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Symetra Term

Fully Underwritten

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
- HIPAA Authorization
- Any State Specific forms (if applicable)

☐ 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.

☐ **The original Replacement form must be completed and returned with the application packet to Life New Business** for the following states: AK, AL, AZ, CO, CT, HI, IA, KY, LA, MD, ME, MS, MT, NC, NE, NH, NJ, NM, OH, RI, SC, SD, TX, VA, VT, WI, and WV, if any existing coverage is listed on the application in the "Replacement" section, even if this is not a replacement.

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

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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.

Click here to clear page

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

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*

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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

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

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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 page

SYMETRA
RETIREMENT | BENEFITS | LIFE

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*

Click here to clear form

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 | TTY/TDD 1-800-833-6388

NOTICE TO APPLICANT REGARDING REPLACEMENT OF LONG TERM CARE INSURANCE OR LIFE INSURANCE INCLUDING ACCELERATED DEATH BENEFITS

According to your application or information you have furnished, you intend to lapse or otherwise terminate your existing life insurance or long-term care insurance and replace it with a life insurance policy with an accelerated death benefit to be issued by Symetra Life Insurance. Your new accelerated death benefit coverage provides 30 days within which you may decide, without cost, whether you desire to keep the coverage. Please note that your underlying life insurance policy may only provide for a 10-day period during which you may decide, without cost, whether you will keep the coverage. For your own information and protection, you should be aware of, and seriously consider, certain factors that may affect the insurance protection available to you under the new coverage.

This accelerated death benefit is NOT Nursing Home, Home Care, or Long-Term Care Insurance, and is not intended or designed to eliminate your need for that coverage. There are no restrictions or limitation on the use of the accelerated death benefit proceeds.

If you want long-term 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) that provides information regarding long-term care insurance.

If you want to replace existing coverage with life insurance that includes an accelerated death benefit, you should note the following:

1. Receipt of accelerated death benefits may be taxable. Prior to electing to buy the accelerated death benefit, policyholders or certificate holders should seek assistance from a qualified tax advisor.
2. Receipt of accelerated death benefits may affect eligibility for public assistance programs, such as Medi-Cal or Medicaid. Prior to electing to buy the accelerated death benefit, the applicant/buyer should consult with the appropriate social services agency concerning how receipt of accelerated death benefits may affect that eligibility.

You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present coverage. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

If, after due consideration, you still wish to terminate your present coverage and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on the application may provide a basis for the company to deny any future claims and to refund your premium as though your coverage had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all the information has been properly recorded.

The above "Notice to Applicant" was delivered to me on: _____/ ____/ _____
Month Day Year

_____ _____
Name of Applicant Signature of Applicant

COMPARISON TO CURRENT COVERAGE

I have reviewed your current coverage. To the best of my knowledge, the replacement of insurance involved in this transaction materially improves your position for the following reasons:

- ☐ Additional or different benefits. (please specify) _____
- ☐ No change in benefits, but lower premiums
- ☐ Fewer benefits and lower premiums
- ☐ Other - please specify. _____

_____ _____
Name of Writing Agent Signature of Writing Agent

Please give a copy to your client

Term Product – Terminal Illness Application Disclosure

Provide to Applicant

Symetra Life Insurance Company
777 108th Avenue NE, Suite 1200 | Bellevue, WA 98004-5135
Mailing Address: PO Box 549291 | Waltham, MA 02454-9291
Phone 1-800-796-3872

IMPORTANT NOTICE TO APPLICANT/BUYER REGARDING ACCELERATED DEATH BENEFITS

TERMINAL ILLNESS RIDER – ACCELERATED DEATH BENEFIT

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.

Receipt of this benefit will reduce the amount your beneficiary(ies) will receive upon your death. In addition, Your Policy's Death Benefit and Premiums will be reduced. You may also lose Your right to receive certain public funds such as 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 deawth benefits may affect that eligibility.

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

This disclosure is intended to help You understand the Terminal Illness Rider. It does not change any provisions of the 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 75% of the Policy's Death Benefit (up to a maximum of $500,000) prior to the death of the Insured if the Insured becomes a Terminally Ill Person, as defined by the Internal Revenue Code.

The Accelerated Death Benefit is paid in a lump sum at least equal to the Death Benefit discounted by one year of interest. [1]

No surrender charge will apply when You receive an Accelerated Death Benefit.

Is there a charge for the Terminal Illess Rider?

No, there is no charge for the Rider.

[1] The interest rate will be determined as described in the Rider.

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[2] 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, but the Policy will continue.

Future Premiums 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 in effect at the time such payment is made.

If You never make a claim under this benefit, there will be no effect on the Policy.

This Disclosure Statement is intended to help You understand the Terminal Illness Rider - Accelerated Death Benefit. 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)

_____ _____
Signature of Proposed Owner Signature of Writing Agent

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

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

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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.

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Receipt of this benefit will reduce the amount your beneficiary(ies) will receive upon your death. In addition, Your Policy's Death Benefit and Premiums will be reduced. You may also lose Your right to receive certain public funds such as 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 deawth benefits may affect that eligibility.

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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.

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

_____ _____
Signature of Proposed Owner Signature of Writing Agent

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