Application for Individual Life Insurance

Pacific Life Insurance Company
750 Main Street, Lynchburg, VA 24504
P.O. Box 42000, Lynchburg, VA 24506
(844) 276-5759, Fax (844) 520-1618
www.PacificLife.com

PACIFIC LIFE

Pacific Life Insurance Company

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LICENSED INSURANCE PRODUCER CHECKLIST FOR LIFE INSURANCE PART I

Please complete the application properly and ensure that you have satisfied all of our requirements. Follow the submission instructions provided through your marketing distribution channel. We sincerely appreciate your business.

This checklist is not part of the application. Please remove this page before submitting the application to the Insurer.

Be sure to…

- Give the *Notice to Proposed Insured and Owner* to the Proposed Insured or Owner before completing the application.
- Ask all questions and fully and accurately record all given answers – the application will be part of any policy issued.
- Enter the Proposed Insured's SSN, date of birth, address and phone numbers.
- Enter each beneficiary's SSN, date of birth, address and phone numbers – it will help us locate the beneficiary at time of claim.
- Print in dark ink.
- Obtain all necessary signatures.
- Complete and sign the Licensed Insurance Producer's report, located after the application.
- Promptly schedule any required medical exam.
- Obtain proper identification and sufficient information about the customer and source of funds to ensure that money laundering is not involved in the transaction.
- If you accept payment with the application:
  - Accept payment only in the form of currently dated check or money order made payable to the selected insurer.
  - Enter the full amount accepted in Section 7e. on page 2.
  - If the answer to any of the questions is "Yes", the Proposed Insured is not eligible for temporary coverage, and no TIAA form or premium should be accepted.
  - Explain the terms and conditions of the TIAA to the Owner and Proposed Insured and have them sign it. Point out that the date of the policy will be the TIAA date and premiums will be due from that date.
  - Complete and sign the Licensed Insurance Producer's Statement on the TIAA.
  - Give the Owner the COPY of the TIAA. Keep the ORIGINAL with the application.
  - Promptly send the payment and the Application Part I, including the ORIGINAL of the TIAA.
- For Term – explain that for premiums not paid on an annual basis at the beginning of a policy year, we adjust the annual premium by a modal factor to compensate for the lost investment earnings, additional administrative costs, and expected early lapses. These modal factors are available and will be provided on request.

Do Not…

- Use pencil or correction fluid
- Attempt to waive any of our requirements or any information that we request; you do not have the authority to make or modify contracts.
- Promise or imply that we will provide insurance.
- Accept payment in the form of cash/currency or Traveler's checks.
- Accept a check or money order made payable to you or with the payee left blank.
- Accept payment when the amount applied for plus existing insurance with the Insurer exceed $1,000,000.
- Accept payment if the Proposed Insured's age nearest birthday exceeds 70 years.
- Accept payment if any question on the Temporary Insurance Application is answered "Yes" or left blank.

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APPLICATION FOR INDIVIDUAL LIFE INSURANCE — PART I

1. Proposed Insured information

First name . Middle name . Last name *(include maiden name)* .

◯ Male ◯ Female | Date of birth . | State/Country of birth . | Social security number .

Home address . City . State . Zip code .

Email address . How long at home address? .

• **Is the Proposed Insured a United States citizen?** ◯ Yes ◯ No ***If "No,"*** *complete the Resident Alien Supplement form.*

Driver's license number/State . **Marital status** *Select one* ◯ Single ◯ Married ◯ Divorced ◯ Widowed

Home phone number . Work phone number . Cell phone number .

Occupation *(include duties)* .

Employer name and address . How long with employer? .

2. Owner information *Complete ONLY if Owner is someone other than the Proposed Insured. If Trust, give full name of trust and date of trust agreement.*

Owner (Full Name) .

Address . City . State . Zip code .

Relationship to Proposed Insured . Email address .

Social security/Tax ID number . Date of birth/Trust .

Home phone number . Work phone number . Cell phone number .

Owner Type *Select One* ◯ Individual ◯ Trust ◯ Corporation ◯ Limited liability company ◯ Limited liability partnership ◯ General partnership ◯ Sole proprietor ◯ Other *(Specify)*: .....

If Owner above is an individual, complete citizenship information below.

• Is the Owner a United States citizen? ◯ Yes ◯ No State/Country of birth .

If "No," complete the *Owner Resident Alien Supplement form.*

If Owner above is a business, complete the business questions below.

Purpose of business . State/country of incorporation/formation . Date of incorporation/formation .

Contingent Owner (Full Name) .

Address . City . State . Zip code .

Relationship to Proposed Insured . Email address .

Social security/Tax ID number . Date of birth/Trust .

Home phone number . Work phone number . Cell phone number .

Contingent Owner Type *Select One* ◯ Individual ◯ Trust ◯ Corporation ◯ Limited liability company ◯ Limited liability partnership ◯ General partnership ◯ Sole proprietor ◯ Other *(Specify)*: .....

2. Owner information *continued*

If Contingent Owner above is an individual, complete citizenship information below.

• Is the Contingent Owner a United States citizen? ◯ Yes ◯ No State/Country of birth

If "No," complete the *Owner Resident Alien Supplement form.*

If Contingent Owner above is a business, complete the business questions below.

Purpose of business | State/country of incorporation/formation | Date of incorporation/formation

3. Beneficiary information *If percentage shares are not given, they will be equal. Use section 12 **REMARKS** to name additional beneficiaries.*

Primary Beneficiary (Full Name)

Address | City | State | Zip code

% Share | Relationship to Proposed Insured | Social security/Tax ID number | Date of birth/Trust

Home phone number | Work phone number | Cell phone number

Primary Beneficiary (Full Name)

Address | City | State | Zip code

% Share | Relationship to Proposed Insured | Social security/Tax ID number | Date of birth/Trust

Home phone number | Work phone number | Cell phone number

Contingent Beneficiary (Full Name)

Address | City | State | Zip code

% Share | Relationship to Proposed Insured | Social security/Tax ID number | Date of birth/Trust

Home phone number | Work phone number | Cell phone number

Contingent Beneficiary (Full Name)

Address | City | State | Zip code

% Share | Relationship to Proposed Insured | Social security/Tax ID number | Date of birth/Trust

Home phone number | Work phone number | Cell phone number

4. Amount and plan of insurance

a. Plan of insurance:

b. Amount of insurance:

$

5. Death benefit (Universal Life only)

◯ Level (specified amount only)
◯ Increasing (specified amount only)
◯ Scheduled Increases (if available)
◯ Simple ..... %
◯ Compound ..... %

6. Riders (If available with Plan)

◯ Waiver of Premium
◯ Waiver of Monthly Deduction
◯ Children's Term Insurance: ..... units
◯ Other (amount and description)
☐

7. Premiums

a. Payment method: ◯ Electronic Funds Transfer (EFT) ◯ Direct Bill ◯ Other *(Specify)*:

b. Payment mode: ◯ Monthly (EFT only) ◯ Quarterly ◯ Semiannual ◯ Annual ◯ Single

c. Send Premium Notices to: ◯ Insured ◯ Owner ◯ Other *(Specify)*:

d. Premium source: ◯ Salary ◯ Investments ◯ Savings ◯ Gifts/Inheritance ◯ Other *(Specify)*:

e. Amount remitted in exchange for Temporary Insurance: $

8. Proposed Insured's tobacco and nicotine use *Additional space for details is available in section 12* ***REMARKS***.

a. Mark the **one** item that best describes your history of tobacco and other nicotine product use:
◯ Never used ◯ Totally stopped ◯ Use now

b. If you have "Totally Stopped," indicate number of **years** since you totally stopped and give date and reason in section 12 ***REMARKS***.
◯ Less than 1 ◯ 1 or more/less than 2 ◯ 2 or more/less than 3 ◯ 3 or more/less than 5 ◯ 5 or more

9. Proposed Insured's Insurance Needs *Complete either the Personal or Business section. Explain "Yes" answers in section 12* ***REMARKS***.

a. Personal: ◯ Income replacement ◯ Debt repayment ◯ Estate conservation ◯ Other

1. Personal Finances: Gross annual income $ Total assets $ Total liabilities $

2. Within the past 5 years, have you filed for bankruptcy or had any judgments, collections or liens filed against you? ◯ Yes ◯ No

b. Business: ◯ Buy-Sell ◯ Key employee ◯ Secure credit ◯ Other

1. Business Finances: Total assets $ Total liabilities $ Net worth $

2. What percentage of the business do you own? %

3. Your gross annual salary (include bonus) $

4. Is business insurance applied for or in force on other key members of the business? ◯ Yes ◯ No
(Explain either answer in section 12 ***REMARKS****.)*

5. Are you employed by a business that, within the last 5 years, has filed for bankruptcy or had any judgments, liens or collection actions filed against it? ◯ Yes ◯ No
   i. If "Yes" for bankruptcy, under what Chapter of the Bankruptcy Code did the bankruptcy proceed?
   Chapter ◯ 7 ◯ 11 ◯ 12 ◯ 13
   ii. Has the bankruptcy been discharged? ◯ Yes ◯ No
   If "yes," provide date of discharge *(If "No," provide details in section 12* ***REMARKS****.)*

10. Proposed Insured's existing insurance/replacement *Additional space for details is available in section 12* ***REMARKS***.

a. Do you have existing life insurance or annuities? ◯ Yes ◯ No

b. If "Yes" to Question 10.a., will the insurance applied for in this application replace, end or change any existing life insurance or annuities? *(If "Yes," you may be required to review and sign additional forms.)* ◯ Yes ◯ No

c. If "Yes" to Question 10.a., list all existing life insurance policies and annuity contracts. *For additional policies/contracts, use section 12* ***REMARKS***.

Full name of company
To be replaced? ◯ Yes ◯ No
Amount $ | Year issued | Beneficiary(ies)

Full name of company
To be replaced? ◯ Yes ◯ No
Amount $ | Year issued | Beneficiary(ies)

Full name of company
To be replaced? ◯ Yes ◯ No
Amount $ | Year issued | Beneficiary(ies)

11. Proposed Insured's History *Explain "Yes" answers in section 12* ***REMARKS***.

a. Do you have any other application or informal inquiry for life insurance pending in any company or society? ◯ Yes ◯ No

b. Have you ever had an application or reinstatement request for life or disability insurance refused, postponed, limited, withdrawn or cancelled, or have you been asked to pay a higher premium? ◯ Yes ◯ No

c. Have you ever been convicted of a misdemeanor or felony? ◯ Yes ◯ No

d. In the past 5 years, have you ever requested or received a Worker's Compensation, Social Security or disability income payment, excluding a pregnancy related payment? ◯ Yes ◯ No

e. In the past 5 years, has your driver's license been suspended or revoked? ◯ Yes ◯ No

f. In the past 5 years, have you been convicted of, or pled guilty or no contest to, reckless driving or driving under the influence of alcohol or drugs? ◯ Yes ◯ No

g. In the past 5 years have you flown, or do you intend within the next 2 years to fly, as a pilot, student pilot, or crew member other than for a scheduled commercial airline? (*If "Yes," complete Aviation Supplement*) ◯ Yes ◯ No

h. In the past 2 years have you engaged in, or do you intend within the next 2 years to engage in, hang gliding, ultra-light flying, hot-air ballooning, mountain, rock, or ice climbing, motor vehicle or boat racing, or scuba or sky diving? ◯ Yes ◯ No
(*If "Yes," complete appropriate activities Supplement[s]*)

i. In the next 2 years, do you intend to travel or reside outside of the U.S. for more than 4 consecutive weeks other than for vacation? (*If "Yes," complete Foreign Residence/Travel Supplement*) ◯ Yes ◯ No

12. Remarks

Please use this section to provide full details to all "Yes" answers from previous sections. **Include question number and section/letter number.**

If beneficiaries are needed beyond those listed in section 3, please provide full details here.

Use application overflow form if additional space is needed.

13. Representations

The application includes the Application – Parts I and II and all approved supplemental forms or amendments the Insurer specifically designates as parts of the application by attaching copies of them to any policy delivered to the Owner. No licensed insurance producer is authorized to: (a) make or modify contracts; (b) waive any Insurer rights or requirements; or (c) waive any information the Insurer requests.

I represent: (1) the statements and answers given in the application are true, complete, and correctly recorded to the best of my knowledge and belief; and (2) the insurance being applied for is suitable for the Owner's insurance needs.

I agree that: (1) I will notify the Insurer if any statement or answer given in the application changes prior to policy delivery; and **(2) except as provided in the Temporary Insurance Application and Agreement, if any, insurance will not begin unless all persons proposed for insurance are living and insurable as set forth in the application at the time a policy is delivered to the Owner and the first modal premium is paid.**

(APPLICABLE ONLY IF THE EMPLOYER OR AN EMPLOYER-CONTROLLED TRUST IS TO BE THE POLICYOWNER OF THIS POLICY) If insurance is being applied for on the life of any non-exempt employee, then I represent such insurance is not prohibited by applicable state law.

If I am an active duty member of the United States Armed Forces (including active duty military reserve personnel), I confirm that this application was not solicited and/or signed on a military base or installation, and I have received from the Producer, whose name appears below, the disclosure required by Section 10 of the Military Personnel Financial Services Protection Act.

No representation is made that, based on information provided in the application, a particular premium rate, risk category, or class will be offered to me. I will review my policy and ask the producer or Pacific Life Insurance Company (PLIC) about the specific premium and risk class referenced in my policy.

The statements and answers in the application are the basis for any policy issued by PLIC, and no information about the applicant will be considered to have been given to PLIC unless it is stated in the application.

I represent that all parties have an insurable interest in the life of the Proposed Insured.

14. Authorization to collect and disclose information

Terms

Information

Facts about the Proposed Insured. It includes the Insured's entire medical record, including facts about mental and physical health; prescription drugs; and facts about communicable diseases such as HIV infection, AIDS, tuberculosis, and sexually transmitted diseases. Information also includes facts about other insurance coverage; hazardous activities; character; finances; vocation; and other personal traits. It does not include facts about sexual orientation. Information does not include a mental health professional's Psychotherapy Notes (actual recorded notes of a counseling session that are separate from the rest of a medical record), but Information does include medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress.

Source

Medical Physicians; chiropractors; physical therapists; psychologists; drug, alcohol, or mental health counselors; care providers or evaluators; hospitals; clinics; drug or alcohol treatment or consultation facilities; nursing homes; mental health facilities; ambulatory care centers; the Department of Veterans Affairs; facilities or offices staffed or run by care providers; other medical or medically related facilities; medical prescription drug databases; pharmacy or pharmacy benefit manager; insurers; reinsurers; health plans; MIB; consumer reporting agencies; laboratories; financial sources; employers; the Social Security Administration; neighbors; friends; and relatives.

Insurer Pacific Life Insurance Company

Proposed Insured The Proposed Insured is the person whose life is proposed to be insured.

Authorization The Authorization is this Authorization to Collect and Disclose Information.

MIB MIB is the medical information bureau known as MIB, Inc.

Understanding

1. The following parties may need to collect Information in connection with proposed insurance coverage: the Insurer and its reinsurers; MIB; consumer reporting agencies; and these parties' representatives.
2. These parties may disclose collected Information to the following recipient parties: other insurers to which the Proposed Insured has applied or may apply; reinsurers; MIB; or persons or organizations that perform business, professional, or insurance tasks for them.
3. All parties may disclose Information as allowed or required by law. MIB and consumer reporting agencies may disclose Information only as set forth in an agreement with a member company or organization.
4. Some Information may be disclosed to persons or organizations that are not subject to federal health information privacy laws, which means that the information may no longer be protected under such laws. But even if information is disclosed to persons or organizations that are not subject to federal health information privacy laws, those persons or organizations must comply with all other applicable legal requirements governing the protection and redisclosure of information.
5. The Insurer and its reinsurers will use Information to evaluate the application, obtain reinsurance, administer claims, administer coverage, and conduct other activities that are allowed or required by law and that relate to any insurance coverage or proposed insurance coverage with the Insurer.
6. Failing to sign, changing, or revoking the Authorization will impair processing of the application; as a result, the application may be denied.
7. This Authorization will be valid for twenty-four (24) months after the date signed. This time limit complies with the time limit, if any, permitted by applicable law in the state where the policy is issued or issued for delivery.
8. The Proposed Insured or person authorized to act on the Proposed Insured's behalf; (a) may revoke this Authorization by sending written notice to the Insurer at P.O. Box 42000, Lynchburg, VA 24506, Attention: Privacy Official, and (b) may ask to receive a copy of this Authorization.
9. I understand that information regarding HIV, AIDS, or ARC shall not be redisclosed without my written consent.

14. Authorization to collect and disclose information *continued*

Authorization and Acknowledgement

The following parties may need to collect Information in regard to proposed coverage: the Insurer and its reinsurers; MIB; consumer reporting agencies; and all persons authorized to represent these parties. Those parties that may need to collect Information may generally disclose Information to the following: other insurers to which the Proposed Insured has applied or may apply; reinsurers; MIB; or persons who perform business, professional, or insurance tasks for them. They may disclose Information as allowed or required by law. MIB and consumer reporting agencies may disclose Information only as set forth in an agreement with a member company or organization. Certain laws may pertain to some kinds of Information and may further restrict disclosure of that Information. The Insurer and its reinsurers will use Information to evaluate the application.

By signing this Application – Part I, the Proposed Insured or the person authorized to act on the Proposed Insured's behalf: (1) authorizes each Source to give Information when this Authorization is presented; and (2) acknowledges receipt of the Notice to Proposed Insured and Owner. A copy of this Authorization will be as valid as the original. The Proposed Insured or the person authorized to act on the Proposed Insured's behalf may revoke this Authorization by sending written notice to the Insurer. Failing to sign, changing, or revoking this Authorization will impair processing of the application; as a result, the application may be denied.

This Authorization will be valid for the period of time permitted by applicable law, in the state where the policy was delivered or issued for delivery, after the date this Application - Part I is signed. The Proposed Insured or an authorized representative of the Proposed Insured may ask to receive a copy of this Authorization.

Fraud Warning: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Review the answers on the Application carefully. If any of your answers are incorrect or untrue, even if unintentional, the company may have the right to deny benefits or rescind your coverage if the misrepresentation is deemed to be material.

If Proposed Insured or Owner is under age 18, a signature of parent/guardian is required in place of the minor's signature.

State in which owner signed application	State in which policy will be delivered	
.	.	
Signature of Proposed Insured	Date	Signature of Owner *If not Proposed Insured*
X	.	**X**
Life Insurance producer signature	Life Insurance producer name printed	
X	.	
License No.	Managing agency/Brokerage No.	
.	.	
Life Insurance producer signature	Life Insurance producer name printed	
X	.	
License No.	Managing agency/Brokerage No.	
.	.	

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PRODUCER'S REPORT

1. Producer Information

First name | Middle initial | Last name | Producer's company code no.

Last four of social security no./tax ID no. | Phone number | Fax number

a. Does the proposed insured have any existing life insurance or annuity? ◯ Yes ◯ No

Is this insurance applied for intended to replace, end, or change any existing insurance or annuity? ◯ Yes ◯ No

If "Yes," to either question, replacement forms may be required by state law. Include copies of any required forms with the application.

If existing insurance may be replaced, ended or changed, attach a full explanation to the application and explain to the Owner and Proposed Insured that a new suicide and contestable periods may apply.

b. If you accepted money with this application, a Temporary Insurance Application and Agreement (TIAA) is required. Was a TIAA given? ◯ Yes ◯ No

c. Has a medical or paramedical exam been scheduled? *If "Yes," give date and Provider with whom scheduled.* ◯ Yes ◯ No

Date (Mo. Day Yr.) | Provider's name

d. If Proposed Insured is married, amount of insurance on spouse. If spouse is not insured, give reason.

Amount $ | Reason

e. If Proposed Insured is a minor, amount of insurance on parents and any siblings. If parents and siblings are not insured, give reason.

Father | Mother

Siblings (name and amount)

I represent that to the best of my knowledge and belief: (1) the insurance being applied for is suitable for the Owner's insurance needs and financial objectives; (2) the information provided in this report and by the Owner and Proposed Insured in the application is complete, accurate, and correctly recorded; and (3) there is nothing adversely affecting the insurability of the Proposed Insured other than as indicated in the application. I also represent that I gave all required form(s) on or before the date the application was taken.

Life insurance producer signature | Date of signature

X

2. Managing Producer/Brokerage Report

Managing Producer/Brokerage name | Managing Producer/Brokerage No. | Email address | Date

3. Life Insurance Producers to Receive Commission *Complete for each producer to receive commission.*

Total Commission Share(s) to equal 100%. Each producer will share equally unless otherwise indicated.

First name | Middle initial | Last name | **Last four** of social security no./tax ID no.

Address | City | State | Zip code

Email address | Commission share | Company code no.

First name | Middle initial | Last name | **Last four** of social security no./tax ID no.

Address | City | State | Zip code

Email address | Commission share | Company code no.

First name | Middle initial | Last name | **Last four** of social security no./tax ID no.

Address | City | State | Zip code

Email address | Commission share | Company code no.

First name | Middle initial | Last name | **Last four** of social security no./tax ID no.

Address | City | State | Zip code

Email address | Commission share | Company code no.

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APPLICATION FOR INDIVIDUAL LIFE INSURANCE - OVERFLOW FORM

Proposed Insured

a. Full Name (First)	(Middle)	(Last)	b. Date of Birth (Mo./Day/Yr.)	c. Social Security Number

Remarks *(Provide explanations and requested information. Identify applicable item number and letter.)*

I represent that the statements and answers given in the application are true, complete and correctly recorded to the best of my knowledge and belief. I agree that: (1) I will notify the Insurer if any statement or answer given in the application changes prior to policy delivery; and (2) **except as provided in the Temporary Insurance Application and Agreement, if any, insurance will not begin unless all persons proposed for insurance are living and insurable as set forth in the application at the time a policy is delivered to the Owner and the first premium is paid.**

Signature of Proposed Insured | Date signed | Signature of Owner (if other than Proposed Insured)

Signature of Licensed Insurance Producer or Examiner

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NOTICE TO PROPOSED INSURED AND OWNER

DETACH AND LEAVE WITH PROPOSED INSURED(S)

In this disclosure, "we", "us", "our", and "PLIC" refer to Pacific Life Insurance Company, its affiliates, and its subsidiaries. This brief description of our underwriting process is designed to help you understand how an application for life insurance, which may contain long-term care benefits, is handled, the types and sources of information we may collect about you, the circumstances under which we may disclose that information to others and your right, or that of your authorized representative, to learn the nature and substance of that information upon written request. The purpose of the underwriting process is to make sure you qualify for insurance under our rules, and assuming you do, establish the proper premium charge for that insurance. The goal of the underwriting process is to have the cost of insurance distributed equitably among all policyowners, so that each individual pays his or her fair share. To determine your insurability, we must consider such factors as your medical history, physical condition, occupation, and hazardous avocations. We get this information from various sources.

Application and Medical Records – Your application, including the medical history, is the primary source of information in the evaluation process. In addition, we may ask you to take a physical examination or other special test such as an electrocardiogram. We may also ask for a report from your doctor or hospital, another insurance company, or MIB, Inc. ("MIB", see below). When we do so, we will use the Authorization To Obtain Information that you signed. The purpose of MIB is to protect member companies, their policyowners, and insureds from those who would conceal significant facts relevant to their insurability.

MIB, Inc. – Information regarding your insurability will be treated as confidential. PLIC or its reinsurers may, however, make a brief report thereon to MIB, Inc., formerly known as Medical Information Bureau, 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 about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have about you in its file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). 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 Park, Suite 400, Braintree, Massachusetts 02184-8734.

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

Federal Fair Credit Reporting Act – As part of our underwriting, we may ask that an investigative consumer report be prepared. An independent source known as a consumer reporting agency will prepare the report. The report will typically include information as to your character, general reputation, mode of living and personal characteristics, as well as information obtained from other data sources. ("Mode of living" does not include information related directly or indirectly to your sexual orientation.) The agency may conduct personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted in order to get this information. If you write to us within a reasonable time after you receive this notice, we will tell you whether or not a report was requested. If a report was requested, we will tell you the name, address and telephone number of the agency to whom the request was made. Upon request, the agency will furnish information as to the nature and scope of its investigation. If you would like to inspect and to receive a copy of the report, you may do so by contacting the agency directly.

DISCLOSURE TO OTHERS

Personal information obtained about you during the underwriting process and at other times is confidential and will not be disclosed to other persons or organizations without your written authorization except to the extent necessary for the conduct of our business and only to the extent permitted by applicable state law. Examples of situations where we may share information about you are as follows:

- The Producer may retain a copy of your application, and if a policy is issued will have access to ongoing policy information to better serve your needs.
- If reinsurance is required, the reinsurance company would have access to our application file.
- We may release information to another insurance company to whom you have applied for life, long-term care, or health insurance or to whom you have submitted a claim for benefits, if you have authorized it to obtain such information.
- As stated earlier, we may report information to MIB.
- We will disclose information to government regulatory officials, law enforcement authorities, and others where required by law.

DISCLOSURE TO YOU

In general, you have a right to learn the nature and substance of any personal information about you in our file upon written request. Whenever an adverse underwriting decision is made, we will notify you of the reason(s) for the decision and the source of the information upon which our action is based. Medical record information, however, will normally be given only to a licensed physician of your choice. Please refer to the section on MIB for that organization's disclosure procedure. Should you feel that any information we have is inaccurate or incomplete, please write to: Manager, New Business Services, Pacific Life Insurance Company, P.O. Box 42000, Lynchburg, VA 24506. Your comments will be carefully considered and corrections made where justified. We hope this Notice will help you to understand how we obtain and use personal information in the underwriting process, and the ways you can learn about this information. We are concerned with ensuring privacy as well as lives, and the collection, use, and disclosure of personal information is limited as specified in this Notice.

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HIV CONSENT FORM - CALIFORNIA

HIV ANTIBODY TESTING CONSENT FORM

To evaluate your insurability, the insurer may request a sample of your blood for testing and analysis to determine the presence of human immunodeficiency virus (HIV) antibodies. This test is a three-step protocol (ELISA, ELISA AND WESTERN BLOT). 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. A test for HIV antibodies is very sensitive. Errors are rare, but they do occur. Your private physician, the County Department of Health, the State Department of Health Services, local medical societies, or alternative test sites can provide you with further information on the medical implications of a positive test.

A positive HIV antibody test will result in your application for insurance being declined.

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 may be disclosed to employees of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer or to outside legal counsel who needs such information to effectively represent the Insurer in regard to your application. 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.

Public health authorities urge that everyone become educated about how to protect themselves from HIV infection. If you have questions, you should contact the AIDS Counseling Resource Office in your area. These offices are listed below:

San Francisco AIDS Foundation, 25 Van Ness Ave., Suite 660, San Francisco, California 94102, (415) 864-5855

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

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

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

AIDS Services Foundation of Orange County, 1685-A Babcock St., Costa Mesa, California 92627, (714) 646-0411

San Diego AIDS Project, 3777 Fourth Ave., San Diego, California 92103, (619) 543-0300

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

ARIS Project, 595 Millich Drive, Suite 104, Campbell, California 95008, (408) 370-3272

If your test results are negative, no routine notification will be sent to you. The insurance company will notify you if your test results are positive or if your results cannot be accurately determined. You should request that your results be sent to your private physician so that he can interpret them for you. If you do not have a personal physician and you wish to receive the results directly, we strongly urge you to contact one of the AIDS Counseling offices listed above, or the County Department of Health.

In the event of a positive or indeterminate test result, I authorize disclosure to my personal physician:

Name

Address

City State Zip Code

INFORMED CONSENT

I have read and understand this information. I voluntarily consent to the withdrawal of blood from me, the testing of that blood, and the disclosure of the test results as described above. I understand that I have the right to request and receive a copy of this form. A photocopy is as valid as the original. For my information, I have been given the brochure “The Truth About HIV and AIDS” information obtained by the American Red Cross.

Proposed Insured’s Name (Print): First MI Last

Proposed Insured or Parent/Guardian’s Signature Date

NOTICE REGARDING STANDARDS FOR MEDI-CAL ELIGIBILITY AND RECOVERY

IF YOU OR YOUR SPOUSE ARE CONSIDERING PURCHASING A FINANCIAL PRODUCT BASED ON ITS TREATMENT UNDER THE MEDI-CAL PROGRAM, READ THIS IMPORTANT MESSAGE!

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

Recovery

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

Unmarried Resident

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

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

Married Resident

Community Spouse Resource Allowance: If one spouse lives in a nursing facility, and the other spouse does not live in a facility, the Medi-Cal program will pay some or all of the nursing facility costs as long as the couple together does not have more than $109,560 in countable resources.

Minimum Monthly Maintenance Needs Allowance: If a spouse is eligible for Medi-Cal payment of nursing facility costs, the spouse living at home is allowed to keep a monthly income of at least his or her individual monthly income or $2,739 in monthly income, whichever is greater.

Fair Hearings and Court Orders

Under certain circumstances, an at-home spouse can obtain an order from an administrative law judge or court that will allow the at-home spouse to retain additional resources or income. The order may allow the couple to retain more than $109,560 in countable resources. The order also may allow the at-home spouse to retain more than $2,739 in monthly income.

Real and Personal Property Exemptions

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

Real Property Exemptions

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

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

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

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

Personal Property and Other Exempt Assets

- *IRAs, KEOGHs, and Other Work-Related Pension Plans.* These funds are exempt if the family member whose name it is in does not want Medi-Cal. If held in the name of a person who wants Medi-Cal and payments of principal and interest are being received, the balance is considered unavailable and is not counted. It is not necessary to annuitize, convert to an annuity, or otherwise change the form of the assets in order for them to be unavailable.
- *Personal Property used in a trade or business.*
- *One motor vehicle.*
- *Irrevocable Burial Trusts or Irrevocable Prepaid Burial Contracts*

There may be other assets that may be exempt.

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

Please note: If you seek Medi-Cal payment for nursing facility services, you may be ineligible for those services if payments from your annuity extend beyond your life expectancy based upon life expectancy tables adopted by the Department of Health Care Services for this purpose. To find out about these tables, you may contact your local county welfare department.

Finally, the Department of Health Care Services is currently refining its policy regarding the treatment of annuities when determining eligibility for nursing facility services. Any regulatory changes will only impact annuities that are purchased after the effective date of any regulatory amendments.

Different rules apply to annuities that are qualified retirement arrangements established pursuant to Title 26, Internal Revenue Code, Subtitle A, Chapter 1, Sub-chapter D, Part 1. In some circumstances, Medi-Cal does not count funds held in an IRA, Keogh, or other work-related retirement arrangements, you may contact your local county welfare department.

I have read the above notice and have received a copy.

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____

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TEMPORARY INSURANCE APPLICATION AND AGREEMENT (TIAA)

ORIGINAL – Return with the application and the payment. COPY – Give to the Owner only if payment is made at the time the Application – Part I is signed.

1. Notice to Proposed Insured and Owner

Payment of the Amount Remitted may only be made at the same time that both the Application - Part I and this TIAA are completed. If the Insurer does not respond to you within 90 days, notify the Insurer at the above address. **Make the Amount Remitted payable to the Insurer. Do not make it payable to the life insurance producer or leave the payee blank. Do not pay cash.**

2. Temporary Insurance Application *Answer all questions*

Insurer
The Insurer designated in Section 4.a. of the Application - Part I.

Temporary insurance cannot begin and you should make no payment if any question is answered "Yes" or left blank.

1. Is the Proposed Insured less than 15 days old or more than 70 years old (age nearest birthday) on the Date of this TIAA? ◯ Yes ◯ No
2. Is the Policy applied for a joint life insurance policy? ◯ Yes ◯ No
3. Does the total amount of insurance on the Proposed Insured's life in force with the Insurer under any policies, conditional receipts, or temporary insurance agreements exceed $1,000,000? ◯ Yes ◯ No
4. In the past 90 days, has the Proposed Insured been admitted, or medically advised to be admitted, to a hospital or other licensed health care facility, had surgery performed or recommended, or been medically advised to have any diagnostic test (excluding an AIDS-related test) that was not completed? ◯ Yes ◯ No
5. In the past 5 years, has the Proposed Insured been diagnosed, treated, tested positive for, or been given medical advice by a professional health care provider for, heart disease, stroke, cancer, or alcohol or drug dependence or abuse? ◯ Yes ◯ No
6. Has a medical physician diagnosed the Proposed Insured as having Hepatitis C or Acquired Immunodeficiency Syndrome (AIDS)? ◯ Yes ◯ No

I represent that: (1) I have read and received a copy of this TIAA and agree to all of its terms and conditions; (2) I understand and agree that temporary insurance will not begin if any question above is answered "Yes" or left blank; (3) the answers given above are true to the best of my knowledge and belief, and I understand that, if they are false, temporary insurance may be denied or declined; (4) I understand that completing this TIAA does not guarantee that the Insurer will issue a policy on the Proposed Insured's life; and (5) I understand that the licensed insurance producer is not authorized to change or waive the terms of this TIAA.

Signature of Proposed Insured	Date of this TIAA	**Signature of Owner** *If other than Proposed Insured*
X	▪	**X**

3. Temporary Insurance Agreement

Agreement. Subject to the terms of the policy applied for and this TIAA, the Insurer agrees to pay the Limited Amount to the beneficiaries listed in the Application - Part I upon receipt of due proof that the Proposed Insured died while temporary insurance was in effect. The consideration for temporary insurance is the Temporary Insurance Application and payment of an amount equal to the first modal premium for the plan applied for.
Limited Amount. The Limited Amount is the lesser of: (1) the Amount of Insurance applied for in the Application - Part I; and (2) $1,000,000 minus the amount of any insurance on the Proposed Insured's life in force with the Insurer under any policies, conditional receipts, or temporary insurance agreements.
Start Date. Temporary insurance equal to the Limited Amount will begin on the Start Date subject to the terms of this TIAA. The Start Date is the Date of this TIAA.
Stop Date - 90 Day Maximum. Temporary insurance automatically ends on the Stop Date and the entire amount remitted will be returned without interest to or for the benefit of the Owner. The Stop Date is the earliest of the following: (1) the date the Owner withdraws the application; (2) 45 days after the Start Date if the Insurer has **not** received a properly completed and signed Application Part II – Medical History and all medical examinations and tests required by the Insurer as set forth in its Initial Submission Guidelines; (3) the date the Owner refuses to accept any policy issued or offered; (4) the date the Insurer sends notice to the Owner at the address shown in the Application - Part I that the Insurer has declined to issue insurance; and (5) 90 days after the Start Date.
Policy Date. The Policy Date of any policy issued will be the Start Date unless the policy is backdated at the Owner's request. The Amount Remitted will be applied to the first modal premium for the policy. Upon policy delivery, the policy will replace this TIAA and coverage will continue under the policy without interruption.
Other Limitations. The Insurer's liability will be limited to a return of the Amount Remitted if: (1) any part of the life insurance application or this TIAA contains a misrepresentation material to the Insurer; or (2) the Proposed Insured dies by suicide.

4. Life Insurance Producer's Statement

Amount remitted	Person from whom received
$	▪

On the Date of this TIAA, I received the Amount Remitted in exchange for this TIAA. The TIAA bears the same date as the Application - Part I. I agree that I am not authorized to change or waive the terms of this TIAA and represent that I have not attempted to do so. I have read and explained the terms of this TIAA to the Proposed Insured and Owner. I have left the Copy with the Owner.

Signature(s) of Life Insurance Producer(s)	Life Insurance Producer Number(s)
X	▪

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DISCLOSURE STATEMENT FOR ACCELERATED DEATH BENEFIT FOR TERMINAL ILLNESS

Rider Benefit

This Rider provides for the early payment of part of the Policy's Death Proceeds. The Accelerated Death Benefit does not qualify as long term care insurance nor is it intended to qualify as such. We will make this Accelerated Death Benefit payment to the Owner of the Policy upon receiving proof that the Insured's life expectancy does not exceed twelve months.

The Owner may make only one request for an accelerated payment. We must receive, in writing, acknowledgement of and Consent for payment under this Rider from any irrevocable beneficiary and any collateral assignee of the Policy before making any payment.

There is no premium or cost of insurance charge for this Rider; however, an administrative fee is deducted before payment.

Consequences of Receiving Accelerated Death Benefit Payment

This Accelerated Death Benefit was not designed for any specific type of favorable tax treatment; such payment may be considered taxable income. A payment may also adversely affect the recipient's eligibility for Medicaid benefits or other state or federal government benefits or entitlements. The Owner should contact a qualified tax advisor and the appropriate government agencies before electing to receive a payment.

Amount of Benefit Available

The Owner requests the amount of Accelerated Death Benefit. Generally, the largest amount available is the benefit maximum minus any Loan Balance. This benefit maximum is the lesser of (a) and (b) where (a) is the amount equal to any Loan Value of the Policy plus 75% of the difference between the Death Proceeds of the Policy and any Loan Value and (b) is $500,000. The benefit maximum can vary by state, however, and is defined by the Rider.

We will deduct an administrative fee from the Accelerated Death Benefit prior to payment to the Owner.

Effect of an Accelerated Death Benefit Payment

The Accelerated Death Benefit will be treated as a lien against the Death Proceeds of the Policy. This lien will limit the availability of any surrender benefit and of any future policy loans or withdrawals under the Policy.

We will charge interest on the lien. We will charge interest at the policy loan interest rate(s), if any, stated in the Policy on the portion of the lien amount equal to any Loan Value. We will charge interest on the portion of the lien amount that exceeds any Loan Value at a rate not exceeding the greater of: (a) the current yield on a 90-day treasury bill; and (b) is the maximum fixed annual rate of 8% or a variable rate determined in accordance with the NAIC Model Policy Loan Interest Rate Bill, model #590.

Policy and rider premiums will not be reduced after an Accelerated Death Benefit payment and will remain payable.

No matter how long the Insured lives, the Policy will not terminate as a result of a payment under this Rider unless the lien equals or exceeds the Death Proceeds. The Owner may repay all or part of the lien subject to the terms of the Rider.

Sample Illustration

Below is a sample illustration of the effect of an Accelerated Death Benefit payment. This illustration shows the effect on the Death Proceeds immediately after the Accelerated Death Benefit payment has been made and 3 months after payment of the Accelerated Death Benefit.

This sample illustration assumes: (1) $800,000 Primary Death Benefit; (2) $0 loan value; (3) no policy loans or Loan Balance; (4) the maximum Accelerated Death Benefit is elected; (5) the policy loan interest rate is 4.00%; (6) the lien interest rate is 8.00%; and (7) the quarterly premiums are $500.

Before Accelerated Death Benefit Payment:

Primary Death Benefit	$800,000
less: Loan Value	$0
	$800,000
Maximum Accelerating Percentage	X 75%
(a)	$600,000
(b) plus: Loan Value	$0
Min of (a+b, $500,000)	$500,000
less: Loan Balance	$0
Maximum Accelerated Death Benefit Available	$500,000
less: Administration Fee	$250
Amount of Accelerated Death Benefit Payment	$499,750

Immediately After Payment of Accelerated Death Benefit:

Amount of Accelerated Death Benefit Payment	$499,750
plus: Administration Fee	$250
Lien Amount	$500,000
Primary Death Benefit	$800,000
less: Lien Amount	$500,000
less: Loan Balance	$0
Payment upon Death	$300,000

3 Months After Payment of Accelerated Death Benefit:

Amount of Accelerated Death Benefit Payment	$499,750
plus: Administration Fee	$250
plus Accrued Lien Interest (3 months)	$9,713
plus: Premiums due and unpaid	$500
(c) Lien Amount	$510,213
(d) Loan Balance	$0
(e) Primary Death Benefit	$800,000
Payment upon Death (e-d-c)	$289,787

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REPLACEMENT NOTICE - CALIFORNIA

NOTICE REGARDING REPLACEMENT OF LIFE INSURANCE OR ANNUITY
REPLACING YOUR LIFE INSURANCE 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 producer 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.

List below the identification of policies you intend to replace.

Name of Existing Insurer	Contract or ID* Number	Generic Name of Policy	Name of Insured

*If the existing insurer has not assigned a policy number, list alternative identification such as an application or receipt number

Applicant's signature _____ Date _____

Producer's signature _____

Producer's name (printed) _____

PRODUCER: PROVIDE A PHOTO COPY OF THIS SIGNED FORM TO ALL SIGNING PARTIES

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AUTHORIZATION FOR PAYMENT - ELECTRONIC FUNDS TRANSFER (EFT) AND/OR CREDIT CARD (INITIAL PREMIUM)

Instructions: Complete this form in its entirety to authorize Pacific Life Insurance Company (PLIC) to collect the life insurance premium set forth below by EFT and/or credit card. This form is to be returned to PLIC along with your application for life insurance. Retain a copy of this form for your records.

1. Policy/Application Information

Name of Proposed Insured

Policy/Application Number (if applicable)

2. Premium Payment Information

A. Premium payment frequency: ☐ **Monthly** ☐ **Quarterly** ☐ **Semi-Annual** ☐ **Annual**

B. Check all that apply below:

☐ **Initial Premium authorized payment method** (Check only one): ☐ EFT ☐ Credit Card (**MasterCard®** or **Visa only®**)
The amount authorized from your account will be equivalent to the amount of premium necessary to pay the policy to current date. If the policy was back-dated, or delivery has exceeded standard time frames, this amount may be greater than one standard payment.

☐ **Recurring Premium authorized payment method** (EFT only)
Recurring drafts will begin on the first available draft date after the policy is in force.

3. Checking Account Information (Complete for EFT only)

Bank Account Holder Name

Additional Bank Account Holder Name (if applicable)

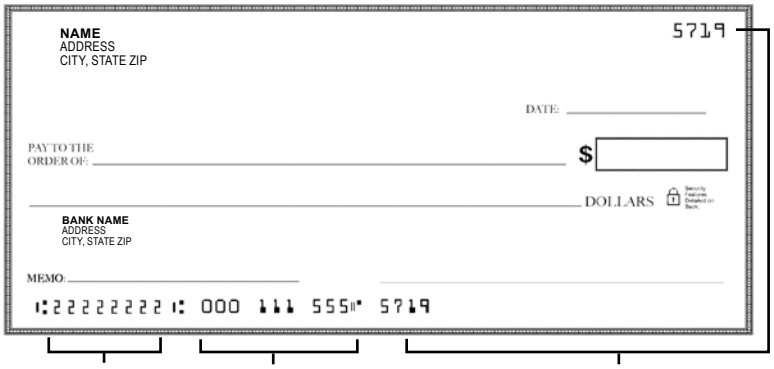
Bank Account Holder Address | City | State | Zip Code

Financial Institution Name

Financial Institution Address | City | State | Zip Code

Bank Routing Number (9 digits)

Checking Account Number



15-47602-00 05/2017

4. Credit Card Information (Complete for Initial Premium only. Not available in **Nevada**, **New York**, or **Pennsylvania**.)

Name of Credit Card Holder (as it appears on the card)

Credit Card Holder Billing Address | City | State | Zip Code

Credit Card Number (**MasterCard® or Visa® only**) | Expiration Date

5. Acknowledgments

By signing below, the signer understands and accepts these term and conditions:

A. Electronic Funds Transfer Payment:

- PLIC is authorized to initiate debit (credit) entries from the above account.
- The origination of ACH transactions must comply with the provisions of the U.S. law.
- PLIC will only allow EFT debit (credit) requests from authorized U.S. financial institutions.
- If I want to cancel or change this authorization, I must contact PLIC at least three business days before a scheduled premium payment.
- PLIC has the right to end withdrawals at any time and bill me directly either quarterly or less frequently for premiums due.
- The financial institution's draft date may vary from the policy's draft date and I further understand that PLIC is not responsible for any bank fees incurred as a result of this variance.
- If an EFT request is not honored by the financial institution upon presentation, PLIC will not consider the payment to be made as a premium. No insurance will be effective. PLIC may, in its sole discretion, resubmit the withdrawal request to the financial institution. PLIC is not responsible for any bank fees incurred by me as a result of insufficient funds or overdraft charges.

B. Credit Card Payment:

- This authorization pertains to the initial premium only. Any amount collected under this authorization that exceeds the initial premium by $2.00 or more will be refunded to me.
- Any refund of premium from credit card will be made directly to me or credited to my account.
- If I want to cancel or change this authorization, I must contact PLIC at least three business days before a scheduled premium payment.
- The use of credit cards may be limited to specific products and cannot be used for premiums paid after policy delivery.
- If a credit card payment request is not honored upon presentation, PLIC will not consider the payment to be made as a premium. No insurance will be effective. PLIC may, in its sole discretion, resubmit the credit card request. PLIC is not responsible for any credit card fees incurred by me as a result of the credit card payment request.

6. Signatures

- By signing below, the signer authorizes PLIC to collect the Initial and/or Recurring premium stated above by the payment method I have selected.
- Signing this authorization does not mean that the policy is effective.
- This Authorization for Payment does not, in any way modify or change the terms of the life insurance policy/contract.

X Authorized Bank Account Holder's Signature (for EFT authorization) | Date

X Credit Card Holder's Signature | Date

X Policyowner Signature | Date

Print Policyowner Name (if different than proposed insured)

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PACIFIC LIFE

PRODUCER'S REPORT

1. Producer Information

First name | Middle initial | Last name | Producer's company code no.

Last four of social security no./tax ID no. | Phone number | Fax number

a. Does the proposed insured have any existing life insurance or annuity? ◯ Yes ◯ No

Is this insurance applied for intended to replace, end, or change any existing insurance or annuity? ◯ Yes ◯ No

If "Yes," to either question, replacement forms may be required by state law. Include copies of any required forms with the application.

If existing insurance may be replaced, ended or changed, attach a full explanation to the application and explain to the Owner and Proposed Insured that a new suicide and contestable periods may apply.

b. If you accepted money with this application, a Temporary Insurance Application and Agreement (TIAA) is required. Was a TIAA given? ◯ Yes ◯ No

c. Has a medical or paramedical exam been scheduled? *If "Yes," give date and Provider with whom scheduled.* ◯ Yes ◯ No

Date (Mo. Day Yr.) | Provider's name

d. If Proposed Insured is married, amount of insurance on spouse. If spouse is not insured, give reason.

Amount $ | Reason

e. If Proposed Insured is a minor, amount of insurance on parents and any siblings. If parents and siblings are not insured, give reason.

Father | Mother

Siblings (name and amount)

I represent that to the best of my knowledge and belief: (1) the insurance being applied for is suitable for the Owner's insurance needs and financial objectives; (2) the information provided in this report and by the Owner and Proposed Insured in the application is complete, accurate, and correctly recorded; and (3) there is nothing adversely affecting the insurability of the Proposed Insured other than as indicated in the application. I also represent that I gave all required form(s) on or before the date the application was taken.

Life insurance producer signature | Date of signature

X

2. Managing Producer/Brokerage Report

Managing Producer/Brokerage name | Managing Producer/Brokerage No. | Email address | Date

3. Life Insurance Producers to Receive Commission *Complete for each producer to receive commission.*

Total Commission Share(s) to equal 100%. Each producer will share equally unless otherwise indicated.

First name | Middle initial | Last name | **Last four** of social security no./tax ID no.

Address | City | State | Zip code

Email address | Commission share | Company code no.

First name | Middle initial | Last name | **Last four** of social security no./tax ID no.

Address | City | State | Zip code

Email address | Commission share | Company code no.

First name | Middle initial | Last name | **Last four** of social security no./tax ID no.

Address | City | State | Zip code

Email address | Commission share | Company code no.

First name | Middle initial | Last name | **Last four** of social security no./tax ID no.

Address | City | State | Zip code

Email address | Commission share | Company code no.