WriteFit Express Requirements

Minnesota Life Insurance Company - A Securian Company
Individual Life New Business • 400 Robert Street North • St. Paul, Minnesota 55101-2098

SECURIAN®

IMPORTANT

Some products/face amounts require e-Applications

NOTE:
We do NOT accept paper applications if the client falls within our WriteFit Express requirements .

Before completing this application
please review the WriteFit Express underwriting chart below to check if an eApp is required.

WRITEFIT EXPRESS UNDERWRITING

Product	Issue Age	Face Amount Range	Underwriting Class
Advantage Elite Select Term 5, 10, 15 and 20 year durations	16 - 54	$50,000 - $99,999	Standard Non-Tobacco Standard Tobacco
Advantage Elite Select Term 30 year duration	16-45	$50,000 - $99,999	Standard Non-Tobacco Standard Tobacco
Advantage Elite Select Term 5, 10, 15 and 20 year durations	16-54	$100,000 - $250,000	Preferred Select Preferred Non-Tobacco Preferred Tobacco Non-Tobacco Plus Standard Non-Tobacco Standard Tobacco
Advantage Elite Select Term 30 year duration	16-45	$100,000 - $250,000	
Product	**Issue Age**	**Face Amount Range**	**Underwriting Class**
Orion Indexed Universal Life	0 - 15	$50,000 - $250,000	Preferred Non-Tobacco
	16-54	$50,000 - $99,999	Standard Non-Tobacco Standard Tobacco
	16-54	$100,000 - $250,000	Preferred Select Preferred Non-Tobacco Preferred Tobacco Standard Non-Tobacco Standard Tobacco
Product	**Issue Age**	**Face Amount Range**	**Underwriting Class**
Secure Protector Whole Life	0 - 15 16 - 55	$10,000 - $249,999 $25,000 - $249,999	Preferred Standard
Secure Accumulator Whole Life	0 - 15 16 - 55	$10,000 - $99,999 $25,000 - $99,999	Preferred Standard

Full underwriting required for Secure Protector Whole Life policies for age 56 and older and face amounts of $50,000 and above.

Outline of Coverage
Accelerated Benefit Agreement

Minnesota Life Insurance Company - A Securian Company
Individual Life New Business • 400 Robert Street North • St. Paul, Minnesota 55101-2098

MINNESOTA LIFE

This outline describes features of the Accelerated Benefit Agreement which will be issued with your policy. This outline is not a contract, as only the actual Agreement provisions control. It is, therefore, important that, when presented to you for delivery, you Read Your Policy Carefully!

The Accelerated Benefit Agreement provides the option to have part of the policy's death benefit paid to you if the insured has a terminal condition. The payment is a lien against the death benefit, which is repaid when the insured dies. Any balance of the death proceeds will be paid to the beneficiary. The agreement will be included in the policy without premium cost to you. Here are some highlights of the benefit:

1. A terminal condition is one, caused by sickness or accident, which directly results in reducing the insured's life expectancy to 12 months or less. You must supply us with evidence of this fact, certified by a qualified physician. We may also ask for independent verification at our expense.

2. The maximum accelerated benefit is the lesser of 75% of the death benefit of $1,000,000, or the lesser of that amount which has been further reduced by the amount of any irrevocable settlement option you may have elected. The minimum payment is $10,000. You can have the payment in one sum, or in another mutually agreeable manner.

3. The interest rate that applies to the lien will be set when we process the benefit payment. The rate will not exceed the greater of the published Moody's Composite Average of Yields on Bonds, or the policy loan interest rate if your policy allows for loans. Interest on the lien, up to the policy loan value, will not exceed the policy loan interest rate. Unpaid interest will be added to the balance of the accelerated benefit lien.

   If your policy is a term policy, the interest rate that applies to the lien will not exceed the greater of the published Moody's Composite Average of Yields on Bonds, or 8%. Unpaid interest will be added to the balance of the accelerated benefit lien.

4. **The policy is affected by accelerated benefits you receive, as follows:**
   - **Death proceeds are reduced by the amount of accelerated benefits paid plus accrued interest.**
   - **Loan or cash surrender values, if any are associated with this policy, are available only if they exceed the accelerated benefits paid plus accrued interest.**
   - **If your policy is a participating policy, we expect no further dividends will be declared for participating policies after the accelerated benefit has been paid.**

5. **This is not long term care or nursing home insurance. And, you may not be eligible for this benefit if:**
   - **creditors, in bankruptcy or otherwise, require this option to meet claims; or**
   - **a government agency requires this option to apply for, obtain, or keep entitlement benefits.**

6. **The receipt of any accelerated benefit payment may be taxable to you. You should seek assistance from your personal tax advisor.**

Please date and sign as indicated and keep a copy. Send the original copy to Minnesota Life with the insurance application.

I have read this Outline of Coverage on _____ (date).

Registered representative signature (witness)	Applicant signature (owner)
X	**X**

Application Part 1

Individual Life Insurance

Minnesota Life Insurance Company - A Securian Company
Life New Business • 400 Robert Street North • St. Paul, Minnesota 55101-2098

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A. Proposed Insured Information

If the insured is 15 or younger, also submit the Proposed Insured Juvenile Information for Ages 0-15 form.

Proposed insured name (last, first, middle)

Social Security number	Date of birth (month, day, year)	Gender ☐ Male ☐ Female
Primary telephone number ☐ Landline ☐ Cell	Birthplace (state or, if outside the US, country)	
Street address (no P.O. Box)		Apartment or unit number
City	State	Zip code
E-mail address	Occupation	Years in occupation
Earned income / Unearned income	Total net worth	Liquid net worth
Driver's license number	Issue state	Expiration date

☐ Exercise the Exchange of Insureds Agreement on policy number _____ for (name of previous insured)_____.

B. Owner (Applicant) Information

Only complete this section if the owner is different than the insured. If multiple owners, all must sign as owner on the Application Part 3 and submit the Authorization and Release for Joint Communication Involving Multiple Owners form.

Owner name (last, first, middle)	Relationship to proposed insured

Owner is:

☐ Individual(s)

☐ Trust (submit Certification of Trustee Authority form)

☐ Corporation (submit Corporate/Non-Profit Resolution form) If the owner is the employer of the proposed insured, please also submit the Employer Notification Regarding the Potential Taxation of Death Benefit forms.

☐ Partnership (submit Partnership/LLC Resolution form) If the owner is the employer of the proposed insured, please also submit the Employer Notification Regarding the Potential Taxation of Death Benefit forms.

Social Security or tax ID number	Gender ☐ Male ☐ Female	Date of birth or trust date
Street address (no P.O. box)		Apartment or unit number
City	State	Zip code
Primary telephone number ☐ Landline ☐ Cell	Email address	

C. Special Mailing Addresses

Complete this section for any requests to mail items anywhere other than the home address listed in Section A or B. If this section is not filled out, everything will be mailed to the address listed in Section A or B. (If there is more than one special address needed, please note in Section O (Additional Remarks).

☐ Third party notification - The address listed below will receive notice of overdue premium or pending lapse.

☐ Billing address - All premium notices will be sent to the address below.

☐ Special mailing address - The address listed below will receive all correspondence for this policy. If a billing address is requested, the special mailing address will not receive a copy of the premium notice.

Name (last, first, middle)

Address		Apartment or unit number
City	State	Zip code

D. Product

Product 1

Product applied for	Amount of insurance (face amount)
Annual planned premium (not applicable to term or whole life products)	Custom pay whole life (indicate number of years)

Pay to age (for whole life products only, defaults to age 121 if not specified)

Death benefit qualification test (for universal life products only, defaults to GPT if none selected)

☐ Guideline Premium Test (GPT) ☐ Cash Value Accumulation Test (CVAT)

Death benefit option (for universal life products only, defaults to level if none selected)

☐ Level ☐ Increasing ☐ Sum of Premiums

Dividend option (for whole life products only, defaults to paid-up additions if none selected) IRS form W-9 is required for accumulation at interest

Product 2

Product applied for	Amount of insurance (face amount)
Annual planned premium (not applicable to term or whole life products)	Custom pay whole life (indicate number of years)

Pay to age (for whole life products only, defaults to age 121 if not specified)

Death benefit qualification test (for universal life products only, defaults to GPT if none selected)

☐ Guideline Premium Test (GPT) ☐ Cash Value Accumulation Test (CVAT)

Death benefit option (for universal life products only, defaults to level if none selected)

☐ Level ☐ Increasing ☐ Sum of Premiums

Dividend option (for whole life products only, defaults to paid-up additions if none selected) IRS form W-9 is required for accumulation at interest

E. Additional Benefits and Agreements

Select only those agreements available on the product(s) applied for.

Product 1	Product 2	
☐	☐	Accelerated Death Benefit/Accelerated Death Benefit for Terminal Illness Agreement (Submit the appropriate Outline of Coverage for the product applying for)
☐	☐	Accelerated Death Benefit for Chronic Illness Agreement (Submit Outline of Coverage Accelerated Death Benefits for Chronic Illness Agreement and Chronic Illness Supplemental Application)
☐	☐	Accidental Death Benefit Agreement $_____(Coverage Amount)
☐	☐	Additional Insurance Agreement $_____(Coverage Amount)
☐	☐	Business Continuation Agreement (Submit Business Continuation Agreement Covered Individuals)
☐	☐	Business Value Enhancement Agreement
☐	☐	Children's Term or Family Term - Child Agreement (Submit Family/Children's Term Application)
☐	☐	Chronic Illness Access Agreement (Submit Outline of Coverage Illness Access Agreement)
☐	☐	Chronic Illness Conversion Agreement (Submit Chronic Illness Supplemental Application)
☐	☐	Death Benefit Guarantee Flex Agreement
☐	☐	Early Values Agreement
☐	☐	Estate Preservation Agreement
☐	☐	Estate Preservation Choice Agreement _____(Designated Life Name)
☐	☐	Exchange of Insureds Agreement
☐	☐	Extended Conversion Agreement
☐	☐	First to Die Agreement $_____(Coverage Amount)
☐	☐	Flexible Term Agreement ☐ 10-year Flexible Term Agreement $_____ (Coverage Amount) ☐ 20-year Flexible Term Agreement $_____ (Coverage Amount)
☐	☐	Guaranteed Income Agreement
☐	☐	Guaranteed Insurability Option Agreement $_____ (Coverage Amount)
☐	☐	Guaranteed Insurability Option for Business Agreement $_____ (Coverage Amount)
☐	☐	Income Protection Agreement (Submit Income Protection Agreement Supplemental Application)
☐	☐	Inflation Agreement
☐	☐	Interest Accumulation Agreement _____% (Increase Factor Percentage)
☐	☐	Level Term Insurance Agreement $_____ (Coverage Amount)
☐	☐	Overloan Protection Agreement
☐	☐	Performance Death Benefit Guarantee Agreement
☐	☐	Premium Deposit Account Agreement (Submit IRS Form W-9)
☐	☐	Single Life Term Agreement_____(Designated Life Name) $_____ (Coverage Amount)
☐	☐	Single Premium Paid-Up Additional Insurance Agreement $_____(Premium Amount)
☐	☐	Surrender Value Enhancement Agreement
☐	☐	Term Insurance Agreement $_____ (Coverage Amount)
☐	☐	Waiver of Charges Agreement
☐	☐	Waiver of Premium Agreement
☐	☐	Other _____
☐	☐	Other _____

THE FOLLOWING BENEFITS AND AGREEMENTS *WILL BE ADDED* IF AVAILABLE FOR YOUR POLICY, UNLESS YOU CHOOSE TO OMIT THEM:

Product 1	Product 2	
☐	☐	Omit Automatic Premium Loan Provision
☐	☐	Omit Indexed Loan Agreement
☐	☐	Omit Policy Split Agreement

F. Special Policy Date

Select one of the following for special dating requests:

☐ Date to save age

OR

☐ Specific date (month/day/year): ______________(cannot select 29th, 30th, or 31st of the month)

Are there any other Minnesota Life applications associated with this application? ☐ Yes ☐ No

If yes, provide the names of the associated applicants: ____

____

If there are multiple applications, should they all have the same date? ☐ Yes ☐ No

(If yes is checked, this will require all applications to be held until all are underwritten.)

G. In Force, Pending and Replacement

Submit the appropriate replacement forms (may be needed even if no replacement is indicated; not needed if only replacing group coverage).

Excluding this policy, does the proposed insured have any life insurance or annuities in force or pending? (This includes life insurance sold or assigned, or that is in the process of being sold or assigned.) If yes, provide details in the chart below. ☐ Yes ☐ No

Excluding this policy, has there been, or will there be, replacement of any existing life insurance or annuities as a result of this application? (Replacement includes a lapse, surrender, 1035 Exchange, loan, withdrawal, or other change to any existing life insurance or annuity.) If yes, provide details in the chart below. ☐ Yes ☐ No

Please indicate all life insurance or annuities currently in force, pending or that have been in force within the last 12 months and identify below if any of this coverage will be replaced. Replacement forms may be required.

In Force and Pending

Full Company Name	Amount	Year Issued	Product Type	The Policy is	Type	Will it be Replaced?
			☐ Annuity ☐ Life	☐ In Force ☐ Pending ☐ Pending w/ money submitted	☐ Individual ☐ Group ☐ Personal ☐ Business	☐ Yes ☐ No
			☐ Annuity ☐ Life	☐ In Force ☐ Pending ☐ Pending w/ money submitted	☐ Individual ☐ Group ☐ Personal ☐ Business	☐ Yes ☐ No
			☐ Annuity ☐ Life	☐ In Force ☐ Pending ☐ Pending w/ money submitted	☐ Individual ☐ Group ☐ Personal ☐ Business	☐ Yes ☐ No
			☐ Annuity ☐ Life	☐ In Force ☐ Pending ☐ Pending w/ money submitted	☐ Individual ☐ Group ☐ Personal ☐ Business	☐ Yes ☐ No
			☐ Annuity ☐ Life	☐ In Force ☐ Pending ☐ Pending w/ money submitted	☐ Individual ☐ Group ☐ Personal ☐ Business	☐ Yes ☐ No
			☐ Annuity ☐ Life	☐ In Force ☐ Pending ☐ Pending w/ money submitted	☐ Individual ☐ Group ☐ Personal ☐ Business	☐ Yes ☐ No

H. Beneficiary

All designated beneficiaries will be considered primary beneficiaries, sharing equally, unless otherwise indicated. If there is more than one primary or contingent beneficiary, the total for each beneficiary class must equal 100%.

Class: ☐ Primary_______% ☐ Contingent_______%

Name (first, middle, last)

Relationship to insured	Birth/trust date
Address	City, state, zip code
Telephone number	Social Security/tax ID number

Email address

Class: ☐ Primary_______% ☐ Contingent_______%

Name (first, middle, last)

Relationship to insured	Birth/trust date
Address	City, state, zip code
Telephone number	Social Security/tax ID number

Email address

Class: ☐ Primary_______% ☐ Contingent_______%

Name (first, middle, last)

Relationship to insured	Birth/trust date
Address	City, state, zip code
Telephone number	Social Security/tax ID number

Email address

Class: ☐ Primary_______% ☐ Contingent_______%

Name (first, middle, last)

Relationship to insured	Birth/trust date
Address	City, state, zip code
Telephone number	Social Security/tax ID number

Email address

Class: ☐ Primary_______% ☐ Contingent_______%

Name (first, middle, last)

Relationship to insured	Birth/trust date
Address	City, state, zip code
Telephone number	Social Security/tax ID number

Email address

I. Premium Information

Payment Method:

☐ Annual ☐ Quarterly
☐ Semi-Annual ☐ Monthly Electronic Funds Transfer (EFT) Plan Number_____
(if new plan, submit EFT Authorization)

☐ Premium Deposit Account (submit a completed IRS form W-9)

☐ List Bill Plan Number _____ (if a new plan, submit List Bill Setup form)

Source of Funds

Indicate below how the policy(ies) will be funded. Select all that apply:

Assets/Income

☐ Earnings
☐ Existing insurance
☐ Gift/Inheritance
☐ Non-qualified retirement plan
☐ Sale of investments
☐ Savings
☐ Non-qualified annuity
☐ Home Equity

Qualified Assets

☐ Employer sponsored qualified retirement plan (401(k) plan, pension plan)
☐ IRA (Including Roth IRA and Individual Retirement Annuities)
☐ Non-Governmental 403(b) plan
☐ Section 457 plan
☐ Governmental or non-electing church qualified retirement plan
☐ Governmental or ministers 403(b) plan

If you are partially or wholly liquidating taxable funds such as income producing funds, qualified retirement assets (including IRA's), annuities or investments, your signature on this application confirms your understanding that there may be tax consequences to doing so. You should consult your tax advisor.

J. Additional Premium

1035 Exchange

$_____

(If yes, submit 1035 Exchange Agreement form)

Universal Life additional premium (excluding 1035)

$_____

Whole Life additional premium (excluding 1035)

$_____ ☐ Billable ☐ Paid at issue ☐ Billable and paid at issue

K. Money Submitted with Application (not available for applications taken in Kansas)

Make all checks payable to Minnesota Life.

Collect money only if the Life Receipt and Temporary Insurance Agreement form is left with the proposed owner, and the application meets the conditions of the Life Receipt.

Money collected should be greater than or equal to the initial minimum premium for the policy applied for.

Has the owner submitted money with this application? ☐ Yes ☐ No

If yes, amount: $_____

Was the Life Receipt and Temporary Insurance Agreement given? ☐ Yes ☐ No

L. Illustration Information

Life Insurance Illustration (required when applying for non-variable life insurance products excluding term)

A life insurance illustration is a projection intended to demonstrate the impact of premium payments and policy charges on the accumulation value and death benefit under a set of assumptions.

If a signed illustration is not submitted with this application, check the appropriate box indicating the reason below:

☐ An illustration was presented to me during the sales process, however, it is not being submitted because the policy I am applying for is different than what was illustrated.

☐ An illustration was not presented to me during the sales process.

By signing the application and checking a box above, both the representative and owner certify that i) no illustration is submitted with the application for the reason indicated above, ii) that a signed illustration will be obtained at the time the policy is delivered to the owner and iii) that the signed illustration will be returned to Minnesota Life after the policy is delivered.

M. Insurable Interest, Premium Financing and Suitability

1. Is this policy in accordance with the owner's insurance objectives and anticipated financial needs? ☐ Yes ☐ No
2. Has the representative discussed with the owner: the need for the policy, the ability to continue to pay premiums and whether the policy is suitable for the proposed owner? ☐ Yes ☐ No
3. Will the owner and/or beneficiary, and/or any individual or entity on the owner's behalf, receive any compensation, whether via the form of cash, property, an agreement to pay money in the future or otherwise as an inducement to apply for this policy? ☐ Yes ☐ No
4. Has the owner been involved in any discussion about the possible sale or assignment of this policy or a beneficial interest in a trust, LLC, or other entity created on the owner's behalf? If yes, provide details and a copy of the applicable entity's controlling documents. ☐ Yes ☐ No

   _____

   _____
5. Is this policy being funded via a premium financing loan or with funds borrowed, advanced or paid from another person or entity (including a loan against your home or other assets)? If yes, submit the Premium Financing Advisor Attestation and Premium Financing Client Disclosure forms. ☐ Yes ☐ No
6. Has the proposed insured had a life expectancy report or evaluation done by an outside entity or company? If yes, explain why the expectancy report was obtained. ☐ Yes ☐ No

   _____

   _____
7. Has the owner previously sold or assigned, or is in the process of selling or assigning a life insurance policy on the proposed insured to a life settlement, viatical or secondary market provider? If yes, provide details. ☐ Yes ☐ No

   _____

   _____
8. Reason for purchasing policy:
   a. Accumulation ☐ Yes ☐ No
   b. Business Planning/Key Person ☐ Yes ☐ No
   c. Charitable Giving ☐ Yes ☐ No
   d. Death Benefit Protection ☐ Yes ☐ No
   e. Estate Planning ☐ Yes ☐ No
   f. Retirement/Deferred Compensation ☐ Yes ☐ No
   g. Other_____ ☐ Yes ☐ No

N. Proposed Insured Underwriting Information

1. Is the proposed insured a U.S. citizen? ☐ Yes ☐ No

   If no, citizen of _____

   Indicate visa type _____

2. Does the proposed insured plan to travel or reside outside the U.S. in the next two years? ☐ Yes ☐ No
   If yes, please complete a Foreign Travel Questionnaire.

3. Has the proposed insured within the last five years, or does the proposed insured plan to engage in piloting an aircraft (including gliders, ultralight vehicles, or any other type of airframe)? ☐ Yes ☐ No
   If yes, complete the Military and Aviation Statement.

4. Has the proposed insured within the last five years, or does the proposed insured plan to engage in skin diving (scuba or other), sky diving, mountain/rock climbing, horse racing, rodeo, bull fighting, bungee jumping, BASE jumping, canyoneering, combat sports (boxing, mixed martial arts or other), professional wrestling, extreme skiing/snowboarding, or motor sports? ☐ Yes ☐ No
   If yes, complete the Sports and Avocation Statement.

5. Is the proposed insured in the Armed Forces, National Guard, or Reserves? ☐ Yes ☐ No
   If yes, complete the Military and Aviation Statement.

6. Has the proposed insured applied for insurance within the last six months? ☐ Yes ☐ No
   If yes, provide details below (number of applications and face amounts, etc.).

   _____

   _____

7. Has the proposed insured applied for life insurance in the past five years that was declined or rated? If yes, provide details below. ☐ Yes ☐ No

   _____

   _____

8. Has the proposed insured, within the past ten years, been convicted of a driving while intoxicated violation, had a driver's license restricted or revoked, or been convicted of a moving violation? ☐ Yes ☐ No
   If yes, provide dates and details below.

   _____

   _____

9. Except for traffic violations, has the proposed insured ever been convicted of a misdemeanor or felony? If yes, provide dates and details below. ☐ Yes ☐ No

   _____

   _____

10. A. Has the proposed insured smoked cigarettes in the past 12 months? ☐ Yes ☐ No
    B. Has the proposed insured ever smoked cigarettes? If yes, complete the table below. ☐ Yes ☐ No

Current smoker	Past smoker	Packs per day	Date last cigarette smoked (mm, dd, yy)
☐	☐		

    C. Has the proposed insured used tobacco or nicotine of any kind, other than cigarettes, in any form, in the last 12 months? ☐ Yes ☐ No

    D. Has the proposed insured ever used tobacco or nicotine of any kind, other than cigarettes, in any form? If yes, complete the table below. ☐ Yes ☐ No

What type	Current user	Past user	How much	Date of last use (mm, dd, yy)
	☐	☐		

O. Additional Remarks

Application Part 2

Individual Life Insurance

MINNESOTA LIFE

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Proposed insured name (last, first, middle)	Date of birth

Height and weight	Change in past year	Cause of weight gain or loss
FT. IN. LBS.	LBS. ☐ GAIN ☐ LOSS	

		Yes	No
1.	A. Have you smoked cigarettes in the past 12 months? (*If yes, complete the table below.)*	☐	☐
	B. Have you ever smoked cigarettes? *(If yes, complete the table below.)*	☐	☐

Current smoker	Past smoker	Packs per day	Date last cigarette smoked (mm, dd, yy)
☐	☐		

C. Have you used tobacco or nicotine of any kind, other than cigarettes, in any form, in the last 12 months? (*If yes, complete the table below.)*	☐	☐
D. Have you ever used tobacco or nicotine of any kind, other than cigarettes in any form? (*If yes, complete the table below.)*	☐	☐

What type	Current user	Past user	How much	Date of last use (mm, dd, yy)
	☐	☐		

2.	Are you taking or do you take any prescription or non-prescription medications or drugs? If so, please provide information below.	☐	☐

_____

_____

3.	During the past 10 years have you had or been treated for:		
A.	Epilepsy; Alzheimer's; Huntington's; Parkinson's; Mild Cognitive Impairment (MCI); dementia; paralysis; sleep apnea; depression; stress disorders; anxiety disorder; or any other brain, nervous, mental, emotional or sleep disorder?	☐	☐
B.	High blood pressure; chest pain; chest discomfort or tightness; heart attack; heart murmur; stroke; irregular heart beat; or any other disease or disorder of the heart or blood vessels?	☐	☐
C.	Asthma; shortness of breath; bronchitis; pneumonia; emphysema; chronic cough; or any other lung or respiratory disorder?	☐	☐
D.	Abdominal pain; ulcer; colitis; cirrhosis; hepatitis; recurrent diarrhea; intestinal bleeding; or any other disease of the liver, gallbladder, pancreas, stomach, or intestines?	☐	☐
E.	Kidney stone; protein, sugar, blood or blood cells in the urine; or any disorder of the urinary tract, bladder or kidneys?	☐	☐
F.	Disorder or abnormality of the prostate, uterus, ovaries, or breasts; pregnancy complication; testicular disease; genital herpes, syphilis, gonorrhea, or other sexually transmitted disease?	☐	☐
G.	Diabetes; thyroid disorder; lymph node enlargement; skin disorder; or disorder of any other glands?	☐	☐
H.	Cancer; tumor; or cyst?	☐	☐
I.	Anemia, leukemia, or other blood disorder (excluding HIV)?	☐	☐
J.	Back or neck pain; spinal strain or sprain; sciatica; arthritis; gout; carpal tunnel syndrome; or any bone, joint, or muscle disorder?	☐	☐
K.	Disorder of the eyes, ears, nose or throat?	☐	☐
L.	Any physical deformity or defect?	☐	☐
M.	Any immune deficiency disorder including AIDS or AIDS-Related Complex (ARC)?	☐	☐
N.	A blood test showing evidence of antibodies to the AIDS (HIV) virus for the purpose of obtaining insurance?	☐	☐
O.	Any chronic or recurrent fever, fatigue or viral illness?	☐	☐

Continue on next page

	Yes	No
4. Do you consume alcoholic beverages? If yes, what kinds, how much and how often?	☐	☐

_____

5. During the past 10 years:		
A. Have you been advised to limit the use of alcohol or drugs; sought or received treatment, advice, or counseling for alcohol or drugs; or joined a group because of alcohol or drug use?	☐	☐
B. Have you tried or used cocaine, heroin, marijuana, barbiturates or other controlled substances?	☐	☐
6. Other than above, have you in the past five years:		
A. Consulted or been advised to consult a physician, psychiatrist, psychologist, therapist, counselor, chiropractor, or other health care practitioner? (Include regular check-ups.)	☐	☐
B. Had a check-up, illness, or surgery, or been treated or evaluated at a hospital or any other health care facility?	☐	☐
C. Had an EKG, x-ray, stress test, echocardiogram, angiography, blood studies or any other diagnostic test (except those for HIV)?	☐	☐
D. Been advised to have any test, hospitalization, or surgery which was not completed?	☐	☐
E. Had a CT Scan, MRI, EEG or any other diagnostic test for fainting spells, convulsions, seizures, headaches, or dizziness?	☐	☐
7. Height:_____ft _____in Weight:_____LBS.		
In the last 12 months have you had a change in weight?	☐	☐
A. If yes, please provide how many pounds lost _____ or how many pounds gained _____		
B. Was your change in weight due to any of the above medical conditions?	☐	☐
C. If no, was your change in weight due to any of the following? (check off all that apply)		

☐ Diet ☐ Exercise ☐ Surgery ☐ Pregnancy ☐ Unknown

8. Family History: Make a note of diabetes, cancer, melanoma, heart, and kidney disease.

		Age(s)	Health History		Age(s)	Cause of Death
Father	Living			Deceased		
Mother						
Siblings						
Siblings						

Continue on next page

	Yes	No
9. Do you have a personal physician or belong to an H.M.O. or clinic? If so, please provide information below.	☐	☐

Name	Phone number

Street address

City	State	Zip code

Date last seen	Reason

Give details of all yes answers, *including doctors' names, phone numbers, addresses and dates.*

I have read the statements and answers recorded on this Application Part 2; they are to the best of my knowledge and belief true, complete and correctly recorded. I agree that they will become part of this application and any policy issued on it.

Proposed insured signature	Date
X	

Witness

Application Part 3
Agreement and Authorization

Individual Life Insurance

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SECURIAN®

Proposed insured name (last, first, middle)

AGREEMENT: I have read, or had read to me the statements and answers recorded on my application. They are given to obtain this insurance and are, to the best of my knowledge and belief, true and complete and correctly recorded. I will notify the company of any changes in the statements or answers given in the application between the time of application and delivery of the policy. I understand that any false statement or misrepresentation on this application may result in loss of coverage under this policy subject to the incontestability provision. I agree that they will become part of this application and any policy issued on it. The insurance applied for will not take effect unless the policy is issued and delivered and the full first premium is paid while the answers, to the best of my knowledge and belief as stated in this application remain true and complete. If such conditions are met, the insurance will take effect as of the earlier of the policy date specified in the policy or the date the policy is delivered to me; the only exception to this is provided in the Life Receipt and Temporary Insurance Agreement, issued if the premium is paid in advance.

VARIABLE LIFE: I understand that the amount or the duration of the death benefit (or both) of the policy applied for may increase or decrease depending on the investment results of the sub-accounts of the separate account. I understand that the actual cash value of the policy applied for is not guaranteed and increases or decreases depending on the investment results. There is no minimum actual cash value for the policy values invested in these sub-accounts.

PERSONAL INFORMATION AUTHORIZATION: I authorize Minnesota Life to share any information provided in this application with any physician, medical practitioner, hospital, clinic or other health care provider, pharmacy, pharmacy benefits manager, insurance or reinsuring company, consumer reporting agency, or the MIB, Inc. (collectively the "Sources") which has any records or knowledge of my credit worthiness, credit standing, credit capacity, character, general reputation, personal characteristics, mode of living, purchase history, drug prescriptions, driving records, or physical or mental health ("collectively, "Personal Information"), and/or the Personal Information of each minor child listed as the proposed insured for the purpose of performing actuarial or internal business studies, research, analytics, or other analysis. This shall include ALL INFORMATION as to any medical history, consultations, diagnoses, prognoses, prescriptions or treatments and tests (except those for HIV), including information regarding alcohol or drug abuse and AIDS or AIDS-related Complex. To facilitate rapid submission of such information, I authorize all the Sources to give such records or knowledge to Minnesota Life Insurance Company or with the exception of MIB, Inc., to any agency employed by Minnesota Life Insurance Company to collect and transmit such information.

I understand the Personal Information is to be used for determining eligibility for insurance and it may be used for determining eligibility for benefits, or for the purpose of performing actuarial or internal business studies, research, analytics and other analysis. I understand the Personal Information may be made available to Underwriting, Claims, and support staff, licensed representatives, and firms of Minnesota Life Insurance Company. I authorize Minnesota Life Insurance Company or its reinsurers to release any such Personal Information to reinsuring companies, the MIB, Inc., or other persons or organizations performing business or legal services in connection with my application, claim or as may be otherwise lawfully required or as I may further authorize. I authorize Minnesota Life Insurance Company, or its reinsurers, to make a brief report of my personal, or if applicable, my protected health information to MIB, Inc. I understand that information used or disclosed under this authorization may be re-disclosed by the recipient and may no longer be protected by federal or state law.

I agree this authorization shall be valid for 24 months from the date it is signed. The 24-month time limit complies with the time limit, if any, permitted by applicable law in the state where the policy is delivered or issued for delivery. I may revoke this authorization at any time by sending a written request addressed to Individual Underwriting department, Minnesota Life Insurance Company, 400 Robert Street North, St. Paul, MN 55101-2098. I understand that a revocation is not effective to the extent that any action has been taken in reliance on this authorization.

I understand that I, or my legal representative, have the right to request and receive a copy of this Authorization and that a photocopy shall be as valid as the original. I understand that no sales representative has the company's authorization, to accept risk, pass on insurability or make, or void, waive or change any conditions or provisions of the application, policy or receipt, as applicable.

I acknowledge that I have been given the Securian Privacy Notice. I understand that a copy of this entire application, including Part 2, will be attached to the policy and delivered to the policyowner.

USA Patriot Act Notification: The USA Patriot Act requires that Minnesota Life Insurance Company establish an Anti-Money Laundering (AML) Program, notify customers that we must verify the identity of the owner(s) of our contracts and collect information sufficient to verify identity. Failure to provide us identification information may result in the delay of insurance coverage and may result in a decision not to accept your business.

FRAUD WARNING: Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud and may be guilty of a criminal offense and subject to penalties under state law.

Proposed insured signature **X**		Proposed insured name (please print)
Date	City	State
Owner signature if other than proposed insured (give title if signed on behalf of a business or trust) **X**		Owner name (please print)
Date	City	State
Owner signature if other than proposed insured (give title if signed on behalf of a business or trust) **X**		Owner name (please print)
Date	City	State
Parent/conservator/guardian signature for juvenile applications signature **X**		Parent/conservator/guardian name (please print)
Date	City	State

Is replacement of existing life insurance or annuity involved in this application? ☐ **Yes** ☐ **No**

I believe that the information provided by the owner and proposed insured is true and accurate. I certify I have accurately recorded all information given by the owner and proposed insured(s).

Licensed representative signature **X**	Licensed representative name (please print)	Date

HIPAA Authorization
For Release of Health-Related Information
To Minnesota Life Insurance Company

Minnesota Life Insurance Company
LIfe New Business • 400 Robert Street North • St. Paul, Minnesota 55101-2098

MINNESOTA LIFE

This authorization complies with the HIPAA Privacy Rule.

Proposed insured/patient name	Date of birth

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, pharmacy benefit manager, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record and any other protected health information concerning me to Minnesota Life Insurance Company (Minnesota Life) and its agents, employees, and 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 Minnesota Life 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 Minnesota Life.

This Authorization shall remain in force for 24 months following the date of my signature below. A copy of this Authorization is as valid as the original. I understand I am entitled to receive a copy of this Authorization. I understand that I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to Minnesota Life at 400 Robert Street North, St. Paul, Minnesota 55101-2098. I understand that a revocation is not effective to the extent that any action has been taken in reliance on this Authorization or to the extent that Minnesota Life 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 may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

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 understand that if I refuse to sign this Authorization to release my complete medical record, Minnesota Life may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I acknowledge that I have received a copy of this Authorization.

Signature of proposed insured/patient or personal representative	Date
X	

Description of personal representative's authority or relationship to patient

MINNESOTA LIFE | SECURIAN®

The application process – what's next?

Thank you for choosing Minnesota Life and Securian Life, a New York admitted insurer. We want to make applying for insurance as simple as possible. That's why we created a confidential, accurate and professional process designed to make it easy for you.

THE FIRST STEPS

By now you and your financial advisor have completed the initial application steps. In most cases, two steps remain:

1. Telephone interview (tele-interview)
2. Physical examination

TELE-INTERVIEW

Once we receive the application, we'll call you to complete the tele-interview. Please see the reverse side of this flyer to prepare important information for this interview. You can expect the tele-interview to be:

- **Flexible** – you give us the number to call and pick the time.
- **Efficient** – it takes 20-25 minutes, but may be longer if additional information is required.
- **Courteous** – interviews are conducted by experienced professionals.
- **Confidential** - information obtained is shared ONLY with your permission.

PHYSICAL EXAM

At the end of your tele-interview, your physical exam is scheduled. You choose the time and place convenient for you. The location will require privacy.

During this exam, the examiner may collect:

- **Height and weight measurements**
- **Blood pressure**
- **Blood and urine samples**
- **An electrocardiogram (EKG)**

THE BEST POSSIBLE OFFER

After the interview and exam are complete, we will use the information to provide the best possible underwriting offer.

We're committed to providing excellent products, solutions and service throughout the life of your policy. Thank you for choosing our company.

more »

Preparing for your tele-interview

Within the next few days, you will be contacted by a representative from our company to gather information regarding your health and finances to help complete your application.

By gathering the following important information, the time required for your tele-interview will be reduced.

Health information

☐ Names and addresses of all physicians and medical facilities that have provided you medical care in the past 10 years:

Physician/Clinic name	Physician/Clinic name	Physician/Clinic name
Address	Address	Address
Phone	Phone	Phone

☐ Prescription and non-prescription medications you are currently taking, including dosage, frequency and reason:

☐ A basic summary of your parents' and siblings' medical history:

Personal information

Keep in mind avocations and hobbies, including:

- Scuba diving
- Rock climbing
- Auto racing

You'll also be asked about related training certifications or completed programs.

Financial information

Be ready to recall your current and previous year's earned income. It is important that we review accurate and verifiable information. You should consider information from the following types of sources:

- Tax returns
- Broker-dealer statements
- Tax assessment or appraisal
- Certified Public Accountant
- Personal attorney
- Personal banker

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www.securian.com

400 Robert Street North, St. Paul, MN 55101-2098 • 1-800-820-4205

F52564-5 Rev 7-2013 DOFU 5-2012
A02091-0512

Representative's Report

Minnesota Life Insurance Company - A Securian Company
Life New Business • 400 Robert Street North • St. Paul, Minnesota 55101-2098

MINNESOTA LIFE

Proposed insured name

Owner name (only complete if the owner is different than the insured.)

Checklist

1. I certify that I left the Securian Privacy Notice with the proposed insured. ☐ Yes ☐ No
2. Do you have a place of business in or do you conduct business in New York? ☐ Yes ☐ No
   If yes, I certify I comply with the Minnesota Life Sales Activities Requirements for Advisors With Offices in or Conducting Business in New York. ☐ Yes ☐ No
3. Do you know anything not disclosed which might affect the underwriting of this policy? ☐ Yes ☐ No
4. Will the Part 2 be completed through the Tele-Interview? ☐ Yes ☐ No
5. If replacement is involved, Sales Material Verification (check one):
   ☐ I certify that I have used only company approved sales materials for this sale, and that a copy of all sales materials used were left with the owner at the time the application was completed.
   ☐ No sales materials were used for this sale.
6. Owner Identity Verification (check one)
   ☐ I certify that I personally met with the owner for the solicitation of this policy and reviewed the identification documents. To the best of my knowledge the documents accurately reflect the identity of the individual. If there are multiple owners, list all identification reviewed.

   Indicate documentation used to verify the insured identity
   ☐ Driver's License ☐ State ID ☐ Passport ☐ Green Card ☐ Juvenile (no ID) ☐ Other_____

Identification number	State/country	Expiration date

   Indicate documentation used to verify the owner identity (if different than the insured)
   ☐ Driver's License ☐ State ID ☐ Passport ☐ Green Card ☐ Other_____

Identification number	State/country	Expiration date

   ☐ I did not meet in person with the owner or was otherwise unable to personally review the identification documents.
   If not in person: ☐ Mail ☐ Internet ☐ Phone
   Are you the agent with whom the solicitation of this policy occurred? ☐ Yes ☐ No
   If no, with whom did the solicitation occur: _____
7. Is the purpose of this insurance to provide an Employee Benefit Plan as defined under ERISA? If yes, complete and submit the required ERISA forms and provide the Services and Compensation Disclosure to the plan fiduciary. ☐ Yes ☐ No

   If yes, will this insurance be part of a pension plan with administrative services provided by Minnesota Life? ☐ Yes ☐ No
8. For Business Insurance (Buy/Sell, Key Person, Split Dollar), check all that apply and complete the following questions:
   ☐ Buy/Sell ☐ Split Dollar ☐ Key Person (If Split Dollar, complete and submit Split Dollar Acknowledgement)
   - If part of a Split Dollar plan, is economic benefit reporting applicable to this split dollar arrangement? (If none selected, default will be yes) ☐ Yes ☐ No
   - What is the value of the business? $_____
   - What percentage does the proposed insured own or control? _____ %
   - Are there other key individuals applying? ☐ Yes ☐ No
     If yes, indicate the name of each person in the additional information section. If no, indicate the reason:

     _____

     _____

9. Are you related to the proposed insured? ☐ Yes ☐ No

   If yes, is the proposed insured a representative listed here, or a spouse or dependent of a listed representative? ☐ Yes ☐ No

10. I explained to the owner that I represent Minnesota Life with respect to the sale and service of this product. ☐ Yes ☐ No

11. Military Sales
    Regarding this life insurance application, is any owner or proposed insured an active duty member of the U.S. Armed Forces? ☐ Yes ☐ No

    - If yes, the Military Personnel Financial Services Disclosure form needs to also be completed. Submit these forms to us with the application and provide a copy of the Disclosure form to the applicant(s).
    - If yes, please note Minnesota Life does not permit the sale of these life insurance products on a military installation. Military Installation means any federally owned, leased, or operated base, reservation, post, camp, building or other facility to which service members are assigned for duty, including barracks, transient housing, and family quarters.

12. Does this sale involve the use of a Captive Insurance Company concept? ☐ Yes ☐ No

13. Will there be a rebate of any kind (i.e., rebate of premium) to the owner or proposed insured or any individual or entity on their behalf? ☐ Yes ☐ No

14. Will financing (payments by a third party, other than persons or entities related to the owner or insured) of premium payments be used at any time in the next two years? ☐ Yes ☐ No
    - If yes, the Premium Financing Disclosure, Advisor Attestation for Premium Financing and the Premium Financing Pre-Application Request forms need to be completed.

15. Did you recommend that the owner and/or proposed insured use home equity to pay the premiums for this policy? ☐ Yes ☐ No

16. Have you gathered sufficient information directly from the owner and proposed insured to support your recommendation that the policy is suitable for them? ☐ Yes ☐ No

17. I certify that for recommendations covered by the Department of Labor Fiduciary regulations I have complied with all of the applicable requirements and prohibited transaction exemptions. ☐ N/A ☐ Yes ☐ No

18. Were the signatures of the owner or proposed insured signed electronically? ☐ Yes ☐ No

Additional Information

Compensation

If compensation received as a result of the issuance of this policy will be split, either directly or indirectly, between two or more representatives, the following section must be completed:

Additional representative name	Firm/rep code	Commission %
Additional representative name	Firm/rep code	Commission %
Additional representative name	Firm/rep code	Commission %

I believe the information provided by this owner and proposed insured is true and accurate. I certify that all information has been given directly to me by the owner and proposed insured(s) and that I have accurately recorded such information. I certify that my statements on this Representative's Report are correct to the best of my knowledge.

I understand that Minnesota Life is relying on the information contained in the application and this Report to determine whether to offer insurance to the owner. Failure to respond accurately to any of these questions is a misrepresentation and may result in Minnesota Life declining the application and in disciplinary action up to and including the termination of my contract and appointment.

The servicing representative signing below is the representative that has access to all policy information, will receive copies of confirmations and has transaction capabilities for the policy. Only one representative will be listed as the servicing representative.

Servicing representative name (please print)

Servicing representative signature **X**	Date	Firm/rep code	Commission %

FACTS WHAT DOES SECURIAN DO WITH YOUR PERSONAL INFORMATION?

Why?	Financial companies choose how they share your personal information. Federal law gives consumers the right to limit some but not all sharing. Federal law also requires us to tell you how we collect, share and protect your personal information. Please read this notice carefully to understand what we do.
What?	The types of personal information we collect and share depend on the product or service you have with us. This information can include: • Social Security number, income, and employment information • Account balances, transaction history and credit history • Medical information and risk tolerance • Assets and investment experience
How?	All financial companies need to share customers' personal information to run their everyday business. In the section below, we list the reasons financial companies can share their customers' personal information; the reason Securian chooses to share; and whether you can limit this sharing.

Reasons we can share your personal information	Does Securian share?	Can you limit this sharing?
For our everyday business purposes - such as to process your transactions, maintain your account(s), respond to court orders and legal investigations, or report to credit bureaus	Yes	No
For our marketing purposes - to offer our products and services to you	Yes	No
For joint marketing with other financial companies	Yes	No
For our affiliates' everyday business purposes - information about your transactions and experiences	Yes	No
For our affiliates' everyday business purposes - information about your creditworthiness	No	We don't share
For our affiliates to market to you	No	We don't share
For non-affiliates to market to you	Yes	Yes

To limit our sharing	Mail the form below to limit sharing by Securian Financial Services, Inc. No other Securian affiliates or subsidiaries share in a manner that allows you to limit the sharing. **Please note:** If you are a new customer, we can begin sharing your information 30 days from the date we sent this notice. When you are no longer our customer, we continue to share your information as described in this notice. However, you can contact us at any time to limit our sharing.
Questions?	**Call 1-855-750-2019**

Mail-in Form

☐ I wish to exercise my right to opt-out of sharing by Securian Financial Services, Inc. Do not share my personal information with an unaffiliated firm should my representative leave Securian Financial Services, Inc.

Name:	
Address:	
City, State, Zip:	
Account/Policy/Contract Number:	

Mail To:
Securian Financial Group, Inc.
Attn: Privacy Preferences
400 Robert St N, St. Paul, MN 55101

Who we are	
Who is providing this notice?	This notice is provided by Securian Financial Group, Inc. and its affiliates. Securian's affiliates are listed below.
What we do	
How does Securian protect my personal information?	To protect your personal information from unauthorized access and use, we use security measures that comply with federal law. These measures include computer safeguards and secured files and buildings.
How does Securian collect my personal information?	We collect your personal information, for example, when you • Open an account or apply for insurance • Enter into an investment advisory contract or seek advice about your investments • Tell us about your investment or retirement portfolio We also collect your personal information from others, such as credit bureaus, affiliates or other companies.
Why can't I limit all sharing?	Federal law gives you the right to limit only • Sharing for affiliates' everyday business purposes - information about your creditworthiness • Affiliates from using your information to market to you • Sharing for non-affiliates to market to you State laws and individual companies may give you additional rights to limit sharing. See below for more on your rights under state law.
What happens when I limit sharing for an account I hold jointly with someone else?	Your choices will apply to everyone on your account.
Definitions	
Affiliates	Companies related by common ownership or control. They can be financial and non-financial companies. • Our affiliates include companies with a Securian name; insurance companies such as Minnesota Life and financial companies such as CRI Securities, LLC.
Non-affiliates	Companies not related by common ownership or control. They can be financial and non-financial companies. The only non-affiliates Securian shares with are your representative and another financial services firm, which your representative may join upon leaving Securian.
Joint marketing	A formal agreement between non-affiliated financial companies that together market financial products or services to you.

If you live in California, North Dakota or Vermont, we are required to obtain your affirmative consent for a non-affiliate to market to you.

This privacy notice applies to Securian Financial Group, Inc., Securian Life Insurance Company, Securian Financial Services, Inc., Securian Trust Company, N.A., Securian Casualty Company, Securian Financial Network, Minnesota Life Insurance Company, American Modern Life Insurance Company, Southern Pioneer Life Insurance Company, and CRI Securities, LLC.

Information we collect

To provide you with products or services, or pay your claims, we collect information that is not publicly available. This may include information such as your name, address, assets, income, net worth, beneficiary designations and other information from your application. We also collect information about your transactions with us, our family of companies or with others, such as insurance policy information, premiums, payment history, and investment purchases. We may also collect information such as claims history or credit scores from consumer reporting agencies.

How we share information

We may share the information we collect as described in this notice with others.

Disclosures are only made if authorized by you or as permitted or required by law. For example, we may disclose information to companies that perform services for us, such as preparing or mailing account statements, processing customer transactions or programming software; to companies to assist us in marketing our own products or services; or to affiliates for the purpose of servicing or administering your account. We may also disclose contact information to financial institutions (such as insurance companies, securities brokers or dealers and banks) with whom we have joint marketing agreements. Additionally, your financial representative and other Securian employees who assist your representative have access to the information they need to provide services to you.

We may share the information described here with government agencies or authorized third parties as required by law. For example, we may be required to share such information in response to subpoenas or to comply with certain laws.

Before we disclose customer information to service providers, companies with whom we have joint marketing agreements, or companies assisting us in marketing our own products or services, we require them to agree to keep this information confidential and to use it only as authorized by us. They are not permitted to release, use or transfer any customer information to any other person without our consent.

How we protect your privacy

We follow these policies and practices to protect the personal information we have about you:

1. We do not sell personal information about you to anyone.
2. We do not share medical information with any affiliates or third parties for any reason unless you have given your consent or unless required or permitted by law.
3. We maintain physical, electronic and procedural safeguards designed to protect your personal information. We restrict access to personal information about you to those employees we believe need access to provide products and services to you. Employees who deal with personal information are trained to adhere to confidentiality standards. Any employee who violates these standards is subject to discipline.

Notice to plan sponsors/ group policyholders

This privacy notice describes our practices for safeguarding personal information about the individuals who purchase our financial products and services primarily for personal, family or household purposes. If you are a plan sponsor or group policyholder, this privacy notice describes our practices for collecting, disclosing and safeguarding personal information about group plan participants.

Former customers

Information about our former customers is kept for the period of time required by our Records Retention Policies. During this time, the information is not disclosed except as required or permitted by law.

The information is destroyed in a secure manner when we are no longer required to maintain it.

Vermont: Under Vermont law, we will not share information we collect about you with companies outside of our corporate family, unless the law allows. For example, we may share information with your consent, to service your accounts or under joint marketing agreements with other financial institutions. We will not share information about your creditworthiness within our corporate family except with your consent, but we may share information about our transactions or experiences with you within our corporate family without your consent.

California: Under California law, we will not share information we collect about you with companies outside of Securian unless the law allows. For example, we may share information with your consent or to service your account(s). We will limit sharing among our affiliates to the extent required by California law.

For Insurance Customers in AZ, CA, CT, GA, IL, ME, MA, MN, MT, NV, NJ, NC, OH, OR and VA only. The term "Information" in this part means customer information obtained in an insurance transaction. We may give your Information to state insurance officials, law enforcement, group policy holders about claims experience or auditors as the law allows or requires. We may give your Information to insurance support companies that may keep it or give it to others. We may share medical Information so we can learn if you qualify for coverage, process claims or prevent fraud, or if you say we can. You can request to review your personal data in our files by writing to us at the address shown on your statement. If you believe your personal data is incorrect, you may contact us at the same address.

For MA Insurance Customers only. You may ask, in writing, for the specific reasons for an adverse underwriting decision. An adverse underwriting decision is where we decline your application for insurance, offer to insure you at a higher than standard rate or terminate your coverage.

Securian Financial Group, Inc.
www.securian.com

400 Robert Street North, St. Paul, MN 55101-2098

F75722 Rev 11-2015 DOFU 11-2015

Electronic Funds Transfer Authorization

Minnesota Life Insurance Company - A Securian Company
Individual Policyowner Services • 400 Robert Street North • St. Paul, Minnesota 55101-2098 • 1-800-649-5726

MINNESOTA LIFE

Policyowner name

Proposed insured name | Policy number

Initial Premium

(Select one only)

☐ I authorize Minnesota Life to initiate a one-time withdrawal, via EFT from the account listed below, upon receipt of my application in the amount of $ _____ or I am providing Minnesota Life with a check in the amount of $ _____. My agent provided me with a copy of the Life Receipt and Temporary Insurance Agreement. This option is not available for applications taken in Kansas.

OR

☐ I authorize Minnesota Life to withdraw the Initial Premium, via EFT from the account listed below. I authorize the withdrawal, upon the receipt of all outstanding Delivery Requirements and at Minnesota Life. At the time my policy is delivered, my agent will inform me of the premium amount.

Recurring Automatic Premium Payments (Only Available on Monthly Pay Plans)

☐ I authorize Minnesota Life to withdraw subsequent monthly premium payments, via EFT from the account listed below. I authorize the withdrawal, subject to the terms of the life insurance contract.

ELECTRONIC FUNDS TRANSFER ACCOUNT HOLDER AUTHORIZATIONS

I hereby authorize Minnesota Life Insurance Company to take deductions each month from the checking or savings account with the financial institution as indicated on this application. I understand and agree that this authorization is subject to the following conditions:

- The amount of the deduction will be equal to the scheduled premium due for my insurance coverage as shown on the policy data pages.
- I will receive notice of each electronic debit entry that varies in the amount from the previous entry.
- This authorization is to remain in full effect until Minnesota Life has received and has had reasonable time to act on the authorized account holder's request to cancel in writing at 400 Robert Street North, Saint Paul, MN 55101 or by telephone at 1-877-282-1930 from 8:00 a.m. CST to 5:00 p.m. CST.

Bank Account Information and Account Holder Authorization

Name of financial institution | City | State

Bank routing number (located on bottom of check) | Bank account number (do not included the check number)

☐ Checking ☐ Savings (Provide account number only)

Print the name(s) of the person(s), business, or entity account holder, AND list all recognized signers on the account:

1. _____ 3. _____

2. _____ 4. _____

☐ Add policy to existing EFT Plan Number _____

If bank/account information and/or draw date on this existing plan is being changed, check here ☐ and indicate changes above.

Authorized account holder signature (include a title if signing on behalf of a business or entity) | Date signed

X

Print authorized account holder name | Address of signer (street, city, state)

Firm/rep code

HOME OFFICE USE ONLY

Home office completion date | Home office signature

X

Individual Life Insurance
Life Receipt and Temporary Insurance Agreement

MINNESOTA LIFE

Minnesota Life Insurance Company - A Securian Company
Life New Business • 400 Robert Street North • St. Paul, Minnesota 55101-2098

THIS IS TO BE LEFT WITH THE OWNER AT THE TIME MONEY IS TAKEN. (NOT VALID FOR USE IN KANSAS.)

All premium checks must be made payable to Minnesota Life; do not make checks payable to the representative and do not leave payee blank.

Money cannot be accepted by the representative if:

1. **The application is taken in Kansas. If money is received with an application taken in Kansas, the application will immediately be declined and the money returned, or**
2. **the proposed insured is 76 or older, or**
3. **the proposed insured has a history of heart disease, stroke, cancer, or diabetes, or**
4. **the proposed insured has been rated or declined for life insurance in the past, or**
5. **the total amount of insurance requested in all applications on the proposed insured (or if survivorship coverage is requested, both proposed insureds combined) exceeds $5,000,000.**

If you have paid our representative at least the initial minimum premium for the policy you applied for, we will provide the following benefits:

TEMPORARY INSURANCE

In consideration of receiving your payment, we provide the following temporary insurance on the life of the proposed insured.

Temporary Accidental Death Insurance: We will pay the beneficiary the amount of life insurance applied for, or $10,000, whichever amount is less, if:

1. Part 1 of the application has been completed, and
2. the proposed insured's death results solely from an accidental injury and not as the result of suicide, and
3. this agreement has not terminated.

Temporary Life Insurance: We will pay the beneficiary the amount of life insurance you applied for (not including any Accidental Death Benefit applied for), or $250,000, whichever is less, if:

1. Both Part 1 and Part 2 of the application have been completed, and
2. all representations on the Part 1 and Part 2 are true and complete, and
3. the proposed insured dies as the result of any cause other than suicide, and
4. this agreement has not terminated.

Termination of Temporary Insurance: The temporary insurance provided by this agreement will terminate on the earlier of:

1. 60 days after the date of this receipt, or
2. on the date we tender to you the policy applied for, or a policy other than as applied for, or a notice of rejection of the application.

THE INSURANCE APPLIED FOR

Insurability of the proposed insured's will be determined at our Home Office according to our underwriting rules. We will have until the actual delivery of the policy to make this determination.

In no event will coverage exist under both this agreement and the policy or policies we offer you.

If you give us a check or draft which is not honored, this receipt and agreement shall be void.

Refund Conditions: We will refund the full amount of your premium payment, unless you accept delivery of the policy we offer or unless we pay a claim under this agreement.

Definitions: When we use the following words in the agreement this is what we mean.

"you", "your" - means the owner.
"we", "our", "us" - means Minnesota Life Insurance Company, St. Paul, Minnesota 55101-2098.
"beneficiary" - means the beneficiary or beneficiaries named in the application.

Representative's Authority: No representative, including any medical examiner, has the authority to determine the insurability of the proposed insured, to waive the answer to any question contained in the application, to modify the application in any respect, or bind us by making any promise or representation other than as contained in this agreement.

Proposed insured name (last, first, middle)

Money paid by	Amount received **$**
Representative signature **X**	Date

Replacement Disclosure Statement

Minnesota Life Insurance Company - A Securian Company
Life New Business • 400 Robert Street North • St. Paul, Minnesota 55101-2098

MINNESOTA LIFE

Policy number (for existing policies)	Insured name	Owner name (if different from insured)

This replacement was initiated by: ☐ Policyowner ☐ Representative

REPLACEMENT DISCLOSURE

I have/will liquidate (includes surrender, loan, or withdrawal) the following products/investments, in conjunction with my insurance purchase:

COMPANY NAME & POLICY NUMBER	PRODUCT LIQUIDATED (i.e.: mutual fund, annuity, cash value or term life insurance)	FULL OR PARTIAL	FACE AMOUNT (Insurance Only)	ANNUAL PREMIUM (Insurance Only)	AMOUNT LIQUIDATED (Cash value)	SURRENDER CHARGES OR REDEMPTION FEE ($ Amount)
	☐ Variable Life ☐ Term Life ☐ Whole Life ☐ Other ☐ Indexed Life _____	☐ Full ☐ Partial	$	$	$	☐ Yes ☐ No $
	☐ Variable Life ☐ Term Life ☐ Whole Life ☐ Other ☐ Indexed Life _____	☐ Full ☐ Partial	$	$	$	☐ Yes ☐ No $

***Attach another form if more replacements taking place**

PRODUCT SUITABILITY (Life to Life Replacements Only)

To be completed by the Representative:

1. Did you sell the client the replaced policy? ☐ Yes ☐ No
2. Does the client have an exchange or conversion feature with the insurance product they intend to replace? If yes, why is the client not taking advantage of it? _____ ☐ Yes ☐ No

   _____
3. What is the benefit of this replacement to the client? _____

   _____

REPLACEMENT ACKNOWLEDGEMENTS

If funds used to purchase this insurance policy come from a lapse, surrender, 1035 Exchange, loan, withdrawal, or other change to any existing life insurance, annuity, or mutual fund, this is considered a replacement and this Disclosure Statement must be completed.

By signing this Disclosure Statement, you acknowledge your understanding of the following in regard to a replacement transaction:

- Issuance of a new policy is subject to underwriting review and approval, and higher risk rating due to health;
- If issued, my new insurance policy will be subject to a new contestability period;
- I will incur new first year expense charges when purchasing this policy;
- I may be subject to capital gain/loss resulting in a tax consequence and have been advised to contact a qualified tax professional to inquire about my individual situation; and
- My policy may be subject to extended surrender charge periods.

SIGNATURES

I have read and understand the statements in this Disclosure, and the information provided is true and accurate.

Owner signature	Date
X	

I have appropriately acted on behalf of my client by reviewing all points in this Disclosure. I believe the information provided in this Disclosure Statement is complete and accurate to the best of my knowledge and that this transaction is suitable for the client.

Representative signature	Date	Firm/rep code
X		

Field principal signature (**required only** for Variable and Indexed Life sales through Securian Financial Services)	Date
X	

Home office signature	Date
X	

Notice Regarding Replacement

MINNESOTA LIFE

Minnesota Life Insurance Company
400 Robert Street North • St. Paul, Minnesota 55101-2098

NAME OF APPLICANT *(Please Print)*

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.

List below the identification of policies which are involved in the replacement transaction.

COMPANY NAME	COMPANY NAME	COMPANY NAME	COMPANY NAME
CONTRACT NUMBER	CONTRACT NUMBER	CONTRACT NUMBER	CONTRACT NUMBER
APPLICANT'S SIGNATURE **X**			DATE
AGENT'S SIGNATURE **X**			DATE

IAN000017

Certification of Trustee Authority

Minnesota Life Insurance Company - A Securian Company
Life New Business • 400 Robert Street North • St. Paul, Minnesota 55101-2098

MINNESOTA LIFE

This form is required for sales of fixed and variable products through Minnesota Life, 400 Robert Street North, St. Paul, Minnesota 55101-2098.

Title of trust

Trust type ☐ Charitable Trust ☐ Irrevocable Living Trust ☐ Living Trust ☐ Testamentary Trust
☐ Family Trust ☐ Irrevocable Trust ☐ Revocable Trust ☐ Other

Policy or account number (if available)	Date trust established	Tax ID or Social Security number used by the trust

List all trustees (Trustees listed here with no corresponding signature below will be required to provide additional identity verification for any transaction. **If trustee is an entity - the entity's corporate resolution is required.)**

Name of trustee/trust officer	☐ Individual Person ☐ Entity	Name of trustee/trust officer	☐ Individual Person ☐ Entity

If there is more than one trustee, how many trustees are required to consent to act on behalf of the trust

☐ Any one trustee ☐ All trustees ☐ _____ out of _____ trustees (number indicated must sign)

****All Trustees/Trust Officers Must Sign This Form Only**

Trustee/trust officers signature	Date
X	
Trustee/trust officers signature	Date
X	

The Trustee(s), ("Trustee"), represents that the terms of the trust allow ownership of the applied for or in force life insurance/annuity/investment/financial plan (the "Contract"). Trustee(s) ☐ does ☐ does not have the authority to establish and maintain an asset management account with debit card, check writing, and margin privileges, from which account funds are directly spent, the reasonability for which is entirely that of the Trustee(s). Trustee acknowledges that Minnesota Life Insurance Company, (the "Company"), is under no duty to review the terms of the trust and that the Company shall not be deemed to have any knowledge of the terms of the trust even if the Company receives any of the trust documents at any time. Therefore, the Company will rely solely on this Certificate of Trustee Authority, or any replacement hereof, and the Trustee's actions pursuant hereto.

The Company will recognize Trustee's authority to act as the legal owner with respect to the Contract that is issued to the trust and the Company may rely on the signature(s) of Trustee to exercise any incidents of ownership with respect to the Contract. Unless otherwise indicated, any one Trustee may act on behalf of the trust.

Trustee acknowledges that the Company's obligation is to perform under the terms of the Contract that is owned by the trust.

Trustee agrees to hold the Company harmless for any action that the Company takes with respect to the Contract at the direction of Trustee. Trustee agrees that the Company may accept directions from Trustee until such time as the Company is notified in writing that Trustee is no longer acting in such capacity. Trustee shall provide a new Certificate of Trustee Authority form if there is a change in Trustee or Trustee authority. Trustee authorization on this form will supersede any earlier designations. Trustee agrees to provide additional information regarding Trustee(s) identification if requested by the Company. Full trust documents may be required at a later date.

By executing his/her signatures below, Trustee agrees to the terms and certifies that the above assertions are true and correct as identified.

Identity Verification

Complete this section for one Trustee whose signature is included above for business submitted through ***Minnesota Life Insurance Company.***

Trustee's identity will be verified by the Company in accordance with the USA Patriot Act. This verification may include, but is not limited to, contact with financial institutions, consumer reporting agencies and government agencies.

Did Registered Representative View ID? ☐ Yes ☐ No

If yes, please complete the section below:

Indicate documentation used to verify identity

☐ Driver's License ☐ State ID ☐ Passport ☐ Greencard ☐ Other _____

Identification number	State/country	Expiration date	Issue date

Registered representative signature	Representative code
X	

If no, please provide the social security number for a Trustee whose signature is above:

Trustee name	Social Security number

Original - Home Office Copy - Client Copy - Client File