SYMETRA
RETIREMENT | BENEFITS | LIFE

Consumer Privacy Statement

Symetra is serious about keeping your personal information private and secure. This notice of our privacy policy explains how we use and protect your information.

Symetra does not sell or rent information about you to others.

Where we get information about you

The information we get about you comes from different sources, and may include:

- Information that you give to us on applications or other forms, such as your name, address and Social Security number.
- Information from your transactions with us, our affiliated companies or our business partners. This includes products and services you have purchased from us or information about your payment history or claims.
- Information we receive from consumer reporting agencies to confirm or add to facts given by you.
- Information we receive from your insurance agent, broker or financial advisor. This may include updated information about your policy or account.

Sharing information

In order to conduct our business and offer you the products and services that you may want, we may share your information as allowed or required by law.

We may share your information with our affiliates or third parties outside the Symetra family of companies to service, market or underwrite our products and services to you.

We may share your information with insurance agents, brokers and financial advisors who sell our products and services. We may also share your information with financial institutions that we have joint marketing agreements with to sell our products and services.

Working with these businesses allows us to provide you with a broader selection of insurance and investment products and services from our companies. These businesses are legally obligated to keep your information private and secure, and to use it only for the services we request.

If any sharing of your information would require us to give you the option to opt-out of or opt-in to the information sharing, we will provide you with this option.

We will continue to follow our privacy policy as described in this notice even when you are no longer our customer.

Medical information

We obtain or share medical information only in connection with specific products and services. This may include underwriting a life insurance policy, processing a claim, or any other use that we disclose to you before the information is collected.

About independent insurance agents, brokers and financial advisors

The independent insurance agents, brokers and financial advisors who sell our products and services are not our employees and are not subject to our privacy policy.

They may have received personal information about you that we do not have. They may use this information differently than we do. Contact your agent, broker or advisor to learn more about their privacy practices.

Keeping your personal information safe

We protect your personal information in a variety of ways.

We maintain physical, administrative and technical safeguards to protect this information from unauthorized access.

Employees receive training to protect personal information, and are authorized to access this information only when they have a business need to do so. We expect the agents, brokers and advisors who sell our products and services to maintain a high regard for privacy and to safeguard customer information.

We follow your state law when it protects your privacy more than federal law.

Accuracy of your information

We need accurate information to provide you with the best possible service.

If you need to update your information, or if the information we have about you is inaccurate or incomplete, please contact us. Please be sure to include your name and policy number or contract number.

- By telephone: You can call us at the telephone number shown on your account statement or on other information we have sent to you. You can also call us at **1-800-796-3872**.
- In writing: You can write to us at the address shown on your account statement or on other information we have sent to you. You can also write to us at **P.O. Box 34690, Seattle, WA 98124-1690**.

You can also request a copy of the information that we have about you in our files to make sure it is correct. You must make your request in writing and send it to the address shown on your policy or contract or to the address shown above. We will send you the information within 30 business days of receiving your request. We will advise you of any person or group to whom we have given the information during the last two years.

If you believe the information about you in our files is wrong, you can notify us in writing. We will review your file and respond to you within 30 business days. If we agree with you, we will change our records. This change will become part of the file. It will be sent to those that received inaccurate information from us. It will also be included in any later disclosures to others.

If we disagree with you, we will explain why. You can provide us with a statement explaining why you believe the information is wrong. This statement will become part of the file. It will be sent to those that received the disputed information from us. It will also be included in any later disclosures to others.

Privacy and Symetra's websites

This notice also applies to our websites. If you would like more information about our website privacy and security practices, go to www.symetra.com and click on the Privacy link.

California Resident?

If you are a California resident, you may have additional privacy rights. Please visit www.symetra.com/CCPA for more information. Alternatively, you can call our CCPA hotline at 1-800-SYMETRA (796-3872) and enter extension 22216.

The Symetra family of companies

This notice applies to the following companies:

- Symetra Life Insurance Company
- Symetra National Life Insurance Company
- First Symetra National Life Insurance Company of New York
- Symetra Assigned Benefits Service Company
- Symetra Securities, Inc.
- Clearscape Funding Corporation

SYMETRA®
RETIREMENT | BENEFITS | LIFE

Symetra Financial Corporation
777 108th Avenue NE, Suite 1200
Bellevue, WA 98004-5135
www.symetra.com

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 35020
Seattle, WA 98124-3420
777 108th Avenue NE, Suite 1200
Bellevue, WA 98004-5135

Click here to clear page

Symetra Life Insurance Company
777 108th Avenue NE, Suite 1200 | Bellevue, WA 98004-5135
Mailing Address: PO Box 35020 | Seattle, WA 98124-3420
Phone 1-800-796-3872

NOTICE AND CONSENT FOR HIV 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. The test 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 a clinical test, laboratory or other, used to identify HIV, a component of HIV, or antibodies or antigens to HIV in connection with your application for life insurance.

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.

If you are informed of a positive test result, we urge you to contact any of the following for proper counseling:

- A private physician;
- The county department of health;
- The State Department of Public Health;
- Local medical societies; or
- Alternative test sites.

CONSENT

I have read and I understand this Notice and Consent for HIV-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 HIV-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 form

Indexed UL

Instruction / 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) _____

Insured Name _____

Agent Name _____

Agent Contact Information (Phone/Fax/Email) _____

Additional Notes_____

ACTIONS REQUIRED FOR ALL SALES:

☐ Complete and obtain signatures on the following required forms:

- Base Product Application
- Index Coverage Details Application
- Accelerated Death Benefit for Terminal Illness Disclosure
- Accelerated Death Benefit for Chronic Illness Rider Disclosure
- HIPAA Authorization
- Any State Specific forms (if applicable)

☐ Obtain a signed illustration for all sales.

☐ Witness the signing of the application and verify the identity of the customer using photo identification.

☐ Provide your client with the Notice of Insurance Information Practices, Symetra Privacy Notice, any state required disclosures, and copies of all forms completed as part of the application packet.

☐ Submit the application through your company's stated process OR you may fax the signed application and any other required forms to us at 1-877-435-5500.

FOR REPLACEMENT SALES:

☐ If the new insurance replaces an existing insurance or annuity, download, complete and obtain signatures on any state Replacement forms (if applicable). For any questions around replacements, please contact us at 1-877-737-3611.

IF YOU PLAN TO, AND QUALIFY FOR TEMPORARY INSURANCE:

☐ Make your Payment to: Symetra Life Insurance Company

☐ Mail your Premium Payment to: Symetra Life Insurance Company
PO Box 35020
Seattle, WA 98124-3420

or Overnight to: 777 108th Ave NE.
Bellevue, WA 98004

Symetra Life Insurance Company
Home Office: 777 108th Avenue NE, Suite 1200 | Bellevue, WA 98004-5135
Mail to New Business: PO Box 35020 | Seattle, WA 98124-3420
Fax: 1-877-435-5500

INDIVIDUAL LIFE INSURANCE APPLICATION

PART 1 – LUC – 246/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) Marital Status
(k) Height	(l) Weight	(m) US Social Security #/ US Tax ID	(n) Driver's License # and State of Issue

(o) US Citizen ☐ Yes ☐ No If not a citizen: Are you a Permanent Resident? ☐ Yes ☐ No
If No, Provide Country of Citizenship _____
Type of US Visa _____ Expiration Date _____

(p) Occupation and Duties

(q) Employer & Employer Address

(r) Earned Annual Income	(s) Unearned Annual Income	(t) 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 Accumulator IUL	☐ Cash Value Accumulation Test (CVAT) ☐ Guideline Premium Test (GPT)	☐ A: Face Amount ☐ B: Face Amount + Accumulation Fund ☐ C: Face Amount + Return of Premium	☐ Charitable Giving Rider (please complete information section below) ☐ Supplemental Protection Rider ☐ Surrender Value Enhancement Rider
☐ Symetra Protector IUL w/Lapse Protection	☐ Cash Value Accumulation Test (CVAT) ☐ Guideline Premium Test (GPT)	☐ A: Face Amount ☐ B: Face Amount + Accumulation Fund ☐ C: Face Amount + Return of Premium	☐ Charitable Giving Rider (please complete information section below) ☐ Surrender Value Enhancement Rider
☐ Symetra CAUL	☐ Cash Value Accumulation Test (CVAT) ☐ Guideline Premium Test (GPT)	☐ A: Face Amount ☐ B: Face Amount + Accumulation Fund ☐ C: Face Amount + Return of Premium	☐ Accidental Death Benefit $_____ ☐ Charitable Giving Rider (please complete information section below) ☐ Insured Children's Benefit (please complete the Part III ICB form) ☐ Term Rider on Others (please complete Part I for each rider insured) ☐ Term Rider on Self $_____

(c) Term Plans:

Product Section	Term Length	Optional Riders
☐ Symetra Term	☐ 10 Years ☐ 30 Years ☐ 15 Years ☐ 20 Years	☐ Accidental Death Benefit $_____ ☐ Insured Children's Benefit (please complete the Part III ICB form) ☐ Term Rider on Others (please complete Part I for each rider insured)

2. COVERAGES *(continued)*

(d) If you Elected the Charitable Giving Rider 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) Relationship of Proposed Owner to Proposed Insured A?

☐ Proposed Insured A
☐ Trust (Provide details in the section below and complete the Trustee Certification form)
☐ 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 (if different)

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

(j) US Citizen ☐ Yes ☐ No

If not a citizen: Are you a Permanent Resident? ☐ 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 (provide details below) ☐ No

Name: _____ Address: _____ Phone # _____

If you do not wish to add a secondary addressee now, you may give us a written notice of a secondary addressee anytime while the policy is in force.

4. 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.)	☐	☐
(c) Do you plan to replace an existing long term care policy or Life Insurance Policy with an Accelerated Death Benefit with this Life Insurance Policy that includes an Accelerated Death Benefit? If Yes, please review and sign the Important Notice to Applicant Regarding the Replacement of Long Term Care Insurance or Life Insurance Including Accelerated Death Benefits.	☐	☐

5. BENEFICIARY INFORMATION

The percentage for each type of beneficiary must total 100% and represent whole percentages. 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** ☐ **C**					
☐ **P** ☐ **C**					
☐ **P** ☐ **C**					
☐ **P** ☐ **C**					
☐ **P** ☐ **C**					

6. 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	Policy Type	Product Type	Face Amount	Issue Date (Month/Year)	Status	Select if Replacing and/or 1035 Exchange*
	☐ Personal ☐ Business	☐ UL ☐ VUL ☐ Term ☐ Group			☐ In Force ☐ Applied For	☐ Replacement ☐ 1035 exchange
	☐ Personal ☐ Business	☐ UL ☐ VUL ☐ Term ☐ Group			☐ In Force ☐ Applied For	☐ Replacement ☐ 1035 exchange
	☐ Personal ☐ Business	☐ UL ☐ VUL ☐ Term ☐ Group			☐ In Force ☐ Applied For	☐ Replacement ☐ 1035 exchange
(b) Total amount of applied for coverage to be placed with all companies including Symetra $						

7. PROPOSED INSURED A PERSONAL HISTORY (For any "Yes" answers, please provide details in Remarks Section 9)

(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? (If "yes", please complete the Residency and Travel questionnaire.)	☐	☐
(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/ice climbing or racing of any motorized vehicles? (If "Yes", also complete Aviation/Avocation questionnaire.)	☐	☐
(d) Has Proposed Insured A ever used any form of tobacco or nicotine based products? If yes, mark all that apply and complete the details below:	☐	☐

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

8. PAYMENT METHOD AND FREQUENCY

(a) Payment Method: ☐ Automatic EFT* ☐ Check
Payment With Application: $_____ (only if qualified for Temporary Insurance – Refer to Section 11)
Subsequent Premiums: $_____

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

Complete for payments to be taken by EFT (either complete the section below OR the Symetra EFT Form:

(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: _____ Routing #:_____ Account #: _____

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

First	MI	Last	☐ Male ☐ Female	US Social Security/US 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 (for Corporate signers, you must be authorized to sign on behalf of the Corporation)

SIGNATURE

* 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.

9. REMARKS

For any "Yes" answers or additional information, please provide details here:

10. ILLUSTRATION CERTIFICATION AND ACKNOWLEDGEMENT (NOT APPLICABLE TO SYMETRA TERM LIFE INSURANCE):

If an illustration (defined as a presentation or depiction that includes non-guaranteed elements of a policy over a period of years), was presented during the sale process and matches the policy applied for, a copy of that illustration must be signed and submitted to Symetra with the application. Otherwise, please review the following section.

As Proposed Owner, I acknowledge that:

☐ An illustration was not presented to me or an illustration was presented to me, however, the policy applied for is different than as illustrated.

If the illustration or revised illustration was not received, I understand that an illustration matching the policy, as issued, will be provided for my signature no later than at the time the policy is delivered.

Computer screen illustration certifications are not permitted on this application certification acknowledgment section. If a computer screen was used, and no illustration was printed, please review Symetra.com for the applicable certification acknowledgement form. This form must be submitted at time of application. If not received the application will be considered not in good order.

11. TEMPORARY LIFE INSURANCE AGREEMENT

Temporary Life Insurance Agreement (TIA) questions: For any Yes answers to questions (a) and (b) or if the face amount is greater than $1,000,000, do not collect premium. No TIA coverage will be in effect.	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 and included at application submission or if "payment of the initial premium by EFT" is selected. For Symetra SUL-G plans, TIA is offered under the Additional Insured Application.

12. AGENT/PRODUCER SECTION (To be completed by Agent/Producer)

AGENT CERTIFICATION (a) Is the Proposed Owner(s):	Yes	No
(i) Planning to fund this Policy using Premium Financing? (Available to IUL only)	☐	☐
(b) 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?	☐	☐
(c) 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?	☐	☐
AGENT REPLACEMENT		
(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?	☐	☐

13. AGENT ILLUSTRATION CERTIFICATION (NOT APPLICABLE TO SYMETRA TERM LIFE INSURANCE)

If an illustration (defined as a presentation or depiction that includes non-guaranteed elements of a policy over a period of years), was presented during the sale process and matches the policy applied for, a copy of that illustration must be signed and submitted to Symetra with the application. Otherwise, please review the following section.

As agent I acknowledge that :

☐ An illustration was not presented to the Proposed Owner or an illustration was presented to the Proposed Owner, however, the policy applied for is different than as illustrated.

Computer screen illustration certifications are not permitted on this application certification acknowledgment section. If a computer screen was used, and no illustration was printed, please review Symetra.com for the applicable certification acknowledgement form. This form must be submitted at time of application. If not received the application will be considered not in good order.

AUTHORIZATION TO RELEASE PERSONAL INFORMATION

I hereby authorize and request any medical care provider, pharmacy, pharmacy benefits manager, individual employer, insurance company, insurance support organizations, reinsuring company, medical examiners, state motor vehicle division, government unit, consumer reporting agency, and MIB, Inc., to disclose any and all medical information, any records or knowledge of my physical or mental health history, diagnosis, treatment, and prognosis, information regarding alcohol or drug abuse and including but not limited to transaction records, financial records, and complete medical records (including information regarding insurance, demographics, referral documents and records from other facilities), or motor vehicle 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, and/or other sexually-transmitted diseases. The authorized use, receipt, and disclosure of HIV test results is limited to those circumstances specifically permitted by Ins. Code §§ 799–799.10 and Health & Safety Code § 120980.

Continued on next page

AUTHORIZATION TO RELEASE PERSONAL INFORMATION *(continued)*

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 time limit may be increased or decreased to assure that the time limit complies with applicable law in the state where the policy is delivered or issued for delivery. 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 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.

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.
A false statement will not bar recovery pursuant to the policy unless the statement was made with intent to deceive**.**

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

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.)

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.

The section below must be completed in entirety to ensure your application can be processed.

Signed this_____**, at** _____**, State of** _____
Date (mm/dd/yyyy) **City** **State**

Printed Name of Proposed Insured A	Printed Name of Proposed Owner* (if other than Proposed insured A)
Signature Name of Proposed Insured A	Signature of Owner* (if other than Proposed Insured A)

Printed Name of Writing/Authorized Primary Insurance Producer	Primary Insurance Producer Phone
Signature of Writing/Authorized Primary Insurance Producer	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.

NOTICE OF INSURANCE INFORMATION PRACTICES

MIB, Inc. (Medical Information Bureau, MIB) - Information regarding the Insured's (You/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 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. If this consumer report has an adverse effect on an individual's eligibility for insurance, 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 as required or permitted by law or to the extent necessary for the conduct of our business. Examples of situations where we may share information about you are as follows:

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 if we receive a release from you authorizing us to release such information to that life insurance company.
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. The authorized use, receipt, and disclosure of HIV test results is limited to those circumstances specifically permitted by Ins. Code §§ 799–799.10 and Health & Safety Code § 120980.

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 35020, Seattle, WA 98124-3420. 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 Proposed Owner; or
(d) the date the Company mails notice of termination of coverage and a return of the payment to the Proposed Owner.

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.

No one is authorized to waive or modify the terms of this Agreement.

Symetra Life Insurance Company
777 108th Avenue NE, Suite 1200 | Bellevue, WA 98004-5135
Mail to New Business: PO Box 35020 | Seattle, WA 98124-3420
Fax: 1-877-435-5500

INDIVIDUAL LIFE INSURANCE APPLICATION – INDEXED COVERAGE DETAILS
LUC – 241

1. PROPOSED OWNER/APPLICANT (IF OTHER THAN PROPOSED INSURED) NAME

First Name, Middle Initial & Last Name/Trust Name	
Symetra Policy Number	Date

2. ALLOCATION OF NET PREMIUMS (MUST TOTAL 100% & MUST BE IN WHOLE INCREMENTS)

Please indicate the percentage of your premiums that you want allocated to an Index or Fixed Strategy below. These allocations will remain in effect until you change them with us.

Symetra Allocation Index Strategy -- Premium Allocation Options	**Premium Allocation**
Symetra Allocation Index 1-Year Point to Point	%
Symetra Allocation Index 2-Year Point to Point	%
Base Index Strategy -- Premium Allocation Options	
S&P 500® Composite Stock Price Index – Base – 1 Year Point to Point	%
JPMorgan ETF Efficiente® 5 Index – Base – 1 Year Point to Point	%
Blended S&P 500® Composite Stock Price Index and JPMorgan ETF Efficiente® 5 Index – Base – 2 Year Point to Point	%
Core Index Strategy -- Premium Allocation Options	
S&P 500® Composite Stock Price Index – 1 Year Point to Point	%
JPMorgan ETF Efficiente® 5 Index – 1 Year Point to Point	%
Blended S&P 500® Composite Stock Price Index and JPMorgan ETF Efficiente® 5 Index – 2 Year Point to Point	%
Select Index Strategy -- Premium Allocation Options **Note: You pay an additional charge when one or more of the 3 options below is elected.**	
S&P 500® Composite Stock Price Index - Select– 1 Year Point to Point	%
JPMorgan ETF Efficiente® 5 Index - Select – 1 Year Point to Point	%
Blended S&P 500® Composite Stock Price Index and JPMorgan ETF Efficiente® 5 Index - Select – 2 Year Point to Point	%
Fixed -- Premium Allocation Options	
Fixed Account	%
Total =	**100%**

3. DOLLAR COST AVERAGING

☐ You wish to use monthly Dollar Cost Averaging (DCA) on your account. Only available when the Payment Frequency elected is Annual or Semi-Annual.

☐ By checking this box, you authorize the Company to automatically transfer 100% of your initial Net Premium Payment over a 12 month period from the DCA Account to your chosen Index Strategy(ies). The first DCA transfer will occur on the first Monthly Anniversary Day following your issue date.

4. PREMIUM FINANCING ELECTION

☐ You plan to use third party Premium Financing on this Policy.

If you check this box, you are indicating that you plan to use third party Premium Financing to pay for your Policy Premiums. You have reviewed and signed the required forms as shown on the Premium Financing Worksheet and have received prior approval from the Symetra Premium Financing Team. Premium Financing is allowed only if you check this box and you receive such approval.

NOTE: Do not submit Premium until the Premium Financing Team and the Symetra Underwriting team have approved this Application for Life Insurance.

PROPOSED OWNER/APPLICANT: The undersigned hereby agree(s) that the statements made above shall be part of the Life Insurance Application. You understand that you are applying for an Indexed Life Insurance policy, and even though the values of the Policy may be affected by an external index, the Policy does not directly participate in any stock, bond, or equity investments. The values of the external indices do not reflect the payment or reinvestment of dividends, with the exception of the JPMorgan ETF Efficiente® 5 Index. Symetra has the right to change an Index Strategy, Index Caps, Index Participation Rates and interest rates as long as they do not go below the minimums shown in the Policy.

You understand that any values shown, other than guaranteed minimum values, are not guarantees, promises or warranties.

You acknowledge and understand that the Select Index Strategy Premium Allocation Options incur a charge payable by you. The charge applies to funds placed there for each index segment term, which will reduce the policy value.

Election of a Select Index Strategy Premium Allocation Option does NOT guarantee a greater index credit for any index segment term.

SIGNATURES (MUST BE COMPLETED IN ENTIRETY IN ORDER TO PROCESS YOUR APPLICATION):

Printed Name of Proposed Owner	Signature of Proposed Owner

INSURANCE PRODUCER: This Application is being submitted after an examination of the interests of the Applicant and an assessment of the stated goals of the Applicant. I have discussed this product with the Applicant and have not made any statements which contradict the disclosure materials provided to the Applicant. I have not made any promises or guarantees about the future values of any non-guaranteed elements.

Printed Name of Insurance Producer	Signature of Insurance Producer

Symetra Life Insurance Company
777 108th Avenue NE, Suite 1200 | Bellevue, WA 98004-5135
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Fax: 1-877-435-5500

AGENT/PRODUCER REPORT

Proposed Owner name

Proposed Insured name

Application/Policy number

1. ADDITIONAL INFORMATION	**YES**	**NO**
(a) Were you in the presence of the Proposed Insured(s) and/or Proposed Owner(s) when the application was taken?	☐	☐
(b) How long have you known the Proposed Insured(s) and in what capacity? Number of years: _____ In what capacity:_____		
(c) 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?	☐	☐
(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) What insurance need is being met with this application?

- ☐ Debt/Family/Business Protection
- ☐ Income Replacement
- ☐ Retirement/Estate Planning
- ☐ Business Coverage Type:
- ☐ Other _____

(f) 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 _____

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

Agent/Producer name *(Primary)*		Symetra agent ID
% Share	Phone number	Email

Contracted firm or sole proprietor name *(This is the firm/sole prop this business submitted through.)*

Broker General Agency (BGA) – *If applicable*

Agent/Producer name		Symetra agent ID
% Share	Phone number	Email

Contracted firm or sole proprietor name *(This is the firm/sole prop this business submitted through.)*

Broker General Agency (BGA) – *If applicable*

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

Agent/Producer name		Symetra agent ID
% Share	Phone number	Email

Contracted firm or sole proprietor name *(This is the firm/sole prop this business submitted through.)*

Broker General Agency (BGA) – *If applicable*

Agent/Producer name		Symetra agent ID
% Share	Phone number	Email

Contracted firm or sole proprietor name *(This is the firm/sole prop this business submitted through.)*

Broker General Agency (BGA) – *If applicable*

4. AGENT/PRODUCER CERTIFICATION & SIGNATURES:	**YES**	**NO**
(a) 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 the application.	☐	☐
(b) 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.	☐	☐
(c) I/We declare I/we have not been involved in any recommendation regarding the possible sale or assignment of the policy to a life settlement, viatical or other secondary market provider.	☐	☐
(d) 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(s) has been disclosed on the 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.	☐	☐
(e) I/We declare, to the best of my/our knowledge that the 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.	☐	☐
(f) I/We declare that I/we have accurately answered all questions contained in the Agent/Producer Report in connection with the application.	☐	☐
(g) I/We certify that I/we have verified the identity of each Proposed Insured and Proposed Owner by reviewing valid government issued photo identification.	☐	☐
(h) I/We certify that the Proposed Insured(s) and Proposed Owner(s) has/have demonstrated that they can read and understand English or I/we am/are fluent in the native language of the Proposed Insured(s) and Proposed Owner(s) and have translated the application questions and contract terms and conditions or we have utilized a translation service to communicate the application questions and contract terms and conditions.	☐	☐

_____ _____

Signature of Agent/Producer Date Signature of Agent/Producer Date

_____ _____

Signature of Agent/Producer Date Signature of Agent/Producer Date

Symetra Life Insurance Company
Mail to: PO Box 34690 | Seattle, WA 98124-1690
Overnight to: 777 108th Avenue NE, Suite 1200 | Bellevue, WA 98004-5135
Phone 1-800-796-3872

IMPORTANT NOTICE TO APPLICANT/BUYER REGARDING ACCELERATED DEATH BENEFITS

ACCELERATED DEATH BENEFIT FOR TERMINAL ILLNESS RIDER

Disclosure Statement

The benefits provided by this Accelerated Death Benefit are not intended to provide, and will never provide, long-term care insurance, nursing home insurance, or home care insurance. If you are interested in long-term care or nursing home or home care insurance, you should consult with an insurance agent licensed to sell that insurance, inquire with the insurance company offering the accelerated death benefits, or visit the California Department of Insurance Internet Web site (www.insurance.ca.gov) section regarding long-term care insurance.

The benefits payable under this Rider are intended to qualify as accelerated death benefits under section 101(g) of the Internal Revenue Code of 1986, as amended ("the Code"). These benefits are not intended to qualify as long-term care insurance under section 7702B of the Code.

The receipt of an accelerated death benefit may be taxable to You, if the benefit does not satisfy all qualification requirements under section 101(g) of the Code. Additionally, the receipt of this benefit will reduce the amount your beneficiar(ies) will receive upon your death.

If You are paid a benefit under this Rider, Your Policy's Death Benefit, Net Surrender Value, and available loan value will be reduced. In addition, You may lose Your right to receive certain public funds such as Medicare, Medicaid, Medi-Cal, Social Security, Supplemental Security Income (SSI), and possibly others. Prior to electing to buy the accelerated death benefit, you should consult with the appropriate social services agency concerning how receipt of accelerated death benefits may affect that eligibility.

YOU SHOULD CONSULT YOUR PERSONAL TAX OR LEGAL ADVISOR BEFORE CLAIMING FOR A BENEFIT UNDER THIS RIDER.

This Disclosure Statement is intended to help you understand the Terminal Illness Rider. It does not change any provisions Rider or the Policy to which it is attached.

What is the Terminal Illness Rider?

The Terminal Illness Rider provides an Accelerated Death Benefit. That is, the Rider allows You to advance or "accelerate" up to 50% of the Policy's Death Benefit, which includes any Rider Specified Amount provided under an attached Supplemental Protection Rider, if applicable, prior to the death of the Insured if the Insured becomes a Terminally Ill Person, as defined by the Internal Revenue Code. You may request a maximum cumulative amount of $500,000 under all Accelerated Death Benefit Riders.

The Accelerated Death Benefit is paid in a lump sum at least equal to the percentage of the Death Benefit being accelerated multiplied by the difference between the current Policy Value and any Loan Amount.

No Surrender Charge will apply when You receive an Accelerated Death Benefit.

Is there a charge for the Terminal Illness Rider?

No, there is no charge for the Rider.

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What triggers the payment of the Accelerated Death Benefit?

While the Insured is alive and the Rider in effect, You can claim an Accelerated Death Benefit, if the Insured was certified by a Licensed Physician[1] as having an illness or a physical condition which can reasonably be expected to result in death within 12 months after the date of certification.

We may, at Our expense, require certification by a Licensed Physician of Our choice. If there is a difference of opinion regarding the Insured's eligibility for benefits, We may seek, at Our expense, a third medical opinion of a Licensed Physician that is mutually acceptable to the Insured and Us.

All irrevocable beneficiaries and assignees must approve, in writing, to the payment of an Accelerated Death Benefit.

What happens to Policy values if an Accelerated Death Benefit is Paid?

Payment of an Accelerated Death Benefit will reduce Your Policy's Death Benefit, Policy Value, and Loan Amount, but the Policy will continue. The Accelerated Death Benefit will first be applied to repay any outstanding Loan Amount.

After We pay the Accelerated Death Benefit, any Withdrawal, Surrender, or Policy loan will be limited to the Net Surrender Value.

Future Premium Payments, Monthly Cost of Insurance Charges, and applicable Expense Charges on this Policy will be proportionally reduced by the payment of an Accelerated Death Benefit.

Payment of an Accelerated Death Benefit will not impact any active riders or benefits of the Policy, excluding other accelerated death benefit riders, in effect at the time such payment is made.

If you never make a claim under an accelerated death benefit, there will be no effect on the policy.

This Disclosure Statement is intended to help You understand the Accelerated Death Benefit for Terminal Illness Rider. This disclosure does not change any provisions of the Rider or the Policy to which it is attached.

I have read, or have had read to me, this Important Notice to Applicant/Buyer Regarding Accelerated Death Benefits and acknowledge receipt of a copy.

Signed in _____, this ____ day of _____, _____
(city, state) (Date) (month) (year)

_____ _____
Proposed Owner (*please print*) Signature of Proposed Owner

_____
Signature of Writing Agent

[1] As defined in the Rider based upon the requirements of the Internal Revenue Service.

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Phone 1-800-796-3872

IMPORTANT NOTICE TO APPLICANT/BUYER REGARDING ACCELERATED DEATH BENEFITS

ACCELERATED DEATH BENEFIT FOR CHRONIC ILLNESS RIDER

Disclosure Statement

The benefits provided by this accelerated death benefits are not intended to provide, and will never provide long-term care insurance, nursing home insurance, or home care insurance. If you are interested in long-term care or nursing home or home care insurance, you should consult with an insurance agent licensed to sell that insurance, inquire with the insurance company offering the accelerated death benefits, or visit the California Department of Insurance Internet Web site (www.insurance.ca.gov) section regarding long-term care insurance.

If you choose to accelerate a portion of your death benefit, doing so will reduce the amount that your beneficiary will receive upon your death.

The benefits payable under this Rider are intended to qualify as accelerated death benefits under section 101(g) of the Internal Revenue Code of 1986, as amended (the "Code"). These benefits are not intended to qualify as long-term care insurance under section 7702B of the Code. Payment of the Accelerated Death Benefit is not conditioned on the receipt of long-term care or medical services.

The receipt of an accelerated death benefit may be taxable to You, if the benefit does not satisfy all qualification requirements under the Code or to the extent it exceeds the maximum per diem limit under section 101(g) of the Code. Additionally, the receipt of this benefit will reduce the amount your beneficiary(ies) will receive upon your death. Prior to electing to buy the accelerated death benefit, you should seek assistance from a qualified tax adviser.

All Accelerated Death Benefit provisions are renewable for the life of the life insurance policy, provided the premiums are timely paid.

If You are paid a benefit under this Rider, Your Policy's Death Benefit, Net Surrender Value, and available loan value will be reduced. In addition, You may lose Your right to receive certain public funds such as Medicare, Medi-Cal, Medicaid, Social Security, Supplemental Security Income (SSI), and possibly others. Prior to electing to buy the accelerated death benefit, You should consult with the appropriate social services agency concerning how receipt of accelerated death benefits may affect that eligibility.

YOU SHOULD CONSULT WITH YOUR PERSONAL TAX OR LEGAL ADVISOR BEFORE CLAIMING A BENEFIT UNDER THIS RIDER.

This Disclosure Statement is intended to help You understand the Chronic Illness Rider. This disclosure does not change any provisions Rider or the Policy to which it is attached.

What is the Chronic Illness Rider?

The Chronic Illness Rider provides an Accelerated Death Benefit. That is, the Rider allows You to advance or "accelerate" up to 50% of the Policy's Death Benefit[1] prior to the death of the Insured, if the Insured is certified

[1] This amount includes any Rider Specified Amount provided under any attached Supplemental Protection Rider.

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as a Chronically Ill Person, as defined by the Code[2]. You may request a maximum cumulative amount of $500,000 under all accelerated death benefit riders attached to the Policy. The amount of the Accelerated Death Benefit will be limited to the per diem amount set by the Internal Revenue Service, if paid in monthly or annual payments. The single lump sum amount payable shall be at least equal to the percentage of Death Benefit being accelerated multiplied by the difference between the current Policy Value and any Loan Amount and liens. A request for a single lump sum payment that exceeds the annual IRS per diem limit is allowed, however, You must acknowledge that there may be tax consequences of such a payment on the Claim Form.

Is there a charge for the Chronic Illness Rider?

No, there is no charge for the Rider.

What triggers the payment of the Accelerated Death Benefit?

While the Insured is alive, You can claim an Accelerated Death Benefit if, during the prior 12-month period, a Licensed Health Care Practitioner[3] certified that the Insured is a Chronically Ill Person.

We may, at Our expense, also require certification by a Licensed Health Care Practitioner of Our choice while the claim for an Accelerated Death Benefit is pending. If there is a difference of opinion regarding the Insured's eligibility for benefits, We may seek, at Our expense, a third medical opinion of a Licensed Health Care Practitioner that is mutually acceptable to You and Us.

All irrevocable beneficiaries and assignees must approve, in writing, the payment of an Accelerated Death Benefit.

What happens to Policy values if an Accelerated Death Benefit is paid?

Payment of an Accelerated Death Benefit will reduce Your Policy's Death Benefit, Policy Value, and Loan Amount. Your policy will remain in force but will be encumbered by a lien against the Death Benefit. The lien will accrue interest and the remaining Death Benefit will be reduced by the amount of the lien

The Accelerated Death Benefit will first be applied to repay any outstanding Loan Amount and accrued loan interest.

Any Withdrawal, Surrender, or loan taken after We pay the Accelerated Death Benefit will be limited to the excess of the Net Surrender Value over the lien.

Future Premium Payments, Monthly Cost of Insurance Charges, and applicable Expense Charges on this Policy will not be affected by the payment of an Accelerated Death Benefit.

When Your Remaining Death Benefit is equal to $5,000, no further Accelerated Death Benefit payments will be allowed. At that time,

- Monthly Deductions and loan interest charges will cease;
- no additional Premium Payments or loan repayments will be accepted; and
- no new Withdrawals or loans will be available.

Payment of an Accelerated Death Benefit will not impact any active riders or benefits of the Policy, excluding other accelerated death benefit riders, in effect at the time such payment is made..

If You never made a claim under an accelerated death benefit rider, there will be no effect on Your Policy.

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[2] Defined as a person who is (a) unable to perform (without substantial assistance from another person) at least two activities of daily living for a period of at least 90 days due to loss of functional capacity or (b) requires substantial supervision to protect himself or herself from threats to health and safety due to severe cognitive impairment.

[3] As defined in the Rider based upon the requirements of the Internal Revenue Service.

This Disclosure Statement is intended to help You understand the Accelerated Death Benefit for Chronic Illness Rider. This disclosure does not change any provisions of the Rider or the Policy to which it is attached.

I have read, or have had read to me, this Important Notice to Applicant/Buyer Regarding Accelerated Death Benefits and acknowledge receipt of a copy.

Signed in _____, this ____ day of _____, _____
(city, state) (Date) (month) (year)

_____ _____
Proposed Owner (*please print*) Signature of Proposed Owner

_____
Signature of Writing Agent

Click here to clear page

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Symetra Life Insurance Company
777 108th Avenue NE, Suite 1200 | Bellevue, WA 98004-5135
Mail to New Business: PO Box 35020 | Seattle, WA 98124-3420
Fax: 1-877-435-5500

INSURANCE PRODUCER REPORT

Proposed Owner name

Proposed Insured name

Application/Policy number

1. ADDITIONAL INFORMATION	YES	NO
(a) Were you physically in the presence of the Proposed Insured(s) and/or Proposed Owner(s) when the application was taken?	☐	☐
(b) How long have you known the Proposed Insured(s) and in what capacity? Number of years: _____ In what capacity:_____		
(c) Are you related in any way to the proposed owner or proposed insured signing this application as the owner or insured? If yes – What is the relationship? _____	☐	☐
(d) Do you employ or are you employed by or affiliated with the same organization or business as the proposed owner or proposed insured signing this application as the owner or insured? If yes – what is the organization or work relationship? _____	☐	☐
(e) 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?	☐	☐
(f) Will there be a rebate of any kind (e.g., return of premium) to the proposed insured or any individual or entity related to them, by you or performed on your behalf or at your direction?	☐	☐
(g) 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?	☐	☐

(h) What insurance need is being met with this application?

- ☐ Family/Business Protection
- ☐ Debt/Family Mortgage
- ☐ Income Replacement
- ☐ Retirement
- ☐ Estate Planning
- ☐ Business Coverage Type:
- ☐ 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)
- ☐ Surrender
- ☐ Withdrawals
- ☐ Loans
- ☐ Reverse mortgage or home equity loan
- ☐ Funds drawn on or originating from a foreign bank or other foreign sources
- ☐ Distribution from an IRA, 401(k), SEP, 403(b) or similar retirement plan
- ☐ Inheritance
- ☐ Gift – source of gift
- ☐ Any form of loan or premium financing
- ☐ Sale of other Assets
- ☐ Other (list) _____

Click here to clear page

2. ADDITIONAL INFORMATION *(continued)*

	YES	NO
(j) Did you discuss with the proposed owner or proposed insured their current life insurance policies and other assets prior to their decision to purchase this life insurance policy?	☐	☐
(k) Did the proposed owner or proposed insured indicate to you that they have sufficient liquid assets available for living expenses and emergencies other than the money allocated to pay the premiums for this life insurance policy?	☐	☐
(l) In reviewing the purchase of this insurance policy, as to the suitability of such purchase for the proposed insured/proposed owner, do you have reasonable grounds for believing this purchase is suitable to meet their insurance needs and financial objectives?	☐	☐

3. INSURANCE PRODUCER INFORMATION – List all Insurance Producers assisting in the sale:

Insurance Producer name *(Primary)*		Symetra Insurance Producer ID
% Share	Phone number	Email

Contracted firm or sole proprietor name *(This is the firm/sole prop this business submitted through.)*

Broker General Agency (BGA) – *If applicable*

Insurance Producer name		Symetra Insurance Producer ID
% Share	Phone number	Email

Contracted firm or sole proprietor name *(This is the firm/sole prop this business submitted through.)*

Broker General Agency (BGA) – *If applicable*

Insurance Producer name		Symetra Insurance Producer ID
% Share	Phone number	Email

Contracted firm or sole proprietor name *(This is the firm/sole prop this business submitted through.)*

Broker General Agency (BGA) – *If applicable*

Insurance Producer name		Symetra Insurance Producer ID
% Share	Phone number	Email

Contracted firm or sole proprietor name *(This is the firm/sole prop this business submitted through.)*

Broker General Agency (BGA) – *If applicable*

4. INSURANCE PRODUCER CERTIFICATION & SIGNATURES:	**YES**	**NO**
(a) 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 the application.	☐	☐
(b) 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.	☐	☐
(c) I/We declare I/we have not been involved in any recommendation regarding the possible sale or assignment of the policy to a life settlement, viatical or other secondary market provider.	☐	☐
(d) 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(s) has been disclosed on the 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.	☐	☐
(e) I/We declare, to the best of my/our knowledge that the 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.	☐	☐
(f) I/We declare that I/we have accurately answered all questions contained in the Insurance Producer Report in connection with the application.	☐	☐
(g) I/We certify that I/we have verified the identity of each Proposed Insured and Proposed Owner by reviewing valid government issued photo identification.	☐	☐
(h) I/We certify that the Proposed Insured(s) and Proposed Owner(s) has/have demonstrated that they can read and understand English or I/we am/are fluent in the native language of the Proposed Insured(s) and Proposed Owner(s) and have translated the application questions and contract terms and conditions or we have utilized a translation service to communicate the application questions and contract terms and conditions.	☐	☐

Signature of Insurance Producer Date

Signature of Insurance Producer Date

Signature of Insurance Producer Date

Signature of Insurance Producer Date

Please complete if servicing producer is different from insurance producer involved in this sale.

Servicing Producer Name	Symetra Insurance Producer ID
Phone number	Email

Broker General Agency (BGA) – *If applicable*

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 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, also may 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 $126,420 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 $3,161 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 $126,420 in countable resources. The order also may allow the at-home spouse to retain more than $3,161 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	Date
Spouse's signature	Date
Legal representative signature	Date

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