

AccordiaLife
www.accordia.com

Accordia Life and Annuity Company
P.O. Box 305027
Nashville, TN 37230-5027
Customer Contact Center – Tel: 877 462 8992 Fax: 800 262 6976

AGENT/PRODUCER CODE:
AGENT/PRODUCER NAME:

(In this receipt, "Company" refers to the insurance company named above)

ADDITIONS, DELETIONS, OR OTHER ALTERATIONS TO THIS AGREEMENT ARE STRICTLY PROHIBITED.

Insurance applied for on the application is provided by this form from the START DATE to the STOP DATE, as defined below. However, NO INSURANCE is provided unless ALL the CONDITIONS AND LIMITATIONS of this Agreement are met. If not met, the Company's liability under this Agreement is limited to a refund of the total premium received.

DO NOT COLLECT CASH IF DEATH BENEFIT AMOUNT APPLIED FOR EXCEEDS $3,000,000.

CONDITIONS AND LIMITATIONS

1. It is a condition precedent that the proposed insured be insurable on the START DATE. This means "insurable" under our rules and limits.
2. There is no insurance before the START DATE.
3. There is no insurance after the STOP DATE.
4. There is no insurance if any material misrepresentation exists on the application or supplements.
5. This form is void if any check or draft is not valid.
6. There is no insurance if less than a full month premium is paid.
7. Life Insurance limits are the lesser of:
   a. $500,000 or the amount in Section D of the application, if the proposed insured is insurable at the rate applied for or better; or
   b. $100,000 or the amount in Section D of the application, if the proposed insured is insurable, but at a higher rate than applied for.
8. If the proposed insured dies by suicide, the Company's liability under this agreement is limited to a refund of the payment received.

START DATE

START DATE means the later of:

1. completion of all parts of the application and supplements thereto; OR
2. the date any medical exam or other required medical studies or tests are completed.

STOP DATE

STOP DATE means the earliest of:

1. the date a non-acceptance notice is mailed by the Company; OR
2. the day before the policy date; OR
3. 60 days after the START DATE.

RECEIVED from _____ Payment in the Amount of $ _____

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE COMPANY. DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE PAYEE BLANK. ALL PREMIUMS AFTER THE FIRST ARE TO BE PROVIDED DIRECTLY TO THE COMPANY.

Signature of Proposed Insured X		
Signed at: City	State	Date Signed / /
Signature of Owner if other than the Proposed Insured X	Signature of Licensed Agent/Producer X	

PLEASE RETURN ONE COPY TO HOME OFFICE WITH CHECK

Agent/Producer Report

AccordiaLife
www.accordia.com

Accordia Life and Annuity Company
P.O. Box 305030
Nashville, TN 37230-5030
Customer Contact Center – Tel: 877 462 8992 Fax: 800 262 6976

AGENT/PRODUCER CODE:

AGENT/PRODUCER NAME:

AGENT INSTRUCTIONS

All questions must be completed in full. In this application, "Company" refers to Accordia Life and Annuity Company.

AGENT QUESTIONS

1. Does the Proposed Insured have any life insurance or annuity contract(s) currently active with our Company or any other company? . . . . . ☐ Yes ☐ No
2. Will any annuity or life insurance presently or recently in-force be replaced or changed by this policy applied for? . . . . . ☐ Yes ☐ No

   If 2 is answered yes, please complete questions a-k, otherwise skip to question 3.

   (State required replacement forms (Replacement Comparison, Notice or Statement) must accompany this application)

   a. What is the primary reason for the replacement?
   b. Are you the writing Agent/Producer on the current policy(ies)? . . . . . ☐ Yes ☐ No
   c. When was the current policy(ies) issued?
   d. With what underwriting classification was the current policy(ies) issued?
   e. What are the current/proposed annualized premiums?
   f. What are the current/proposed death benefit amounts?
   g. What are the remaining surrender charges on the current policy(ies)?
   h. Have you discussed/described the surrender charges and surrender charge period regarding the proposed policy? . . . . . ☐ Yes ☐ No
   i. If values from an existing annuity contract(s) are being used to pay premiums on the proposed policy, how has the original objective of the annuity contract(s) changed?
   j. If values from an existing annuity contract(s) are being used to pay premiums on the proposed policy, have the tax implications been explained to the customer? . . . . . ☐ Yes ☐ No
   k. 1035 Exchange ☐ External ☐ Internal Attach 1035 forms

3. a. How long have you known the Proposed Insured?

   b. Is the Proposed Insured a relative of or does the Proposed Insured have a business relationship with you? . . ☐ Yes ☐ No

   If yes, explain

   c. Did you personally see the Proposed Insured to be covered and were answers recorded exactly as given? . . . ☐ Yes ☐ No

   If no, explain and arrange for additional evidence of insurability

   d. I personally viewed all driver's licenses or other government issued photo identification documents . . . . . ☐ Yes ☐ No
4. Does the Proposed Insured and Owner speak and understand English? . . . . . ☐ Yes ☐ No

AGENT QUESTIONS (continued)

5. Was any other person present to answer questions? . . . . . ☐ Yes ☐ No

If yes, who and why

6. a. **If the Proposed Insured is a minor dependent, complete for all brothers and sisters:**

Age	Gender	Amount of Life Insurance In-force

Age	Gender	Amount of Life Insurance In-force

b. Amount of life insurance in-force on each supporting parent or legal guardian $

7. Will any policy issued as a result of this application have any portion of the initial or future premiums paid, or otherwise provided, by anyone other than the insured, their family or employer? . . . . . ☐ Yes ☐ No

If yes, explain

8. In the last 5 years, has the Owner or Proposed Insured sold a life insurance policy or annuity contract to a life settlement or viatical company, secondary market purchaser or investor? . . . . . ☐ Yes ☐ No

9. Will any person or entity, other than a life insurance company, evaluate the Proposed Insured to provide any form of life expectancy evaluation? . . . . . ☐ Yes ☐ No

10. Is the Proposed Insured an active duty (full-time) service member (officer or enlisted) of the United States Armed Forces (Army, Navy, Air Force, Marine Corps, and Coast Guard)? . . . . . ☐ Yes ☐ No

11. Is the Owner an active duty (full-time) service member (officer or enlisted) of the United States Armed Forces (Army, Navy, Air Force, Marine Corps, and Coast Guard)? . . . . . ☐ Yes ☐ No

If answering yes, please complete the Sale to Military Personnel Disclosure Form

12. Medical requirements arranged: ☐ Paramedical Exam ☐ EKG ☐ Blood Analysis ☐ Physician's Exam

Date Scheduled ☐ Check here if the exam has already been done.

Name & Phone number of vendor

13. If Married:

Spouse's Name Spouse's Occupation

Amount of life insurance in force on spouse $ Spouse's annual earned income $

14.a. Purpose of insurance ☐ Business ☐ Personal ☐ Estate

(If multi-purpose, give percentage of face or split the amount by purpose in the box below)

b. If Business: ☐ Deferred Comp ☐ Buy/Sell ☐ Split Dollar ☐ Key Person ☐ Premium Financing

☐ Other

Business net annual income $ Business net worth $

Proposed Insured's business life insurance in-force $ % of ownership

Business life insurance issued or applied for on other owners, officers, partners or key person(s):

Name and Title	% of Business Owned	Insurance Company	Amount In-force
			$
			$

ADDITIONAL INSURANCE

15. ☐ Additional policy: Amount $ _____ Plan _____

☐ Alternate policy: Amount $ _____ Plan _____

16. How did this sale originate?

AGENT CERTIFICATION

I certify that I saw and know the Proposed Insured to be the person described in this application. I reviewed the appropriate documents, and have truly and accurately recorded the information supplied by the Proposed Insured. I know of no condition affecting the eligibility or insurability of the Proposed Insured not fully set forth in the application. I have made no declaration, representation, or waiver regarding coverage or the provisions or terms of the application or policy. I am licensed in the state in which this application was completed. I have delivered all required notices and disclosures and fully complied with all privacy and replacement regulations. All state approved disclosure notices, statements or other information required by state or federal laws were given to the Owner at the time of application and only Company authorized sales materials were used.

I have read and understand Accordia's policies regarding Stranger Owned Life Insurance (STOLI) and Premium Financing, and to the best of my knowledge, the insurance policy being applied for does not violate the stated intent or spirit of either such policy. I have not promoted, been involved with and I am not aware of: (1) any planned sale or assignment of this insurance policy to a life settlement or viatical company, secondary market purchaser or investor, (2) any planned sale or assignment of any interest in a trust or entity that shall own or have interest in this insurance policy, or (3) any Owner, Proposed Insured or Beneficiary receiving or being offered money, future payments, "free insurance" or anything of value in connection with the insurance policy being applied for. I assume full responsibility for the delivery of the policy and the submission of the first premium.

List of all agents (please print)	Agent Code Number	Commission Share

Signed at:	Writing Agent Signature X
Date:	Phone Number Fax Number
E-Mail	Preferred mode of communication? ☐ Phone ☐ E-mail ☐ Fax

Strategy Allocation Request – Life

AccordiaLife
www.accordia.com

Mail or fax completed form to:
Accordia Life and Annuity Company
P.O. Box 305030, Nashville, TN 37230-5030

Contact us:
Customer Contact Center – Tel: 877 462 8992 Fax: 800 262 6976

AGENT/PRODUCER CODE & NAME:

A. INFORMATION ABOUT THE INSURED

First Name	M. I.	Last Name	Suffix

Social Security Number XXX-XX-	Date of Birth (MM/DD/YY)

Mailing Address	City	State	Zip	Country

How Strategy Allocations Work:

- You have choices – in the form of strategies – on how to manage a portion of the net premiums depending upon your life insurance policy objectives. "Net premiums" are the premiums paid less a percentage charge (varies depending upon your product). Policy charges and insurance costs for approximately one year are held in the Basic Interest Strategy. Any additional net premiums beyond this can be directed into the strategies you select.
- Checkmarks represent strategies available on each product.
- Allocation Percentage must be in 1% increments.
- The sum of the Allocation Percentage must equal 100%.

Instructions:

- Please allocate my life insurance premium to the strategies indicated below:

Strategy	Lifetime Builder	Survivorship Builder	Accordia Life Provider	Allocation Percentage
One-Year Point-to-Point Increased Participation	✓	✓	✓	%
One-Year Point-to-Point Indexed Strategy	✓	✓	✓	%
One-Year Point-to-Point International Index	✓	✓	✓	%
One-Year Point-to-Point Elevated Cap	✓	✓	✓	%
One-Year Monthly Cap	✓	✓	✓	%
Two-Year Point-to-Point	✓	✓	✓	%
One-Year Fixed Term	✓	✓	✓	%
				100%

I authorize Accordia Life and Annuity Company to allocate premium net as shown in the table above.

Signature of Owner	
If Owner is a Corporation, Business firm or Trust, print name and title of individual authorized to sign	
Signature of Authorized Signer X	Title of Authorized Signer

Accordia Life and Annuity Company
HOME OFFICE: 215 10th Street, Suite 1100, Des Moines, IA 50309
ADMINISTRATIVE OFFICE: PO Box 305030, Nashville TN, 37230-5030
(877) 462-8992
www.accordia.com

TERMINAL ILLNESS ACCELERATED DEATH BENEFIT RIDER
POLICY OWNER DISCLOSURE

WHAT IS THE RIDER?

This Rider is a way to provide benefits if the Insured becomes terminally ill. The benefits can be used to fit your individual needs; whether to help cover medical costs, provide a replacement income, or help manage other expenses. These funds can be used however you wish to use them.

HOW DOES IT WORK?

Upon proof that the base policy insured on a single life policy (or the sole surviving base policy insured on a survivor life policy) is terminally ill with a life expectancy of 12 months or less, an Accelerated Benefit may be paid to the Owner. The Accelerated Benefit will equal either $250,000, or 50% of the Eligible Amount (whichever is less), reduced by any outstanding policy loans.

WHAT DOES IT COST?

The Rider adds nothing to your current premium or monthly deduction. A one time administrative fee of up to $300 may be charged at the time benefits are applied for under the Rider. If an administrative fee is charged, we will deduct it from the amount of the initial Accelerated Benefit paid. We will notify you if an administrative fee is to be charged.

HOW DOES THIS AFFECT MY POLICY?

When an Accelerated Benefit is paid, a lien is established against your policy. The Accelerated Benefit lien will be charged interest. The interest rate is the same as the policy's loan interest rate unless a loan provision is not included in your policy. If there is no loan provision, the interest rate will not exceed the greatest of:

a) the current yield on the ninety-day Treasury bill; or
b) the published monthly average (Moody's Corporate Bond Yield Average – Monthly Average Corporate as published by Moody's Investors Service, Inc., or its successor) for the calendar month ending two months prior to the date the rate is determined; or
c) the Guaranteed Interest Rate as shown on the Policy Data Page, plus 1% per annum.

On a policy anniversary, if lien interest is not paid, it will be added to the lien at the same interest rate.

Your policy premiums or monthly deductions are still payable after taking an Accelerated Benefit unless they are being provided under any Waiver of Premium or Waiver of Monthly Deduction provisions. Access to the net cash value of your policy, if any, through policy loans, partial withdrawals or full surrender will be limited to any excess of the net cash value over the lien amount. The ultimate death proceeds will be reduced by the amount of the Accelerated Benefit paid.

ARE THE BENEFITS TAXABLE?

Benefits under this Rider may or may not be taxable. You should seek assistance from your personal tax advisor before exercising this Benefit. You should also consider that receiving or having the contractual right to receive such benefits may affect your eligibility for Medicaid or other government benefits or entitlements.

Insured	Date
Owner	Date
Agent	Date

AccordiaLife
www.accordia.com

Accordia Life and Annuity Company
P.O. Box 305030, Nashville, TN 37230-5030
Customer Contact Center –
Tel: 877 462 8992 Fax: 800 262 6976

NOTICE REGARDING REPLACEMENT

REPLACING YOUR LIFE INSURANCE POLICY OR ANNUITY?

Are you thinking about buying a new life insurance policy or annuity 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 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.

_____	_____	_____
(applicant)	Signature and Printed Name (agent)	(date)

NOTICE: In the case of a replacement, you have the right to return the policy or contract within 30 days of its delivery and receive a full refund of all premiums or considerations paid, including any policy fee or charges.

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

Insurer as it appears on the policy	Insured as it appears on the policy	Policy Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

RETURN TO ACCORDIA, PROVIDE COPY TO APPLICANT, KEEP COPY FOR YOUR RECORDS