Application for Individual Life Insurance

Pacific Life Insurance Company

Lynchburg Operations

6750 Mercy Rd., Ste. B, Omaha, NE 68106
P.O. Box 2869, Omaha, NE 68103
(844) 276-5759 • Fax (844) 520-1618 • www.PacificLife.com

PACIFIC LIFE

Pacific Life Insurance Company

CA BK-10565-06 11/2020

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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.

Does your applicant qualify for PL Smooth Sailing?

- Applicant is between age nearest birthday 50-69, any risk class including Substandard
- Amount of coverage applied for and in force with Pacific Life is less than or equal to $1,000,000.
- Applicant had a comprehensive physical and bloodwork with their primary care health provider within the last 18 months, with two or more years of history with the doctor

If all three requirements can be met, check "Yes" Section 3 of the Producer's Report indicating your application meets the pre-screen requirements.

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. (If the Proposed Insured does not qualify for PL Smooth Sailing)
- 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 Temporary Insurance Application Agreement (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 TIAA is answered "Yes" or left blank.

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ELECTRONIC INFORMATION OPT-IN CONSENT

E-Mail address: _____

By providing the e-mail address above and signing, I voluntarily consent to receive documents and notices applicable to my contract as permitted by law, including prospectuses, prospectus supplements, reports, statements, immediate confirmations, tax forms, proxy solicitations, privacy notice and other notices and documentation in electronic format when available instead of receiving paper copies of these documents by U.S. Mail. Pacific Life will send paper copies of annual statements if required by state or federal law. Not all contract documentation and notifications may be currently available in electronic format. For jointly owned contracts, both owners are consenting to receive information electronically.

Pacific Life suggests that in order to receive documents electronically, the contract owner should have ready access to a computer with Internet access, an active e-mail account to receive this information electronically, and ability to read and retain it. I understand that:

- **There is no charge for electronic delivery, although my Internet provider may charge for Internet access.**
- **I should provide a current email address and notify Pacific Life promptly when my e-mail changes.**
- **I should update any e-mail filters that may prevent me from receiving e-mail notifications from Pacific Life.**
- **I may request a paper copy of the information at any time for no charge, even though I consented to electronic delivery, or if I decide to revoke my consent.**
- **For jointly owned contracts, all information will be provided to the email address listed. Electronic delivery will be cancelled if e-mails are returned undeliverable.**
- **This consent will remain in effect until I revoke it.**

Please call (844) 276-5759 and tell a customer service representative if you would like to revoke your consent, wish to receive a paper copy of the information above, or need to update your e-mail address. You may opt out of electronic delivery at any time.

Owner's Signature	Date (mo/day/yr)	Signed at: City	State
SIGN HERE	DATE	CITY	STATE _____
Joint Owner's Signature (if applicable)	Date (mo/day/yr)		
SIGN HERE	DATE		

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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*

Life Insurance producer signature

Life Insurance producer name printed

License No.

Managing agency/Brokerage No.

Life Insurance producer signature

Life Insurance producer name printed

License No.

Managing agency/Brokerage No.

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PRODUCER'S REPORT

1. Life Insurance Producers to Receive Commission (Complete for each producer to receive commission.) Total Commission Share(s) to equal 100%, including a Producer Report Overflow page, if applicable. Each producer will share equally unless otherwise indicated.

A. Producer's Name: First	MI	Last		B. Last four of SSN/TIN
C. Address: Street		City	State	Zip
D. Email Address	E. Telephone # (include area code)		F. Commission Share	G. Company Code #

A. Producer's Name: First	MI	Last		B. Last four of SSN/TIN
C. Address: Street		City	State	Zip
D. Email Address	E. Telephone # (include area code)		F. Commission Share	G. Company Code #

2. Managing Agency/Brokerage Report

A. Managing Agency/Brokerage Name	B. Managing Agency/Brokerage #
C. Email Address	D. Date

3. Smooth Sailing Underwriting Pre-Screen

The Proposed Insured may be eligible for Pacific Life Smooth Sailing underwriting without the need for a paramed exam with lab testing. If you and the Proposed Insured believe he/she meets the following criteria, please check "Yes" below indicating your client meets the pre-screen:

- Applicant is age nearest birthday 50-69, any risk class including Substandard
- Amount of coverage is <= $1M pending and inforce with Pacific Life Insurance Company
- Has Attending Physician Statement (APS) with physical and blood work within the last 18 months, with two or more years of history with the doctor

☐ **Yes, the applicant qualifies for Pacific Life Smooth Sailing** (If the box is **NOT** selected, you will be required to order the paramed exam with lab testing)

4. General Information

A. Indicate which language(s) the Proposed Insured speaks and understands.
☐ English ☐ Spanish ☐ Other: Provide Details _____

B. If the Proposed Insured is married, provide the amount of insurance on the spouse. $_____
If the spouse is not insured provide reason:_____

C. If the Proposed Insured is a minor, provide the amount of insurance on parents and siblings, include sibling's name, below:
Father: $_____ Mother: $_____ Sibling:_____ $_____
Sibling: _____ $_____ Sibling:_____ $_____
If parents and siblings are not insured provide reason:_____

5. Signature

I represent 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, and I have discussed the appropriateness of replacement, if any, and followed applicable state laws; (2) the information provided in this report and by the Owner and Proposed Insured in the application is complete, accurate and correctly recorded; (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.

X _____ Date (mm/dd/yyyy)

Producer's Signature

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PRODUCER'S REPORT OVERFLOW

1. Life Insurance Producers to Receive Commission (Complete for each producer to receive commission.) Total Commission Share(s) to equal100%, including Producer listed on Producer Report form. Each producer will share equally unless otherwise indicated.

A. Producer's Name: First	MI	Last		B. Last four of SSN/TIN
C. Address: Street		City	State	Zip
D. Email Address			E. Commission Share	F. Company Code #

A. Producer's Name: First	MI	Last		B. Last four of SSN/TIN
C. Address: Street		City	State	Zip
D. Email Address			E. Commission Share	F. Company Code #

A. Producer's Name: First	MI	Last		B. Last four of SSN/TIN
C. Address: Street		City	State	Zip
D. Email Address			E. Commission Share	F. Company Code #

2. Signature

I represent 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; (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.

X

Producer's Signature

Date (mm/dd/yyyy)

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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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RIGHT TO NAME A SECONDARY ADDRESSEE TO RECEIVE POLICY NOTIFICATIONS

The law in your state permits you to designate a secondary party to receive duplicate copies of your policy billing correspondence, including a notice of lapse or cancellation due to nonpayment of premium. You may designate this party at time of application, policy delivery or any time the policy is in force by written notice to Pacific Life. In addition, a Secondary Addressee Designation form will be provided at the time of policy delivery. You may revoke your designated secondary party at any time also by written notice to Pacific Life.

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PACIFIC LIFE

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.

PACIFIC LIFE

OUR PRIVACY PROMISE

CUSTOMERS, PROSPECTIVE CUSTOMERS, AND RELATED PARTIES

- **We do not sell information about you.**
- **We do not share your information with anyone for their marketing purposes.**
- **We only use your personal information to help maintain and grow the business relationship you have with us.**

Privacy Notice to Our Customers, Prospective Customers, and Related Parties
As our customer or prospective customer, you have entrusted us to help you achieve your unique financial life goals. You may also be an individual designated by a customer or prospective customer as a related party, for example, a beneficiary. We are providing this privacy notice to assist you in understanding the types of personal information we may collect, where we receive it, how we use it, and how we protect the privacy of the personal information you share with us.

What Personal Information Do We Collect, Where Do We Get It, and Why Do We Collect It?
Most of the personal information we collect is obtained from you, with your consent, or from one of our customers. We collect personal information needed to service and manage your relationship with us. The type of information that we collect depends on the type of product or service you request, and includes:

- Information you provide on an application or other form (for example, name, address, social security number, or income);
- Information we get from other sources such as credit reporting agencies and information to verify employment or income;
- Information about your business relationship and history with us;
- Medical or health information you permit us to receive from doctors or other health care providers.

The primary use of your information is to confirm your identity and to underwrite policies or contracts, process claims, and service your relationship with us. Pacific Life will provide you an updated notice if the types of personal information we collect, or use, is materially different, unrelated, or incompatible with this notice.

How Do We Use and Disclose Your Information?
We may share information within our corporate family to service and grow the business relationship we have with you. Additionally, we may provide information to individuals and entities with whom you authorize us to share such information. If necessary, we disclose information when it is required by law,

for example, a filing to the Internal Revenue Service (such as Form 1099). We may also disclose certain information to other entities to help us report or prevent fraud, including reports to regulatory or law enforcement agencies. We do not share medical or health information among our family of companies or with unrelated companies, except as needed to maintain and process your transactions.

Pacific Life may disclose your personal information to a third party for a business purpose. When we disclose personal information for a business purpose, we require the recipient to keep that personal information confidential and not use it for any purpose except performing the service. Categories of third parties that may be given access to your personal information include:

- Consultants and contractors (e.g., external auditors)
- Financial services professionals
- Software service providers
- Attorneys and other legal professionals
- Cloud service providers
- Regulatory agencies
- Third party administrators

How Do We Protect the Security of Your Information?

We have policies that maintain the physical, electronic, and procedural safeguards to protect the confidentiality of your personal information. Access to your personal information is limited to those who need to know it to help service our relationship with you. Should your relationship with us end, we will continue to follow the privacy policies described in this notice to the extent that we retain information about you. If we no longer need to retain that information, we will dispose of it in a secure manner.

Do You Need to Do Anything?

It is not necessary for you to take any action. This is because we do not share your information except to service and grow the business relationship you have with us. You do not need to "opt-out" or "opt-in" as you may have done with other financial companies because we do not sell your information.

You May Request Your Information

You may request what information Pacific Life has collected about you and its purpose. We will provide a response once we receive and confirm your request. Your request must provide sufficient information to allow us to reasonably verify your identity. You do not need to create an account to request your information. For more information about submitting a request, please use one of the following methods:

- Call us at 877-722-7848, or
- Visit https://www.pacificlife.com/home/privacy-and-other-policies/your-personal-information.html

Confidentiality Practices for Victims of Domestic Violence or Abuse

Pacific Life understands that certain personal information may require special handling. This may be especially true in instances where an individual is, or has been, a victim of domestic violence or abuse. This information may include the individual's address, telephone number, name and place of employment, and other contact or location information.

If you are a Pacific Life applicant, policyowner, insured or beneficiary, who is a victim of domestic violence or other abuse, and would like Pacific Life to take steps to further safeguard your information from others or need to remove a previously submitted request, our Customer Service Representatives are available to assist you.

- For Life Insurance policies that have policy numbers beginning with “2L”, please call 844-276-0193 from 9:00AM-8:00PM ET
- For all other Life Insurance policies, please call 800-347-7787 from 5:00AM-5:00PM PT
- For Annuity Contracts, please call 800-722-4448, from 6:00AM-5:00PM PT

Pacific Life, as referred to in this notice, means Pacific Life Insurance Company and its affiliates and subsidiaries, including, but not limited to, Pacific Life & Annuity Company, and Pacific Select Distributors, LLC.

Residents of California

The information below supplements Our Privacy Promise and applies to residents of the State of California. The California Consumer Privacy Act of 2018 (CCPA) defines categories of personal information as the following:

Information Categories and Examples
Personal Identity, Financial, and Personal Health • Name • Alias • Address • Signature • Driver's license • Email address • Social Security number • Medical information • Health insurance information
Protected Classification Characteristics • Race • Ancestry • Citizenship • Marital status • Medical condition • Physical or mental disability • Sex (including gender, gender identity)
Commercial Information • Personal property • Products or service purchased
Biometric Information • Genetic characteristics • Physiological characteristics • Biological characteristics
Internet or Other Similar Network Activity • Information on your interaction with our websites
Sensory Data - Audio, Electronic, Visual, Thermal, Olfactory or similar information • Voice Recordings
Professional or Employment-Related Information • Current or past job history
Inferences Drawn from Personal Information • Profile created by analyzing information provided (for example, underwriting analysis)

Pacific Life obtains the categories of personal information listed above from the following categories of sources:

- Directly from you
- Healthcare professional or firm
- Financial service professional or firm
- Publicly available records
- Third parties that are not healthcare professionals or financial services professionals (e.g., consumer reporting agency, credit reporting agency, staffing agency, companies that provide services to us)
- Family member, dependent or beneficiary
- Analytical technology (e.g., internet usage, cookies, or automated underwriting technology)

You may request Pacific Life to delete personal information that we have collected and retained. Once we receive and confirm the request, we will delete (and direct our service providers to delete) your personal information from our records, unless an exception applies. We will not discriminate against you for exercising any of your rights**.** Please see **You May Request Your Information** section above for more information on how to submit a deletion request.

- Reviewed – November 25, 2019

PACIFIC LIFE INSURANCE COMPANY

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P.O. Box 2869, Omaha, NE 68103
(844) 276-5759 • Fax (844) 520-1618 • www.PacificLife.com

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: _____

Life Insurance

Buyer's Guide

GET SMART ABOUT INSURANCE

INSURE U

NAIC

National Association of Insurance Commissioners

Life Insurance *Buyer's Guide*

Prepared by the National Association of Insurance Commissioners

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

This guide does not endorse any company or policy

Before You Buy Life Insurance

Understand What Life Insurance Is

Life insurance pays a death benefit if you die while the policy is in effect, in exchange for premiums you pay before your death. You can use the death benefit to protect against financial hardships such as loss of your income, funeral expenses, medical or nursing care expenses, debt repayments, and child care costs after your death. You can get information from the NAIC InsureU Life Insurance website -- *www.insureuonline.org/insureu_type_life.htm*

If You Need Life Insurance, Decide How Much Coverage to Buy

How much life insurance to buy depends on the financial needs that will continue after your death. Examples include supporting your family, paying for child(ren)'s education, and paying off a mortgage. Some questions you may want to ask about your own needs include:

- Does anyone depend on me financially?
- How much of the family income do I provide?
- How will my family pay my final expenses and repay debts after my death?
- Do I want to leave money to charity or family?
- If I have life insurance through my employer, is it enough to meet my financial obligations?

The answers to these questions can help you decide how much coverage you need. An insurance agent, financial advisor, or insurance company representative can help you evaluate your insurance needs and give you information about available policies.

If You Already Have Life Insurance, Assess Your Current Life Insurance Policy

It's important to compare your current policy with any new policy you might buy. Keep in mind that you may be able to change your current policy to get benefits you want. Also, know that any changes in your health may impact your ability to get a new policy or the premium you'll pay. Don't cancel your current policy until you get the new one.

Also, while you may have free or low-cost life insurance through your employer, the death benefit usually is less than you need. And if you leave the employer, you may not be able to take this coverage with you.

Life Insurance *Buyer's Guide*

Compare the Different Types of Insurance Policies

There are many types of life insurance policies. You should choose a policy with features that fit your individual needs. Some things to consider are:

- ***Term Insurance vs. Cash Value Insurance.*** Term insurance is intended to provide lower-cost coverage for a specific period of time ("a term"). If you want coverage for a longer period of time, such as for your lifetime, cash value insurance may be more cost effective. Most term policies don't build up cash values that you can use in the future.

- ***Renewable Term vs. Non-renewable Term.*** Most term life insurance coverage can be continued ("renewed") at the end of the term, even if your health has changed. If you renew a term policy, the new premiums are higher. Ask what the premiums will be before you renew the policy. Also ask if you'll lose the right to renew the policy at a certain age. A Non-renewable term policy can't be continued. You'll have to apply for a new policy if you still want coverage.

- ***Whole Life vs. Universal Life.*** Whole life and universal life insurance are two types of cash value insurance. A key difference between the two is how you pay for the coverage. You typically pay premiums for whole life insurance according to a set schedule. In a universal life policy, you can choose a flexible premium payment pattern as long as you pay enough to keep your policy in force.

- ***Variable Life vs. Non-variable Life.*** The investments you will choose (such as stock and bond funds) in a variable life policy directly impact your cash value. These policies have the greatest potential to build cash value but also the greatest risk of losing cash value. Non-variable life policies often have guaranteed minimums for some features (interest or cash value, for example) but not all. Non-variable life policies also have less potential to build cash value than variable life policies.

Be Sure You Can Afford the Premium

Before you buy a life insurance policy, be sure you can pay the premiums. Can you afford the initial premium? If the premium increases later, will you still be able to afford it? The premiums for many life insurance policies are sensitive to changes in the company's investment earnings, claims costs, and other expenses. If those are worse than expected, you may have to pay a much higher premium. Ask what might be the highest premium you'd have to pay to keep your coverage.

Understand the Application Process

You can apply for life insurance through life insurance agents, the mail, and online. In addition to basic information, such as your name, address, employer, job title, and date of birth, you'll be asked for more personal information. Depending on the type of policy, the insurer may require you to see a doctor, answer health-related questions, or have a medical professional come to your home or office to assess your health. Usually a policy that doesn't require detailed health information will cost more and provide less coverage than one that does.

It's important to tell the truth on the application. The insurance company will check your answers so review the application before you sign. If the insurance company discovers false statements on your application after it issues your policy, it could reduce or cancel your coverage.

Choose a Beneficiary

A beneficiary is the person(s) or organization(s) you name to receive your life insurance policy's death benefit. You'll need to know the Social Security or tax identification number for all beneficiaries. Experts advise you not to name a minor child as a beneficiary. Insurance companies won't pay a minor. Instead, consider leaving the money to your estate or trust.

Evaluate the Future of Your Policy

Does your policy have a cash value? In some cash value policies, the values are low in the early years but build later on. In other policies the values build up gradually over the years. Most term policies have no cash value. Ask your insurance agent, financial advisor, or an insurance company representative for an illustration showing future values and benefits.

After You Buy Life Insurance

Read Your Policy Carefully

After you carefully read your policy, you should be able to answer the following important questions:

- Is your personal information correct?
- Do premiums or policy values vary from year to year?
- What part of the premium or policy value isn't guaranteed?
- How will the timing of money paid and received affect any interest the policy might earn?

Your insurance agent, financial advisor, or an insurance company representative can help you understand anything that isn't clear.

If you're not satisfied with your new policy, you can return it for a full refund within a certain period, usually 10 days after you receive it. The review period usually is stated on the first page of the policy.

Review Your Life Insurance Program Every Few Years

Review your policy with your insurance agent, financial advisor, or an insurance company representative every few years to keep up with changes in your policy and your needs.

- Have the premiums or benefits changed since your policy was issued?
- Do the death benefits still meet your needs?
- Do you need more or less coverage after life events, such as birth, adoption, marriage, job change, death, or divorce?

The insurance company can provide policy statements and illustrations to help with this review. As the policy owner, you can change beneficiaries at no cost. Be sure to review your beneficiaries every few years, especially after major life events that affect your life insurance needs.

Notes

National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197
(816) 842-3600

PACIFIC LIFE

PACIFIC LIFE INSURANCE COMPANY
Lynchburg Operations | P.O. Box 2869, Omaha, NE 68103
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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 X _____ Date of this TIAA _____ **Signature of Owner** *If other than Proposed Insured* 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) X _____ Life Insurance Producer Number(s) _____

PACIFIC LIFE

PACIFIC LIFE INSURANCE COMPANY

Lynchburg Operations | 6750 Mercy Rd., Ste. B, Omaha, NE 68106
P.O. Box 2869, Omaha, NE 68103
(844) 276-5759 • Fax (844) 520-1618 • www.PacificLife.com

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)

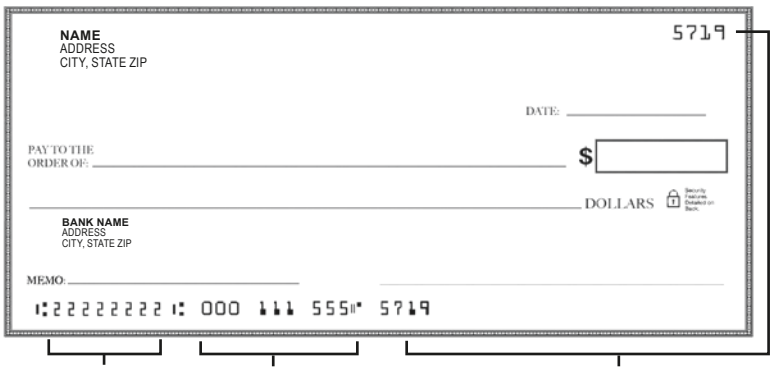
Bank Account Holder Name _____ Additional Bank Account Holder Name (if applicable) _____

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 _____



4. Credit Card Information (Complete for Initial Premium only. Not available for Universal Life products or 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

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 as defined in the Policy plus 75% of the difference between the Face Amount of the Policy and any Loan Value and (b) is the Maximum Accelerated Amount as shown in your Policy Specifications, which is the lesser of $500,000 or the Policy's Face Amount. 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. Any Policy Value, if applicable under the Policy, is not impacted. However, this lien will reduce the Policy's Death Proceeds and limit the availability of any applicable surrender benefit, future policy loans and 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. Any premiums due and unpaid will be added to the lien.

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 Face Amount; (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 4.50%; (6) the lien interest rate is 8.00%; and (7) the quarterly premiums are $500.

Before Accelerated Death Benefit Payment:

Face Amount	$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
Face Amount	$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) Face Amount	$800,000
Payment upon Death (e-d-c)	$289,787