Click here to clear form

SYMETRA
RETIREMENT | BENEFITS | LIFE

# Application/Fax
Cover Sheet

**Symetra Life Insurance Company**
777 108th Avenue NE, Suite 1200
Bellevue, WA 98004-5135
www.symetra.com

**New Application Fax Number: 1-877-435-5500**

Date_____ Number of pages (including cover sheet)_____

Agent Name _____ Agent Fax _____

Proposed Insured_____

Agent Notes _____

---

**To Apply:**

To help you remember all the steps involved with submitting an application, please follow the checklist below:

- Complete and obtain signatures on the attached application, any state specific forms (if applicable) and the HIPAA Authorization.
- Complete and obtain signatures on any state Replacement forms (if applicable).

  Note: For states requiring the LU-745 replacement form, the form must be completed if any existing coverage is listed on the application in the "Replacement" section, even if this is not a replacement. Exceptions are Arkansas, Oregon and Utah. For Arkansas, Oregon and Utah, complete and obtain the LU-745 only if the client is replacing existing coverage.
- If the customer is replacing existing coverage, a replacement form may or may not be required. Please contact the Life Sales Desk at 1-877-737-3611 for more information.
- A signed and dated illustration may be required to accompany this application, depending on the product applied for and the application state. If a signed illustration is required, provide your client with a copy and forward the original, including all pages, along with the application packet to Life New Business.
- Witness the signing of the application and verify the identity of the customer using photo identification.
- Complete the "What happens next" form and give it to your client.
- Provide client with the Notice of Insurance Information Practices, Symetra Privacy Notice and any state required disclosures, and copies of all forms completed as part of the application packet.
- For payments by check, mail premium to:

  Symetra Life Insurance Company
  PO Box 84068
  Seattle, WA 98124
- Fax the signed application and any other required forms to Symetra Life Insurance Company at 1-877-435-5500.

Click here to clear form

SYMETRA
RETIREMENT | BENEFITS | LIFE

**Symetra Life Insurance Company**
Home Office: 777 108th Avenue NE, Suite 1200 | Bellevue, WA 98004-5135
Mail to New Business: PO Box 84068 | Seattle, WA 98124
Fax: 1-877-435-5500

# INDIVIDUAL LIFE INSURANCE APPLICATION
## PART 1 – LUC – 199/CA



### 1. PROPOSED INSURED A INFORMATION

| | | |
|---|---|---|
| (a) First Name | (b) Middle Initial | (c) Last Name |
| (d) Residence Address (may not be a P.O. Box) City State Zip | | |
| (e) Mailing Address (may be a P.O. Box) | | |
| (f) Phone Number | | |
| (g) Date of Birth | (h) State of Birth | (i) Gender ☐ Male ☐ Female |

| | | | |
|---|---|---|---|
| (j) Height | (k) Weight | (l) Social Security #/Tax ID | (m) Driver's License # and State of Issue |

(n) US Citizen ☐ Yes ☐ No If No, provide Country of Citizenship _____
Type of US Visa _____ Expiration Date_____

| | | |
|---|---|---|
| (o) Occupation/Duties | (p) Employer & Employer Address | |
| (q) Earned Annual Income | (r) Unearned Annual Income | (s) Net Worth |

### 2. COVERAGES

(a) Amount of Coverage: _____

(b) Universal Life Plans:

| Product Selection | Life Insurance Qualification Test (choose one) | Death Benefit Election (choose one) | Optional Riders |
|---|---|---|---|
| ☐ Symetra UL-G w/Lapse Protection | ☐ Guideline Premium Test (GPT)<br>☐ Cash Value Accumulation Test (CVAT) | ☐ A: Face Amount] | ☐ Accidental Death Benefit $_____<br>☐ Charitable Giving Rider (please complete information section below)<br>☐ Chronic Illness Plus Rider (please complete CIPR supplemental app)<br>☐ Insured Children's Benefit (please complete the Part III ICB form)<br>☐ Term Rider on Others (please complete Part I for each rider insured) |
| ☐ Symetra SUL-G w/Lapse Protection | ☐ Guideline Premium Test (GPT)<br>☐ Cash Value Accumulation Test (CVAT) | ☐ A: Face Amount | ☐ Charitable Giving Rider (please complete information section below)<br>☐ Estate Preservation Rider |
| ☐ Symetra CAUL | ☐ Guideline Premium Test (GPT)<br>☐ Cash Value Accumulation Test (CVAT) | ☐ A: Face Amount<br>☐ B: Face Amount + Accumulation Fund<br>☐ C: Face Amount + Return of Premium | ☐ Accidental Death Benefit $_____<br>☐ Charitable Giving Rider (please complete information section below)<br>☐ Chronic Illness Plus Rider (please complete CIPR supplemental app)<br>☐ Insured Children's Benefit (please complete the Part III ICB form)<br>☐ Term Rider on Others (please complete Part I for each rider insured)<br>☐ Term Rider on Self $_____ |

(c) Term Plans:

| Product Section | Term Length | Optional Riders | |
|---|---|---|---|
| ☐ Term | ☐ 10 Years ☐ 30 Years<br>☐ 15 Years<br>☐ 20 Years | ☐ Accidental Death Benefit $_____<br>☐ Guaranteed Insurability Option $_____<br>☐ Insured Children's Benefit (please complete the Part III ICB form) | ☐ Term Rider on Others (please complete Part I for each rider insured)<br>☐ Waiver of Premium |

(d) If you Elected the Charitable Giving Rider Information Please Complete this Section:

Name of Charitable Giving Beneficiary: _____
Address: _____
501(c) Tax ID Number: _____
Who will provide confirmation to the charitable organization? (choose one)
☐ I will notify the charity of my intent ☐ Permit the Company to notify the charity of my intention upon my death

## 3. PROPOSED OWNER INFORMATION

(a) Who is the Owner?
- ☐ Proposed Insured A
- ☐ Proposed Insured B (For Symetra SUL-G plans only)
- ☐ Trust (Provide details in the section below and complete the Trust Certification)
- ☐ Other (Provide details in the section below and complete the Entity Certification, if appropriate)

| (b) First Name | (c) Middle Initial | (d) Last Name |
|---|---|---|
| | | |

(e) Residence Address (may not be a P.O. Box) City State Zip

(f) Mailing Address (may be a P.O. Box)

| (g) Date of Birth | (h) Social Security/Tax I.D. | (i) Relationship to Insured |
|---|---|---|
| | | |

(j) US Citizen ☐ Yes ☐ No If No, provide Country of Citizenship _____
Type of US Visa _____ Expiration Date_____

(k) Would you like to designate a Secondary Addressee to receive notice of lapse or termination of the policy for nonpayment of premium? ☐ Yes ☐ No (provide details below)

Name: _____ Address: _____

## 4. BENEFICIARY INFORMATION

The percentage for each type of beneficiary must total 100%. Do not indicate multiple beneficiaries as a group – e.g., "All Children of Proposed Insured."

| P = Primary C = Contingent | Name (first, middle initial, last) or Organization Name, Residence Address and Telephone Number | Date of Birth/Trust | SSN, TIN or 501(c) Tax ID Number | Relationship to Proposed Insureds | % |
|---|---|---|---|---|---|
| ☐ **P** | | | | | |
| ☐ **P**<br>☐ **C** | | | | | |
| ☐ **P**<br>☐ **C** | | | | | |
| ☐ **P**<br>☐ **C** | | | | | |
| ☐ **P**<br>☐ **C** | | | | | |
| ☐ **P**<br>☐ **C** | | | | | |

**For any "Yes" answers or additional information to Sections 5, 7, 8 & 10, please provide details in Remarks Section 9**

## 5. PROPOSED INSURED A IN FORCE COVERAGE

(a) Does Proposed Insured A have any other existing life insurance policies in force or applied for with this or any other company? If yes, please list below. **Yes** ☐ **No** ☐

| Company Name | Face Amount | Policy Type (UL/VUL/Term/Group) | Issue Month/Year | Select if Replacing | 1035 Exchange* |
|---|---|---|---|---|---|
| | | | ____ MO/YR<br>☐ In Force<br>☐ Applied For | ☐ | ☐ |
| | | | ____ MO/YR<br>☐ In Force<br>☐ Applied For | ☐ | ☐ |
| | | | ____ MO/YR<br>☐ In Force<br>☐ Applied For | ☐ | ☐ |
| | | | ____ MO/YR<br>☐ In Force<br>☐ Applied For | ☐ | ☐ |

(b) Total in force and applied for with all companies including Symetra $_____

(c) Existing Policy Cash Value $ _____

* If 1035 Exchange complete the 1035 Absolute Assignment form

**6. PAYMENT METHOD AND FREQUENCY**

(a) Payment Method: ☐ Automatic EFT* ☐ Check ☐ Wire Transfer
Payment With Application: $_____ (only if qualified for Temporary Insurance – Refer to Section 10)
Planned Subsequent Premium: $_____

(b) Payment Frequency: ☐ Monthly (EFT only) ☐ Quarterly ☐ Semiannually ☐ Annually

Complete for payments to be taken by EFT*:

(c) Draft the following Premiums: ☐ Initial and Subsequent Premiums ☐ Subsequent Premiums Only

(d) Account Details: Name On Account: _____ Type of Account: ☐ Checking ☐ Savings
Bank Name: _____ Account #: _____
Routing #: _____ Draft date (Not available on 29th, 30th or 31st): _____

(e) If the Premium Payor is someone other than Proposed Insured A or the Proposed Owner (complete information below):

| First | MI | Last | ☐ Male ☐ Female | Social Security/Tax I.D. | Date of Birth |
|---|---|---|---|---|---|
| | | | | | |

| Residence Address (may not be a P.O. Box) | City | State | Zip |
|---|---|---|---|
| | | | |

Mailing Address (may be a P.O. Box)

Signature of Premium Payor

* By electing EFT you are authorizing Symetra to automatically deduct the premium from the listed checking or savings account by electronic funds transfer (EFT). The required premium amount may differ from the amount indicated above due to any changes that may occur prior to issue.

**7. PROPOSED OWNER(S) REPLACEMENT**

| | Yes | No |
|---|---|---|
| (a) Does the Proposed Owner(s) have existing life insurance policies or annuity contracts with this or any other company on the life of Proposed Insured A? | ☐ | ☐ |
| (b) Is the policy applied for expected to replace or change any existing life insurance policy or annuity, or is any part of the premium to be paid by policy loan or cash value from insurance presently in force? (If yes, complete state required replacement form.) | ☐ | ☐ |

**8. PROPOSED INSURED A PERSONAL HISTORY**

| (a) Has Proposed Insured A: | Yes | No |
|---|---|---|
| i) Had any Life or Disability Insurance application declined or rated? | ☐ | ☐ |
| ii) Had any driver's license suspended or revoked, plead guilty to or been convicted of driving while impaired, intoxicated or under the influence of any drug; or plead guilty to or been convicted of two or more moving violations within the past three years? | ☐ | ☐ |
| iii) Ever plead guilty to, or been convicted of, a felony or misdemeanor; or is any such charge pending? | ☐ | ☐ |
| iv) Declared personal or business bankruptcy in the past five years or does Proposed Insured A anticipate declaring bankruptcy within the next two years? | ☐ | ☐ |
| (b) Does Proposed Insured A have any plans to travel or live outside of the U.S or Canada within the next 12 months? | ☐ | ☐ |
| (c) Within the past two years, has Proposed Insured A engaged in, or is he or she currently engaging in, aviation activities as a pilot or crew, scuba diving, parachuting, hang gliding, mountain/rock climbing or racing of any motorized vehicles? (If "Yes", also complete the Aviation/Avocation questionnaire.) | ☐ | ☐ |
| (d) Has Proposed Insured A ever used any form of tobacco or nicotine based products? If yes, make all that apply and complete the details below: | ☐ | ☐ |

| Type | Frequency | MO/YR Last Used | Type | Frequency | MO/YR Last Used |
|---|---|---|---|---|---|
| ☐ Cigarettes | | | ☐ Nicotine Patches | | |
| ☐ Cigars | | | ☐ Nicotine Gum | | |
| ☐ Pipes | | | ☐ Snuff | | |
| ☐ Chewing Tobacco | | | ☐ Other (list): | | |

**9. REMARKS**

For any "Yes" answers or additional information to Sections 5, 7, 8 & 10, please provide details here:

**10. TEMPORARY LIFE INSURANCE AGREEMENT**

| Temporary Life Insurance Agreement (TIA) questions: For any "Yes" answers to questions (a) – (b) below please provide details in the Remarks Section 9 including doctor names, addresses, dates and treatments. | Yes | No |
|---|---|---|
| (a) Within the past 90 days, has Proposed Insured A been admitted to, or been advised by a member of the medical profession, to be admitted to a hospital? | ☐ | ☐ |
| (b) In the past two years, has Proposed Insured A been treated for: heart disease, stroke, tumor, mass, cancer, alcohol, drugs, or Acquired Immunodeficiency Syndrome (AIDS)/Aids Related Complex (ARC) by a member of the medical profession? | ☐ | ☐ |

For all plans, except Symetra SUL-G, if Proposed Insured A is under age 75 and the face amount is $1,000,000 or less and the TIA questions above are answered NO, Proposed Insured A will be covered for up to $250,000 under the TIA if a check is collected for the initial payment or if initial premium payment by EFT or wire transfer is selected (maximum coverage for all Symetra applications is $250,000). For Symetra SUL-G plans, TIA is offered under the Additional Insured Application.

NOTE TO AGENT/INSURANCE PRODUCER: For any Yes answers to questions (a) – (b) or if the face amount is greater than $1,000,000, do not collect premium. No TIA coverage will be in effect.

**AUTHORIZATION TO RELEASE PERSONAL INFORMATION**

I hereby authorize and request any medical care provider, pharmacy, pharmacy benefits manager, individual employer, insurance company, reinsuring company, medical examiners, government unit, consumer reporting agency, or other person or organization, and MIB, Inc., to disclose any and all medical information, non-medical information, employment information, and insurance information they hold concerning me, to the employees, agents, or attorneys of Symetra Life Insurance Company. This disclosure Authorization will permit employees, agents or reinsurers of Symetra Life Insurance Company to view, copy, be furnished copies, share, or be given details of all such information described above including, but not limited to, mental and physical condition, evaluation, diagnoses, treatment, prognoses, prescription records, and/or toxicology results; specifically to include drug or alcohol use, mental illness, psychiatric treatment or diagnosis, testing and/or treatment of HIV (AIDS virus) and/or other sexually-transmitted diseases. Symetra Life Insurance Company obtains medical information only in connection with specific products or claims. Symetra Life Insurance Company will not use or share personally identifiable medical information for any purpose other than the underwriting or administration of your policy, claim or account. I understand that the information obtained pursuant to this Authorization will be used for the purpose of verifying, evaluating, negotiating, and other pertinent legal uses, with respect to my application for insurance, or claim under a policy of insurance. This Authorization will expire at the end of the contestability period of any insurance policy issued in reliance on the records obtained through this Authorization or twenty-four (24) months after the date of signing this Authorization. The individual signing this Authorization has the right to revoke Authorization in writing, except to the extent that action has been taken in reliance on the Authorization, or during a contestability period. A written statement revoking this Authorization delivered to Symetra Life Insurance Company at its usual business address will revoke this Authorization. Any copy of this Authorization shall have the same authority as the original. I also understand that I or my representative have a right to receive a copy of this Authorization upon request.

I authorize Symetra Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB.

I (we) agree that all statements and answers recorded on this application are true and complete to the best of my/our knowledge and belief, and shall form a part of any policy issued. I have also read the Temporary Life Insurance Agreement. (Maximum Temporary Insurance Coverage is $250,000.)

**Fraud Warning**: Any person who, with intent to defraud or knowing he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

☐ Please check here if you would like to receive a copy of an investigative report (if any) obtained during the application process.

I acknowledge this insurance policy was not a prerequisite to receiving credit, property or services from any bank and that the amount of insurance I am applying for may not meet my complete financial needs. I have received information both orally and in writing stating that this insurance product is not a deposit or other obligation of, or guaranteed by, any bank or an affiliate of a bank and that the insurance product is not insured by the Federal Deposit Insurance Corporation (FDIC) or any other agency of the United States, or an affiliate of a bank.

**[Under penalties of perjury, I certify that the number shown on this form is my correct Social Security or Tax Identification Number, I am a U.S. citizen or other U.S. person, and I am not subject to backup withholding due to failure to report all interest or dividends.**

☐ Check this box if you have received a notification from the IRS that you are subject to backup withholding.

☐ Check this box if you are claiming Non-U.S. status and submitting an appropriate withholding certificate (usually a signed IRS Form W-8 or IRS Form 8233) instead of agreeing to this certification.

**The IRS does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.]**

Signed this _____ (Date) , at _____ (City) , State of _____ (State)

_____ Printed Name of Proposed Insured A

_____ Signature of Proposed Insured A (Age 15 or older)

_____ Signature of Proposed Owner* (if other than Proposed Insured)

_____ Printed Name of Writing/Authorized Primary Insurance Producer

_____ Signature of Writing/Authorized Primary Insurance Producer

_____ Primary Insurance Producer Phone

_____ Primary Insurance Producer Email

*If Proposed Owner is a corporation/partnership, a corporate officer/partner or a Trust or Trustee, other than Proposed Insured must sign including title.

| **1. AGENT REPLACEMENT QUESTIONS** | **Yes** | **No** |
|---|---|---|
| (a) Does the Proposed Owner(s) have any existing life insurance policies or annuity contracts with this or any other company? | ☐ | ☐ |
| (b) To the best of your knowledge, is this insurance expected to replace or change any existing life insurance or annuity? | ☐ | ☐ |
| (c) If replacing, how does this policy better serve the Proposed Owner's needs? | | |

| **2. ADDITIONAL INFORMATION** | **Yes** | **No** |
|---|---|---|
| (a) Were you in the presence of the Proposed Insured(s) and/or Owner(s) when the application was taken? | ☐ | ☐ |
| (b) Based on your reasonable inquiry about the Proposed Owner(s) financial situation, insurance objectives and needs, do you believe that the coverage, as applied for, is suitable for their insurance needs and anticipated financial objectives? | ☐ | ☐ |
| (c) Is this Policy being funded via a premium financing loan or with funds borrowed, advanced or paid from another person or entity? | ☐ | ☐ |
| (d) Do you have any knowledge as to whether a formal or informal application for life insurance on the Proposed Insured(s) has been submitted to another insurer or reviewed by one or more reinsurance companies on a facultative basis in the past two years? | ☐ | ☐ |
| (e) Does the Proposed Owner(s) intend to assign or sell, or has the Proposed Owner(s) been involved in any discussion about the possible sale or assignment of, the life insurance policy for which the application is being made? | ☐ | ☐ |
| (f) Has the Proposed Owner(s) ever sold a policy to a life settlement, viatical or other secondary market provider, or is the Proposed Owner(s) in process of selling a policy? | ☐ | ☐ |
| (g) How long have you known the Proposed Insured(s) and in what capacity? | | |

(h) What insurance need is being met with this application?
- ☐ Debt/Family/Business Protection
- ☐ Income Replacement
- ☐ Retirement/Estate Planning
- ☐ Other _____

(i) Source of funds used to pay premiums on this policy?
(Check all that apply):
- ☐ Current Income
- ☐ CD's or Savings
- ☐ Mutual Funds or Brokerage Account
- ☐ Existing Life Insurance or Annuity Policy(ies)
- ☐ Other _____

**3. AGENT INFORMATION – List all Agents/Producers assisting in the sale:**

| Agent/Producer Name | Firm | Phone # | STAT # | Commission Share (%) |
|---|---|---|---|---|
| (1) Primary: | | | | |
| (2) | | | | |
| (3) | | | | |
| (4) | | | | |

| **4. AGENT CERTIFICATION & SIGNATURES:** | **Yes** | **No** |
|---|---|---|
| 1. I/We have reviewed all the questions on this application and certify that the answers have been recorded accurately. I/We know of nothing affecting the insurability of the Proposed Insured(s) which is not fully recorded in this application. | ☐ | ☐ |
| 2. I/We declare that if replacement is involved, I/We certify that only company approved sales materials were used in this sale and that copies of all sales materials were left with the Proposed Owner. | ☐ | ☐ |
| 3. I/We declare I/We have not been involved in any recommendation regarding the possible sale or assignment of this policy to a life settlement, viatical or other secondary market provider. | ☐ | ☐ |
| 4. I/We declare that I/We have verified that all life insurance coverage in force, or in the process of being applied for, on the Proposed Insured has been disclosed on this application, including any coverage that has been sold or is in the process of being sold to a life settlement, viatical or other secondary market provider. | ☐ | ☐ |
| 5. I/We declare, to the best of my knowledge that this policy is not being funded via non-recourse premium financing and is not being paid for with funds from any person or entity whose only interest in the policy is the potential for earnings based on the provision of funding for the policy. | ☐ | ☐ |
| 6. I/We declare that I/We have accurately answered all questions contained in the Agent's Report in connection with this application. | ☐ | ☐ |
| 7. I/We certify that I/We have verified the identity of each owner/insured by reviewing a valid government issued photo identification. | ☐ | ☐ |

_____ Signature of Producer 1 Date

_____ Signature of Producer 2 Date

_____ Signature of Producer 3 Date

_____ Signature of Producer 4 Date

## NOTICE OF INSURANCE INFORMATION PRACTICES

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

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. 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. Information for consumers about MIB may be obtained on its website at www.mib.com. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734. MIB may also be contacted at 1-866-692-6901 (TTY 1-866-346-3642). Symetra Life or its reinsurers may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

**Investigative Consumer Report** – As a part of our underwriting procedure, we may request an investigative consumer report from a consumer reporting agency. A consumer report confirms and supplements the information on your application about your employment, residence, finances, smoking habits, marital status, occupation, hazardous avocations and general health. This report may also include information concerning your general reputation, personal characteristics and mode of living except as may be related directly or indirectly to your sexual orientation, including drug and alcohol use, motor vehicle driving record and any criminal activity. This information may be obtained through personal interviews with you, your family, friends, neighbors and business associates. If a report is required, you may request to be personally interviewed. If you wish to be personally interviewed, request this in the remarks section of this application and we will notify the consumer reporting agency.

The information contained in the report may be retained by the consumer reporting agency and later disclosed to other companies to the extent permitted by the Fair Credit Reporting Act. We hold investigative consumer reports in strict confidence, and we use them only to evaluate your application on a fair and equitable basis. You have a right to inspect and obtain a copy of this report from the consumer reporting agency. Such a report rarely has an adverse effect on an individual's eligibility for insurance. If it should, however, we will notify you in writing, and identify the reporting agency. You, or your authorized representative, are entitled to a copy of the Notice of Insurance Information Practices.

**Disclosure to Others** – Personal information we obtain about you during the underwriting process is confidential, and we will not disclose it to other persons or organizations without your written authorization, except to the extent necessary for the conduct of our business. Examples of situations where we may share information about you follow:

1. The agent may retain a copy of your application. If reinsurance is required, the reinsurance company will have access to our application file. We give the consumer reporting agency enough identity information about you so that it may initiate a consumer report investigation.
2. We may release information to another life insurance company to whom you have applied for life or health insurance, or to whom you have submitted a claim for benefits, if you have authorized that company to obtain such information, and it submits your authorization to us with its request for information.
3. As stated earlier, we may report information to MIB.
4. We may release information to persons or organizations conducting bona fide actuarial or scientific research studies, audits or evaluations, or to our affiliates who may wish to market products or services.
5. We will disclose information to government regulatory officials, law enforcement authorities, and others where required by law.

**Access and Correction** – In general, you have a right to learn the nature and substance of any personal information about you in our file, upon your written request. Whenever we make an adverse underwriting decision, we will notify you of the reasons for the decision and the source of the information on which we based our decision. Please refer to the section on MIB, Inc., for that organization's disclosure procedure. There are procedures by which you can obtain access to personal information about you appearing in our policy files, including information contained in investigative consumer reports. We have also established procedures by which you may request correction, amendment or deletion of any information in our files which you believe to be inaccurate or irrelevant. A description of these procedures will also be sent to you upon request. If you feel that any information we have is inaccurate or incomplete, please write to the Life New Business Department of Symetra Life, PO Box 84068, Seattle, Washington 98124. Your comments will be carefully considered and corrections made where justified.

## TEMPORARY LIFE INSURANCE AGREEMENT

**For All plans EXCEPT Symetra UL-G. The Temporary Life Insurance Agreement for Symetra UL-G plans is provided for in the Additional Insured Application.**

**AMOUNT OF COVERAGE:** If the Temporary Life Insurance questions have been answered "no" and if money has been accepted as advance payment for life insurance and Proposed Insured A dies while this temporary insurance is in effect, we will pay the beneficiary an amount equal to the lesser of:

(a) the amount of all death benefits applied for with this application, including any accidental death benefits, if applicable; or
(b) a maximum amount under all Temporary Life Insurance Agreements with Symetra Life of $250,000.

**COVERAGE BEGINS:** Life insurance under this Agreement will begin on the date of this application, if the Temporary Life Insurance questions have been completed and answered "no" and money equal to the first full premium has been accepted as advance payment for life insurance.

**COVERAGE ENDS:** Life insurance under this Agreement will terminate on the earliest of:

(a) 90 days from the date of this Agreement; or
(b) the date that insurance takes effect under the policy applied for; or
(c) the date a policy, other than as applied for, is offered to the Applicant; or
(d) the date the Company mails notice of termination of coverage and a return of the payment to the Applicant.

**LIMITATIONS:**

(a) This Agreement does not provide benefits for disability.
(b) Fraud or material misrepresentation in the application or in the answers to the questions of this Agreement invalidate this Agreement and the Company's only liability is for refund of the payment made.
(c) If Proposed Insured A is less than 15 days old or more than 75 years old, the Company's liability under this Agreement is limited to a refund of the payment made.
(d) If Proposed Insured A commits suicide, the Company's liability under this Agreement is limited to a refund of the payment made.
(e) If the check or draft submitted as payment is not honored by the bank, there is no coverage under this Agreement.
(f) No one is authorized to waive or modify the terms of this Agreement.

# HIPAA Compliant Authorization for Release of Medical Information to Symetra Life Insurance Company*

_____
Policy Number

_____ _____
Name of proposed insured/patient (please type or print) Date of birth

**I authorize** any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf ("My Providers") to disclose my entire medical record, prescription history, medications prescribed and any other protected health information concerning me to Symetra Life Insurance Company, its employees, agents or representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

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, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that Symetra Life Insurance 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 or have applied for with Symetra Life Insurance Company.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written notification to Symetra Life Insurance Company. I understand that a revocation is not effective to the extent that any of My Providers has already relied on this Authorization to disclose information about me or to the extent that Symetra Life Insurance Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be redisclosed by Symetra Life Insurance Company except as authorized by me or as required by law.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, Symetra Life Insurance Company may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I understand that any authorized representative or I will receive a copy of this authorization upon request.

_____

Signature of Proposed Insured/Patient or Personal Representative Date

_____

Description of Personal Representative's Authority or Relationship to Patient

* Symetra Life Insurance Company
Mailing Address: PO Box 84068
Seattle, WA 98124
777 108th Avenue NE, Suite 1200
Bellevue, WA 98004-5135

Click here to clear form

SYMETRA
RETIREMENT | BENEFITS | LIFE

**Symetra Life Insurance Company**
777 108th Avenue NE, Suite 1200 | Bellevue, WA 98004-5135
Mailing Address: PO Box 84068 | Seattle, WA 98124-9918
Phone 1-800-796-3872 | TTY/TDD 1-800-833-6388

# FINANCIAL INFORMATION SUPPLEMENT TO PART 1 APPLICATION

Proposed Insured _____ Date of birth_____

## SECTION I - PERSONAL INSURANCE
## TO BE ANSWERED IF THE INSURANCE APPLIED FOR IS PERSONAL COVERAGE

1. Net Worth

| Assets: | | Liabilities: | |
|---|---|---|---|
| Cash/Other Liquid Assets $ | _____ | Mortgages | _____ |
| Personal Property | _____ | Other Liabilities | _____ |
| Real Estate | _____ | Total Liabilities: | _____ |
| Stocks/Bonds | _____ | | |
| Other (describe) | _____ | | |
| Total Assets: | _____ | | |
| | | Total Net Worth: | _____ |

2. Please give your total income

| | Last Year | Year Prior |
|---|---|---|
| Annual Salary | $ _____ | $ _____ |
| Investment Income, Dividends, etc. | _____ | _____ |
| Other Income (describe) | _____ | _____ |
| TOTAL | $ _____ | $ _____ |

## SECTION II - BUSINESS INSURANCE
## TO BE ANSWERED IF THE INSURANCE APPLIED FOR IS BUSINESS COVERAGE:

1. Name of Company _____
2. Length of time in business ☐ Corporation ☐ Partnership ☐ Sole Proprietorship
3. Is the business being reorganized or expanded? ☐ Yes ☐ No

   If yes, provide details.

4. Please attach a copy of your Company's latest audited financial statements (balance sheet and profit & loss). If not available, complete the following:

a. CURRENT COMPANY BOOK VALUE

| | |
|---|---|
| Assets | $ _____ |
| Liabilities | _____ |
| Net Worth | _____ |
| Insured's % Ownership | _____ |

b. COMPANY NET PROFIT - Past Two Years (After taxes and bonuses)

| | |
|---|---|
| 20_____ | $_____ |
| 20_____ | $_____ |
| This Year (Est.) | $_____ |

c. List below Business Insurance on all other key persons or owners of this business:

| Name | Title | Amount Applied For | Amount In Force | Percent of Ownership |
|---|---|---|---|---|
| | | $ | $ | % |
| | | $ | $ | % |
| | | $ | $ | % |

If other stockholders, partners, or key persons are not being similarly insured, why not?

_____

_____

5. (Check at least one box and furnish details)

☐ KEY PERSON

a. What special skills, knowledge, or experience does the proposed insured possess which makes the insurance necessary?

_____

b. What is his/her compensation from the business? $_____

c. If the business is a new venture or was recently reorganized, please describe the key person's business background.

_____

_____

☐ STOCK REDEMPTION/BUY AND SELL

a. Is there a written agreement in effect? ☐ Yes ☐ No (Attach signed copy)

b. Current value of the business? $_____

c. How was the value determined? _____

☐ BUSINESS LOAN

a. Lender _____

b. Amount of loan $ _____ Date of loan _____ Is lender requiring the insurance? ☐ Yes ☐ No

c. The repayment terms are _____

_____

d. The purpose of the loan is _____

_____

---

I represent that all the statements and answers to the above questions are complete and true, to the best of my knowledge and belief, and I agree that they shall form a part of my application for insurance.

Signed at _____ this _____ day of _____ , _____

Signature of Proposed Insured Date

Signature of Applicant Date

Witnessed by Date

SYMETRA
RETIREMENT | BENEFITS | LIFE

**Symetra Life Insurance Company**
777 108th Avenue NE, Suite 1200 | Bellevue, WA 98004-5135
Mailing Address: PO Box 34690 | Seattle, WA 98124-1690
Phone 1-800-796-3872 | TTY/TDD 1-800-833-6388

# FINANCIAL PRODUCTS DISCLOSURE

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

Prior to purchasing the new life insurance or annuity product, you may want to obtain independent legal or financial advice before selling or liquidating any assets.

***Are you or your spouse considering purchasing this product based on its treatment under the Medi-Cal program?***

☐ **No.**
☐ **Yes**. If **yes**, read and complete the California DHCS-7102

I/We have read the above disclosures and have received a copy of this form.

Dated: _____

_____ _____
Owner's Name (Please print) Joint Owner's Name (Please print)

_____ _____
Owner's Signature Joint Owner's Signature

_____
Agent's Name (Please print)

_____
Agent's Signature

---

Note: Agent Instructions Below
If your client selects the **YES** box above, have them complete the DHCS-7102 form. Submit the completed DHCS-7102 and the completed LA-4026 along with the client's completed application.

If your client selects the **NO** box above, then simply submit this completed LA-4026 form along with the client's completed application. The DHCS-7102 is not required if the client checks the **NO** box.

Click here to clear page

SYMETRA®
RETIREMENT | BENEFITS | LIFE

**Symetra Life Insurance Company**
777 108th Avenue NE, Suite 1200 | Bellevue, WA 98004-5135
Mailing Address: PO Box 84068 | Seattle, WA 98124-9718
Phone 1-800-796-3872 | TTY/TDD 1-800-833-6388

# NOTICE AND CONSENT FOR AIDS-RELATED BLOOD, URINE, OR SALIVA TESTING

To evaluate your insurability, the Insurer named above, Symetra, has requested that you provide a sample of your blood, urine, or saliva 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. Please see additional information regarding testing on the reverse side of this form.

## TESTS TO BE PERFORMED

We will use an ELISA test or a Western Blot Assay, or both.

An ELISA test is an enzyme-linked immunosorbent assay serologic test which has been licensed by the Federal Food and Drug Administration to detect antibodies to the human immunodeficiency virus. A positive ELISA test means an ELISA test performed in accordance with the manufacturer's specifications which is reactive on an initial testing and on at least one of two additional tests of the same serum or plasma specimen.

A Western Blot Assay is an assay which uses reagents consisting of HIV antigens separated by polyacrylamideget electrophoresis and then transferred to nitro-cellulose paper to detect antibodies to the human immunodeficiency virus. A reactive Western Blot Assay is a Western Blot Assay which is reactive according to the standards of performance and results specified in the manufacturer's Federal Food and Drug Administration approved product circular for the Western Blot Assay reagents and laboratory apparatus.

## NOTIFICATION OF TEST RESULTS

If your test results are negative, no routine notification will be sent to you. If your test results are reported by the laboratory to the Insurer as being positive, 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, you are asked to list your private physician so that the Insurer can have him or her tell you the test result and explain its meaning.

Name of physician for reporting positive test result:

_____
Name

_____
Street City State Zip

If you do not wish to know the results of the test, initial here: _____. In the event the test is positive 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.

If you want to know the results of the test but do not at present have a private physician, initial here:_____ . The result will be sent to you at the address provided by registered mail with delivery restricted to you only.

The result will be sent to that person by registered mail with restricted delivery.

## CONSENT

I have read and I understand this Notice and Consent for AIDS-Related Blood, Urine, or Saliva Testing. I voluntarily consent to providing a sample of my blood, urine, or saliva (or providing a sample of my child's blood, urine, or saliva) and to the testing of that blood, urine, or saliva and the disclosure of the test results as described above. I have read the information on the reverse side of 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.

_____
Name of Proposed Insured

_____
Street City State Zip

_____ _____
Signature of Proposed Insured or Parent/Guardian Date Signed

Please give a copy to your client.

PRE-TESTING CONSIDERATIONS

Many public health organizations have recommended that before taking an AIDS-related blood, urine, or saliva test a person seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, prior to being tested.

MEANING OF POSITIVE TEST RESULTS

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 will be treated confidentially. They will be reported by the laboratory to the Insurer. When necessary for business reasons in connection with insurance you have or have applied for with the Insurer, the Insurer may disclose test results to others involved solely in the underwriting process such as its affiliates, reinsurers, employees or contractors. If the Insurer is a member of the Medical Information Bureau (MIB, Inc.), and if the test results for HIV antibodies/antigens are other than normal, the Insurer will report to the MIB, Inc., a generic code which signifies only a non-specific test abnormality. If your HIV test is normal, no report will be made about it to the MIB, Inc. The organizations described in this paragraph may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or as authorized by you.

Click here to clear page

SYMETRA
RETIREMENT | BENEFITS | LIFE

**Symetra Life Insurance Company**
777 108th Avenue NE, Suite 1200 | Bellevue, WA 98004-5135
Mailing Address: PO Box 34690 | Seattle, WA 98124-1690
Phone 1-800-796-3872 | TTY/TDD 1-800-833-6388

# CERTIFICATION AND ACKNOWLEDGEMENT

(Check One)

☐ As the agent/producer, I certify that either **no illustration of life insurance was used during the sales process**, or that the illustration used did not conform to the policy as applied for.

☐ As the agent/producer, I certify that **I displayed a computer screen illustration of life insurance** that complies with state requirements and for which no printed copy was furnished to the applicant. The screen illustration was based on the following information:

| | |
|---|---|
| Name of Primary Proposed Insured | |
| Product* | Flexible Premium Universal Life Insurance ☐ Classic UL (ICC11_LC5 or L-10055) ☐ CVAT ☐ GPT ☐ SUL (L-9994) |
| Number of Years Illustrated | _____Years To Age _____ Other _____ |
| Planned Premium | $_____ Number of Premium Paying Years_____ |
| Goal<br>Goal Year | Cash Value $_____ Cash Value Year $_____<br>Death Benefit $ _____ Death Benefit Year _____ |
| 1035 Exchange | ☐ No ☐ Yes Estimated Value_____ Cost Basis_____ |
| Riders* | ☐ Additional Term Rider $_____<br>☐ *Self* ☐ *Other*_____<br>☐ Lapse Protection Benefit (Classic Only) _____ Term/YR<br>☐ Accidental Death Benefit _____ Units<br>☐ Guaranteed Insurability Option _____ Units<br>☐ Cognitive Impairment Term Illness Rider _____ Units<br>☐ Waiver of Premium (SUL Only) |

*Not all policies/riders/benefits available in all states.

(Check One)

☐ As the applicant, I acknowledge that either no illustration of life insurance has been provided to me, or that the illustration used did not conform to the policy as applied for. I further acknowledge and understand that a printed illustration conforming to the issued policy will be provided no later than the date the policy is delivered.

☐ As the applicant, I acknowledge that I viewed a computer screen illustration of life insurance based on the information stated above and that no printed copy of it was provided to me. I further acknowledge and understand that a printed illustration conforming to the issued policy will be provided to me no later than the date the policy is delivered.

_____

Agent/Producer's signature Date

_____

Applicant's signature Date

**Send a copy to the Home Office with application; provide a copy to applicant; and retain a copy for your records.**

Click here to clear page.

SYMETRA
RETIREMENT | BENEFITS | LIFE

777 108th Avenue NE, Suite 1200 | Bellevue, WA 98004-5135
Mailing Address: PO Box 84068 | Seattle, WA 98124-9918
Phone 1-800-796-3872 | Fax 1-877-435-5500
TTY/TDD 1-800-833-6388

# INITIAL PAYMENT BY BANK DRAFT (EFT) – AUTHORIZATION

Please attach a copy of a voided check or complete the information below for the account from which you wish to have your initial and future premiums paid by EFT.

12-345
6789 **0000**

**Mr./Mrs. Checkwriter**
Address
City, State Zip

Date_____

Pay to the
Order of_____ _____ $ _____

_____ **VOID** _____ DOLLARS

**Bank Name**

Branch

For _____ _____

00000000000 00000 000 0000

**Tape voided check here.**

**– OR –**

| | |
|---|---|
| **Name on Account:** Enter exactly as it appears on your check | _____ |
| **Account Type:** | ☐ Checking ☐ Savings |
| **Bank Name:** | _____ |
| **Routing Number:** | _____ |
| **Account Number:** | _____ |
| | |

**Complete this section.**

If your face amount is $1,000,000 or less and you answered "no" to the temporary insurance questions, you will be covered under the Temporary Insurance Agreement if a check is collected for the initial premium payment or you sign up for initial payment by EFT (maximum coverage is $250,000). This is subject to change if, during the underwriting of your application, we determine we are unable to offer the temporary coverage. Please refer to the Temporary Insurance Agreement, included with the Notice of Insurance Information Practices.

| | |
|---|---|
| **Bank Draft/EFT Requests** | |
| **Draft Date:** | _____ **Note: Completion of this section is required for all Bank Draft/EFT requests.** Draft dates cannot include the 29th, 30th, or 31st. The initial bank draft will be taken the next business day after the policy has been put in force. Future drafts will be taken on the draft date selected. To stop future drafts, contact our Customer Service Department at 1-800-SYMETRA. |

Policy number_____

_____ _____
Applicant/Payor Signature Date

## Agent Instructions for initial payment EFT authorization form:

1) Remind your client to deduct the initial payment from their checking or savings account register, immediately.

   The initial payment will be drafted immediately, when the policy is put in force.
   Subsequent premiums will be deducted each month, on the selected draft date.

2) Attach a voided check from the account to be drafted, **or** complete the account information section on the EFT authorization form.

3) Always indicate the draft date, in the Bank Draft/EFT Requests section on page 1.

4) Have the applicant sign and date the form.

5) Send the completed form with the application, **or** if sending separately, FAX it to 1-877-435-5500.

Please be sure the information on the form is accurate, and that the client understands that their account will be drafted for the initial premium as soon as we issue the policy.

If there are changes to the EFT information, at any time, please have the client contact us. If we are not notified of a change, an EFT draw can be returned unpaid.

The most common causes for returned EFTs are:

The account was closed
Incorrect account number
Insufficient funds

# NOTICE REGARDING STANDARDS FOR MEDI-CAL ELIGIBILITY AND RECOVERY
## For Distribution by Insurers, Agents, and Brokers

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 will 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/she has less than $2,000 in countable resources.

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

### Married Resident

Community Spouse Resource Allowance: If one spouse lives in a nursing facility and the other spouse does not live in a facility, the Medi-Cal program will pay some or all of the nursing facility costs as long as the couple together does not have more than $119,220 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/her individual monthly income, or $2,981 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 $119,220 in countable resources. The order also may allow the at-home spouse to retain more than $2,981 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 that 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, Subchapter D, Part 1. In some circumstances, Medi-Cal does not count funds held in an IRA, Keogh, or other work-related retirement arrangement. To find out if Medi-Cal would count your IRA, Keogh, or work-related retirement arrangements, you may contact your local county welfare department.

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

➢ _____

Spouse’s signature

➢ _____

Legal representative signature

➢ _____

**Symetra Life Insurance Company**
777 108th Avenue NE, Suite 1200 | Bellevue, WA 98004-5135
Mailing Address: PO Box 34690 | Seattle, WA 98124-1690
Phone 1-800-796-3872 | TTY/TDD 1-800-833-6388

# IMPORTANT NOTICE REGARDING REPLACEMENT

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 agent or company that sold you your existing policy to give you information about it.

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

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

The following policies will be replaced:

| Company | Policy No. | Insured |
|---|---|---|
| | | |
| | | |
| | | |

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

Applicant/Co-Applicant signature

Applicant address

Date

Certification by the agent: I hereby certify that only Symetra approved sales materials were presented and left with the applicant.

Agent signature

Date

**Please give a copy to your client**

Click here to clear page

SYMETRA
RETIREMENT | BENEFITS | LIFE

**Symetra Life Insurance Company**
777 108th Avenue NE, Suite 1200 | Bellevue, WA 98004-5135
Mailing Address: PO Box 34690 | Seattle, WA 98124-1690
Phone 1-800-796-3872 | TTY/TDD 1-800-833-6388

# TRUST CERTIFICATION

This form is used for situations in which a trust is the owner of a policy issued by Symetra Life Insurance Company ("the Company").

The trustee(s) and the grantor / settlor should complete and execute this form. The grantor / settlor is the creator of the trust.

If additional space is needed, use a separate piece of paper, provide all required signatures and attach it to this form.

## 1. Policy and Trustee Information

*If more than two trustees, please attach additional sheet with trustee names, addresses and signatures.*

| Insured name (first, middle initial, last) | Policy number(s) |
|---|---|
| | |

Trust name

| Trustee name | Trustee name |
|---|---|
| Trustee address | Trustee address |
| Date of trust | Trust tax ID |

If any trustee is also the Insurance Producer/Agent, provide below the reason and relationship of that individual to the insured/grantor/settler:

## 2. Trust Information

*If Section 2 is not completed, the Company will be hereby authorized to accept and be bound by the instructions for any one trustee.*

Type of trust ☐ Irrevocable ☐ Revocable (if selected, you must list persons with power to revoke)

| Name of person with power to revoke | Name of person with power to revoke |
|---|---|
| | |

If the trust has more than one trustee, select one:

☐ Must act in unison ☐ Other (only designated trustees may bind the trust, list names below)

☐ May act independently

_____

_____

## 3. Certification

Each undersigned Trustee does hereby represent and certify the following:

- There are no other trustees of the trust other than the ones named in this form.
- The trust is valid under the laws of the applicable state and is currently in full force and effect.
- The trust has an insurable interest in the life of the insured(s) named in the application/policy.
- I/we have the authority to make this certification and, acting on behalf of the trust, to purchase or surrender policies, to make distributions from the trust, and to give the Company instructions regarding policies. My/our instructions to the Company will be binding on the trust.
- I/we will promptly notify the Company, in writing, in the event of any amendment to or termination of the trust, any change in the identity of the trustee(s), or any other event affecting the representations made in this form while above policy is in force.
- The trust will not hold the Company responsible for any duties or obligations other than its contractual obligations as issuer of the above policy.
- I/we are aware of the tax requirements for trust ownership of this policy; the trust will not hold the Company responsible for any adverse tax consequences as a result of the actions of the trustee(s).
- The information contained in this document is correct, and we/I understand and agree that the Company will rely on this information for all purposes related to trust ownership of the identified policy.

Click here to clear page

## 4. Signatures

The undersigned declare(s) that the trust has not been revoked, modified or amended in any manner which would cause the representations contained herein to be incorrect. The undersigned, on behalf of the trust, agree(s) to indemnify and hold harmless the Company from any and all liabilities and expenses, including attorneys' fees, for claims, judgments, surcharges, or settlement amounts that the Company may incur as a result of relying upon the representations and certifications made herein. Each trustee will be jointly and severally liable for performing the obligations stated above. Such obligations and this indemnification will survive termination of the trust or the policy and will be binding upon all heirs, successors, or assigns.

I/we understand that the Company will rely on this form until it receives signed written notice of any charges as noted in the certifications above.

*Please PRINT clearly.*

| Print name | | Print name | |
|---|---|---|---|
| Signature | Date (MM/DD/YYYY) | Signature | Date (MM/DD/YYYY) |
| Print name | | Print name | |
| Signature | Date (MM/DD/YYYY) | Signature | Date (MM/DD/YYYY) |

***In Michigan only,*** the settlor or the attorney for the settlor / trust may sign this form; however, only the trustee(s) may authorize transactions on the policy. If you are signing this form as one of these individuals, please indicate your title below.

☐ Settlor ☐ Attorney ☐ Trustee

## 5. Notary Signature and Stamp

*Notarization is only a requirement in the State of Michigan.*

**The signer(s) named in this certification have appeared before me, have been sworn and have attested that the information contained in this affidavit is true.**

| Notary signature | Date (MM/DD/YYYY) |
|---|---|

Notary seal

My commission expires:

The Company reserves the right to request a copy of the full trust at any time.