



# Term Life - New York Submission Checklist

## Application Submission Checklist (Please submit with application)

Please mail application and appropriate forms to: Companion Life Insurance Company  
c/o Mutual of Omaha Insurance Company,  
Attn: Individual Life Underwriting, 9330 State Hwy 133,  
Blair, NE 68008

**For**

- Life Insurance
  - Adult Life
  - Juvenile Life
  - Additional Insured Rider (AIR)
  - Specified Amount Increase

**To The Agent/Broker:**

- Tear off the Notice of Exchange of Information, Summary of Rights Under the Fair Credit Reporting Act and give it to the Applicant.
- Have Authorization To Release Information on reverse side of this page signed and dated.
- Assure that all applicable questions in Part I and Part II are answered in clear printed fashion.
- Complete Nonmedical Supplement in **all** cases.
- Be sure the application is signed by the Proposed Insured(s) and the Applicant if other than Proposed Insured(s).
- Any changes should be initialed by the Proposed Insured(s) and, if applicable, the Applicant.
- Use age last birthday.
- Always provide the attached Conditional Receipt when you accept a premium.

Section 2

**If a Proposed Insured age 65 or over applies for a face amount of \$1 million or more, have Applicant/Owner and Proposed Insured sign both the Statement of Policyowner Intent form and the Premium Funding and Acknowledgement form**

**Premium Acceptance Guidelines:**

Premium should only be accepted if:

- (a) The Conditional Receipt form is signed, dated and witnessed by all parties indicated on the form on the day the application is taken.
- (b) A **full modal premium** is collected at the time of application unless the Bank Service Plan (BSP) is used, in which case **two** BSP premiums should be collected.
- (c) Premium should not be accepted if the total of all life insurance applied for (including any accidental death benefit) with Companion Life Insurance Company is greater than \$500,000.
- (d) **If, within the past 60 days, the Proposed Insured has been hospitalized or been advised to have a surgical operation or medical test other than for this insurance which has not been completed, money may not be collected with the application and a conditional receipt may not be given.**
- (e) Do not collect a partial premium.

**To The Applicant: All checks must be made payable to Companion Life Insurance Company. Do not make checks payable to the agent or leave the payee blank.**

**If you do not hear from us within 75 days concerning the insurance you applied for, please notify the Company at the above address.**

# Part I of Application for Life Insurance to Companion Life Insurance Company

## A. General Questions

- 1 Proposed Insured's Name: \_\_\_\_\_ Former Name (if applicable): \_\_\_\_\_
- 2 Home Phone Number: ( ) \_\_\_\_\_ Best Time to Call: \_\_\_\_\_ a.m. \_\_\_\_\_ p.m.
- 3 Legal Residence Address: \_\_\_\_\_  
Street No., Apt. No. City, State ZIP
- 4 Mailing Address: \_\_\_\_\_  
Street No., Apt. No. City, State ZIP
- 5 Mail Premium Notices to:  Residence  Owner  Business  
 Address: \_\_\_\_\_  
Street No., Apt. No. City, State ZIP
- 6 Sex:  M  F Age: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Birthplace (state): \_\_\_\_\_
- 7 Social Security Number: \_\_\_\_\_ Driver's License Number: \_\_\_\_\_ State of Issue: \_\_\_\_\_
- 8 Are you a U.S. citizen?  Yes  No If "No," date of arrival in U.S. \_\_\_\_\_  
 Do you have an alien registration receipt "Permanent Visa"?  Yes  No If "Yes," Permanent Visa No.: \_\_\_\_\_
- 9 Occupation: \_\_\_\_\_ Duties: \_\_\_\_\_  
 Businessowner?  Yes  No Retired Military?  Yes  No Active Duty?  Yes  No  
 If "Yes," are you on flying status or receiving hazardous duty pay?  Yes  No  
 If "Yes," explain type of duty or type of aircraft: \_\_\_\_\_
- 10 Name of your firm or employer: \_\_\_\_\_
- 11 Business Phone Number: ( ) \_\_\_\_\_ Best Time to Call: \_\_\_\_\_ a.m. \_\_\_\_\_ p.m.
- 12 Local Business Address: \_\_\_\_\_  
Street No., Apt. No. City, State ZIP
- 13 Do you use tobacco in any form?  Yes. What form? \_\_\_\_\_ No. per day: \_\_\_\_\_  
 No.  Never Used.  Stopped on \_\_\_\_/\_\_\_\_/\_\_\_\_
- 14 Applicant/Owner Name (if different from Proposed Insured or if Proposed Insured is under Age 15):  
 \_\_\_\_\_  
First Initial Last  
 Address: \_\_\_\_\_  
Street No., Apt. No. City, State ZIP  
 Relationship to Proposed Insured: \_\_\_\_\_ Social Security No. (or Taxpayer ID No.): \_\_\_\_\_
- 15 Complete only if Spouse/Children (must be full time student if over age 19) are Proposed for Insurance:
- | First Name, Middle Initial and Last Name | SSN No. | Relationship to Proposed Insured | Birth Date | Age | Sex | Ht. | Wt. |
|--|---------|----------------------------------|------------|-----|-----|-----|-----|
|  |         |                                  |            |     |     |     |     |
|  |         |                                  |            |     |     |     |     |
|  |         |                                  |            |     |     |     |     |
- 16 Spouse's Occupation: \_\_\_\_\_ Birthplace (state): \_\_\_\_\_  
 Income: \$ \_\_\_\_\_ If self-employed, income after expenses and before taxes: \$ \_\_\_\_\_  
 Driver's License Number: \_\_\_\_\_ State of Issue: \_\_\_\_\_
- 17 Is spouse a U.S. citizen?  Yes  No If "No," date of arrival in the U.S. \_\_\_\_\_  
 Does spouse have an alien registration receipt "Permanent Visa"?  Yes  No  
 If "Yes," Permanent Visa Number: \_\_\_\_\_
- 18 Does spouse use tobacco in any form?  Yes. What form? \_\_\_\_\_ No. per day: \_\_\_\_\_  
 No.  Never Used.  Stopped on \_\_\_\_/\_\_\_\_/\_\_\_\_

19 Do all family members proposed for insurance live with the Proposed Insured?  Yes  No If "No," explain and give name and phone number where family member can be contacted \_\_\_\_\_

20 Plan Information

a. Plan of Insurance: \_\_\_\_\_  
Amount: \_\_\_\_\_

b.  Addition to Existing Policy No.: \_\_\_\_\_  
Amount: \_\_\_\_\_

c. Death Benefit Option:  
 Option 1: Accumulation Value included in Specified Amount  
 Option 2: Accumulation Value in addition to Specified Amount

d. I elect the Automatic Premium Deduction Option.  
(Not available with all plans)  Yes  No

e. Riders:  
(Please Note: Not all riders are available with all plans)

- Waiver of Premium or Disability \_\_\_\_\_
- Accidental Death Benefit \_\_\_\_\_
- Guaranteed Issue Benefit \_\_\_\_\_
- Children's Rider \_\_\_\_\_
- Spouse (indicate type of coverage) \_\_\_\_\_
- Additional Insured Rider (Self, Spouse) \_\_\_\_\_
- Other Insured Rider \_\_\_\_\_
- Other \_\_\_\_\_

Amount or No.  
of Units (if applicable)

	Premium	THIS BOX FOR ADMINISTRATIVE PURPOSES ONLY
	\$ _____	
	\$ _____	
	\$ _____	
	\$ _____	
	\$ _____	
	\$ _____	
	\$ _____	
	\$ _____	
	\$ _____	
Total Premium	\$ _____	

f. Amount Collected (Cash with App):	Explanation of Amount Collected	Mode	Total Premium
\$ _____			\$ _____

21 List all Life Insurance now in force or pending on any Proposed Insured(s). If none, write "None." Have you had or do you intend to have any life insurance policy replaced, converted, reduced, reissued, subjected to borrowing, or otherwise discontinued because of this application? If "Yes," so indicate below.

Company	Policy Number	Face Amount	Pending	ADB Amount	To Be Replaced, etc. <input type="checkbox"/> Yes <input type="checkbox"/> No	1035 Exchange? <input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

22 Life Insurance Beneficiary (Give full names and relationship).

**Note:** Unless you specify otherwise, payments will be shared equally by all primary beneficiaries who survive the Insured or, if none, by all contingent beneficiaries who survive the Insured. The right to change the beneficiary is reserved unless otherwise stated.

See Attached Beneficiary Designation

Primary Beneficiary(ies)

Name \_\_\_\_\_ Relationship \_\_\_\_\_ SSN No. \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ SSN No. \_\_\_\_\_

Contingent Beneficiary(ies):

Name \_\_\_\_\_ Relationship \_\_\_\_\_ SSN No. \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ SSN No. \_\_\_\_\_

23 Complete only for PRD or Association Group or Franchise Coverage:

Full Name of Group/Organization \_\_\_\_\_ Date Joined \_\_\_\_\_

Group/Membership No.: \_\_\_\_\_ Relationship to above:  Shareholding Member

Dues-paying Member  Other \_\_\_\_\_

# Part II of Application for Life Insurance — Nonmedical Supplement

Please Print. All Questions Relate to Anyone Proposed for Insurance.

1 Name, address and telephone number of personal physician of each person proposed for insurance:

\_\_\_\_\_

\_\_\_\_\_

(a) Date last seen: \_\_\_\_\_

(b) State reason, findings and treatment: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

2 Name and address of physician most recently consulted by each person proposed for insurance: \_\_\_\_\_

(a) Date: \_\_\_\_\_ (b) State reason, findings and treatment \_\_\_\_\_

3 Have you, or any person proposed for insurance, ever been told that you had, or have you consulted or been treated by a physician or licensed practitioner for any of the following:

YES NO

- (a) Any disease or abnormal condition of the heart, circulatory system or blood vessels, high blood pressure, rapid pulse, rheumatic fever, murmur, coronary artery disease, chest pain, angina or stroke? .....
- (b) Any disease of the lungs or respiratory system, including tuberculosis, asthma, bronchitis, emphysema or shortness of breath? .....
- (c) Any digestive system disease, including stomach or duodenal ulcer, indigestion, stomach pain, liver or gallbladder disease, colon or rectal disorder? .....
- (d) Any genitourinary system disease including albumin, blood or sugar in urine, kidney infection or stones, tumor or disease of the prostate, testis, breasts, uterus or ovaries? .....
- (e) Any nervous, brain or mental disorder, convulsions, dizziness, headaches, epilepsy, nervous breakdown or paralysis? .....
- (f) Any bone or joint disorder, arthritis or rheumatism, bodily deformity, back or spinal disorder? .....
- (g) Any disease or impairment of vision or hearing? .....
- (h) Gout, diabetes, thyroid or other glandular disorder, cancer, tumor or blood disorder other than AIDS or AIDS Related Complex (ARC) .....

4 Have you, or any person proposed for insurance, ever been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), or been treated for AIDS or ARC by a physician or licensed practitioner? .....

5 During the past 10 years, have you, or any person proposed for insurance:

- (a) had any illness, injury, surgery, hospitalization, medical examination or care not listed above? .....
- (b) had or received treatment for any unexplained fever, fatigue or chronic cough? .....
- (c) had any X-rays, electrocardiograms, blood or other studies, except for an HIV test? .....
- (d) been advised by a physician to have a surgical operation? .....
- (e) been advised by a physician to limit your use of alcohol? .....

6 Are you, or any person proposed for insurance, now taking any medication prescribed by a physician? .....

7 During the last 10 years, have you, or any person proposed for insurance:

- (a) used alcohol or other drugs to a degree that required treatment or advice from a physician or other licensed practitioner? .....
- If "Yes," has use been discontinued? .....
- (b) been or are currently a member of Alcoholics Anonymous or Narcotics Anonymous? .....

8 If pregnant, enter approximate delivery date: \_\_\_\_\_

9 Height: \_\_\_\_\_ ft. \_\_\_\_\_ ins. Weight: \_\_\_\_\_ lbs.  
 Weight change during last 12 months: Lbs. Gained: \_\_\_\_\_ Lost: \_\_\_\_\_





# Agent's/Broker's Report

(Must be completed by the agent/broker who obtained the application on the Proposed Insured named below.)

1 Is Proposed Insured self-supporting?  Yes  No If "No," provide the following information about the person on whom Proposed Insured is dependent:

Full Name \_\_\_\_\_ Address \_\_\_\_\_ Birth Date \_\_\_\_\_

Amount of insurance carried with all companies \$ \_\_\_\_\_ If none, state why \_\_\_\_\_

2 If Proposed Insured used different name in past, give previous full name \_\_\_\_\_

3 (a) Are you related to Proposed Insured or Owner?  
 Yes  No  
 If "Yes," state relationship \_\_\_\_\_

(b) How long have you known Proposed Insured? \_\_\_\_\_

(c) How long have you known Proposed Owner? \_\_\_\_\_

4 When did you last see Proposed Insured? \_\_\_\_\_

5 Did you ask Proposed Insured or Owner every question as printed (if "No," explain below)?  
 Yes  No

6 Do you have any information not presented in this application which might in any way affect this risk (if "Yes," explain below)?  Yes  No

7 Proposed Insured's Annual Income \$ \_\_\_\_\_  
 Exact  Estimated

8 What is the purpose of this insurance? Give details including financial information (for amounts of \$500,000 or more, financial statements may be requested)  
 \_\_\_\_\_  
 \_\_\_\_\_

9 (a) Is a medical exam to be completed?  Yes  No  
 (b) Name of examiner or paramedical facility \_\_\_\_\_  
 \_\_\_\_\_

10 Previous residence and business addresses of Proposed Insured for past five years.

Address	From	To

11 Is another policy requested based on this application?  
 Additional policy Plan \_\_\_\_\_  
 Alternate policy Amount \$ \_\_\_\_\_  
 Owner (if different) \_\_\_\_\_  
 Beneficiary (if different) \_\_\_\_\_

12 Is Proposed Insured applying for insurance with any other company (if "Yes," give details)?  Yes  No  
 \_\_\_\_\_  
 \_\_\_\_\_

13 To the best of your knowledge will this policy replace any existing life insurance or annuity (if "Yes," give details and fulfill all state requirements)?  Yes  No  
 \_\_\_\_\_  
 \_\_\_\_\_

**Details:**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Agent(s)/Broker(s) to Receive Commission and Volume Credit for This Application**

Agent's/Broker's Full Name	Agent's/Broker's Production No.	% Credit
1 _____		
2 _____		

I hereby certify that I have truly and accurately recorded the information furnished by the Owner and/or Proposed Insured.

\_\_\_\_\_  
 Date Signature of Agent(s)/Broker(s) Agent(s)/Broker(s) Name (Please Print)

\_\_\_\_\_  
 Name of Division Office/Wholesaler Name of Assistant Wholesaler (Brokerage Only)

# New York - Authorization To Disclose Personal Information To Companion Life Insurance Company

## Meanings of Terms

**“Medical Persons and Entities” means:** all physicians, medical or dental practitioners, hospitals, clinics, pharmacies, pharmacy benefit managers, other medical care facilities, health maintenance organizations and all other providers of medical or dental services.

**“Personal Information” means:** all health information, such as medical history, mental and physical condition, prescription drug records, drug and alcohol use and other information such as finances, occupation, general reputation and insurance claims information about me and, if my children are proposed insureds, my children also. Personal Information does not include Psychotherapy Notes.

**“Psychotherapy Notes” means:** notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a counseling session, which notes are separated from the rest of the person’s medical record. Certain information, such as that relating to prescriptions, diagnosis and functional status, is not included in the term Psychotherapy Notes.

**“Specified Companies” means:**

- The group of companies which presently includes Mutual of Omaha Insurance Company, United World Life Insurance Company, Companion Life Insurance Company, Exclusive Healthcare, Inc., additional companies which may become part of this group of companies and their successors.
- Other persons and entities which act on behalf of those companies to provide services to them.

## Authorization to Disclose

I authorize the Medical Persons and Entities, the Specified Companies, employers, consumer reporting agencies and other insurance companies to disclose Personal Information about me and, if my children are proposed insureds, about my children to Companion Life Insurance Company.

## Purposes

The Personal Information will be used to determine my or my children’s eligibility for insurance and to resolve or contest any issues of incomplete, incorrect or misrepresented information on this application which may arise during the processing of my application or in connection with claims for insurance benefits.

## Potential For Redisclosure

If the person or entity to whom Personal Information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the Personal Information may then be subject to further disclosure by that person or entity without the protections of the federal privacy regulations.

## Failure to Sign

I understand that I may refuse to sign this authorization. I realize that if I refuse to sign, the insurance for which I am applying will not be issued.

## Expiration and Revocation

Unless revoked earlier, this authorization will remain in effect for 24 months from the date I sign it. I understand that I may revoke this authorization at any time, by written notice to:

ATTN: Individual Underwriting  
Companion Life Insurance Company  
Mutual of Omaha Plaza  
Omaha, NE 68175-0001

I realize that my right to revoke this authorization is limited to the extent that Companion Life Insurance Company has taken action in reliance on the authorization or the law allows Companion Life Insurance Company to contest the issuance of the policy or a claim under the policy.

## Copy

I understand that I will receive a copy of the signed authorization. A copy of this authorization is as effective as the original.

## Names and Signatures

Name(s) used for medical records (if different than the name(s) below): \_\_\_\_\_

\_\_\_\_\_  
Printed Name of Proposed Insured

\_\_\_\_\_  
Spouse’s Printed Name  
(If Proposed Insured)

\_\_\_\_\_  
If children are to be insured, their printed names

\_\_\_\_\_  
Signature of Proposed Insured

\_\_\_\_\_  
Signature of Spouse  
(If Proposed Insured)

\_\_\_\_\_  
Signature of Parent or Guardian  
(If Proposed Insured is a Minor)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

**THIS AUTHORIZATION COMPLIES WITH HIPAA AND OTHER FEDERAL AND STATE LAWS**

**Meanings of Terms**

**"MIB Group, Inc. (MIB)" means:** a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members.

**"Personal Information" means:** all health information, such as medical history, mental and physical condition, prescription drug records, drug and alcohol use and other information such as finances, occupation, general reputation and insurance claims information about me and, if my children are proposed insureds, my children also.

**"Specified Companies" means:**

- The group of companies which presently includes Mutual of Omaha Insurance Company, Companion Life Insurance Company, additional companies which may become part of this group of companies and their successors.
- Other persons and entities which act on behalf of those companies to provide services to them.

**Authorization to Receive and Disclose**

To the MIB:

I authorize you to disclose Personal Information about me (the undersigned) or my children to the Specified Companies and their reinsurers. You are not authorized to disclose information about me to a consumer reporting agency. Information received will assist in verifying the accuracy of the information I have provided in my application(s) for insurance with one or more of the Specified Companies.

I also authorize the Specified Companies and their reinsurers to disclose Personal Information about me or my children to the MIB. I understand that the Personal Information received by the MIB may be disclosed, upon request, to another member company with whom I apply for life or health insurance or to whom I may submit a claim for benefits.

I understand that I may refuse to sign this authorization. I realize that if I refuse to sign, the insurance for which I am applying will not be issued.

Unless revoked earlier, this authorization will remain in effect for 24 months from the date I sign it. I understand that I may revoke this authorization at any time, by written notice to:

Attn: Individual Underwriting  
Mutual of Omaha  
Mutual of Omaha Plaza  
Omaha, NE 68175-0001

I also understand that any revocation of this authorization will not affect any use or disclosure of Personal Information that occurred prior to the receipt of my revocation.

I have been advised that I, or my authorized representative, am entitled to receive a copy of this authorization. A copy of this authorization is as effective as the original.

Name(s) used for medical records (if different than the name(s) below): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Proposed Insured

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Spouse (If Proposed Insured)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent or Guardian  
(If Proposed Insured is a Minor)

\_\_\_\_\_  
Date

# Bank Service Plan Request Form

## Complete the following information:

Insured's Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ ZIP \_\_\_\_\_

Coverage ID Number(s):

\_\_\_\_\_

\_\_\_\_\_

## Specify Preferred Date of Withdrawals

Please indicate when you prefer the monthly premiums to be withdrawn from your checking account:

Withdraw on the \_\_\_\_\_ (1st through 28th) of the month

## Bank Service Plan Authorization

As a convenience to me, I authorize Companion Life Insurance Company to withdraw funds from my account.

I also authorize you, my financial institution, to pay from my account any checks, drafts or preauthorized electronic fund transfers from my account to Companion Life Insurance Company. Your rights with each such charge will be the same as if personally paid by me. This authorization will be effective until I give you at least three business days' notice to cancel it. If notice is given verbally, you may require written confirmation from me within 14 days after my verbal notice.

Date \_\_\_\_\_

\_\_\_\_\_  
Authorized Signature as Shown on Account

\_\_\_\_\_  
Joint Account or Other Authorized Signature

COMPANION LIFE INSURANCE COMPANY 303 Merrick Road Lynbrook, New York 11563-2515

**Confidential Suitability Information**

NASD Rules require that the agent/broker have reasonable grounds for believing that an investment is suitable for you. Such a decision is based on facts, if any, that you disclose. Please answer all questions to the best of your ability. If you are not certain of a particular value, please make a reasonable estimate. If a category does not apply to you, indicate this by entering an N/A. If you do not wish to provide this information, please check the box and initial.

\_\_\_\_\_

Federal Tax Bracket \_\_\_\_\_

Investment Objectives  
(Check or rank)

- A Income
- B Capital Preservation
- C Capital Appreciation
- D Tax-Free/Advantaged
- E Other \_\_\_\_\_

Annual Income  
(From all sources)

- A Under \$25,000
- B \$25,000 - \$50,000
- C \$50,000 - \$100,000
- D \$100,000 - \$200,000
- E Over \$200,000

Net Worth  
(Excluding residence)

- A Under \$50,000
- B \$50,000 - \$100,000
- C \$100,000 - \$500,000
- D \$500,000 - \$1,000,000
- E Over \$1,000,000

- PRIOR INVESTMENT EXPERIENCE
- Stocks \_\_\_\_\_ Years \_\_\_\_\_ Trades per year
  - Bonds \_\_\_\_\_ Years \_\_\_\_\_ Trades per year
  - Mutual Funds \_\_\_\_\_ Years \_\_\_\_\_ Trades per year
  - Other \_\_\_\_\_ Years \_\_\_\_\_ Trades per year

Other Relevant Information \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**X** \_\_\_\_\_  
Signature of Proposed Insured (Age 15 & over) Date

**X** \_\_\_\_\_  
Signature of Agent/Broker Date

**X** \_\_\_\_\_  
Signature of Parent or Guardian (If Proposed Insured under age 15) Date

## Companion Life Insurance Company – MIB Group, Inc. Pre-Notice

Information regarding your insurability will be treated as confidential. Companion Life Insurance Company, 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. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information is: Post Office Box 105, Essex Station, Boston, MA 02112.

Companion Life Insurance Company, 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.

## Fair Credit Reporting Act Disclosure Statement

Companion Life Insurance Company, or its duly authorized representative(s), may request and obtain an investigative consumer report for the purpose of serving as a factor in the underwriting of your insurance application.

An investigative consumer report means any written, oral or other communication of any information by a consumer reporting agency bearing on your character, general reputation, personal characteristics or mode of living obtained through personal interviews with your neighbors, friends, acquaintances, associates, or those who may have knowledge concerning such items of information.

Upon written request, we will provide you with additional disclosures relating to the nature and scope of the investigative consumer report. Following this Disclosure Statement is a written Summary of Your Rights under Section 609 (c) of the Fair Credit Reporting Act, as amended.

If you request the additional disclosures from Companion Life Insurance Company, please send your request to the following address: **Attention:** Companion Life Insurance Company, Underwriting Department, 303 Merrick Road, Lynbrook, NY 11563-2515

## Companion Life Insurance – Notice of Information Practices

In the course of properly underwriting and administering your insurance coverage, Companion Life Insurance Company will rely heavily on information provided by you. The Company may also collect information from others, such as medical professionals who have treated you, hospitals, other insurance companies, consumer reporting agencies, or the Medical Information Bureau, Inc. (MIB).

In certain circumstances, and in compliance with applicable law, our Company may disclose personal or privileged information to third parties without your authorization.

You have the right to be told about and to see a copy, if you wish, of items of personal information about you which appear in our files, including information contained in investigative consumer reports. You also have the right to seek correction of personal information you believe to be inaccurate.

**The above is a general description of the Company's and your agent's/broker's information practices. If you would like to receive a more detailed explanation of these practices, please send your request to: Companion Life Insurance Company, Underwriting Department, 303 Merrick Road, Lynbrook, NY 11563-2515.**

**GIVE THIS NOTICE TO THE APPLICANT**

## A Summary of Your Rights Under the Fair Credit Reporting Act

The federal Fair Credit Reporting Act (FCRA) promotes the accuracy, fairness, and privacy of information in the files of consumer reporting agencies. There are many types of consumer reporting agencies, including credit bureaus and specialty agencies (such as agencies that sell information about check writing histories, medical records, and rental history records). Here is a summary of your major rights under the FCRA. **For more information, including information about additional rights, go to [www.ftc.gov/credit](http://www.ftc.gov/credit) or write to: Consumer Response Center, Room 130-A, Federal Trade Commission, 600 Pennsylvania Ave. N.W., Washington, D.C. 20580.**

- **You must be told if information in your file has been used against you.** Anyone who uses a credit report or another type of consumer report to deny your application for credit, insurance, or employment – or to take another adverse action against you – must tell you, and must give you the name, address, and phone number of the agency that provided the information.
- **You have the right to know what is in your file.** You may request and obtain all the information about you in the files of a consumer reporting agency (your “file disclosure”). You will be required to provide proper identification, which may include your Social Security number. In many cases, the disclosure will be free. You are entitled to a free file disclosure if:
  - a person has taken adverse action against you because of information in your credit report;
  - you are the victim of identify theft and place a fraud alert in your file;
  - your file contains inaccurate information as a result of fraud;
  - you are on public assistance;
  - you are unemployed but expect to apply for employment within 60 days.In addition, by September 2005 all consumers will be entitled to one free disclosure every 12 months upon request from each nationwide credit bureau and from nationwide specialty consumer reporting agencies. See [www.ftc.gov/credit](http://www.ftc.gov/credit) for additional information.
- **You have the right to ask for a credit score.** Credit scores are numerical summaries of your credit-worthiness based on information from credit bureaus. You may request a credit score from consumer reporting agencies that create scores or distribute scores used in residential real property loans, but you will have to pay for it. In some mortgage transactions, you will receive credit score information for free from the mortgage lender.
- **You have the right to dispute incomplete or inaccurate information.** If you identify information in your file that is incomplete or inaccurate, and report it to the consumer reporting agency, the agency must investigate unless your dispute is frivolous. See [www.ftc.gov/credit](http://www.ftc.gov/credit) for an explanation of dispute procedures.
- **Consumer reporting agencies must correct or delete inaccurate, incomplete, or unverifiable information.** Inaccurate, incomplete or unverifiable information must be removed or corrected, usually within 30 days. However, a consumer reporting agency may continue to report information it has verified as accurate.
- **Consumer reporting agencies may not report outdated negative information.** In most cases, a consumer reporting agency may not report negative information that is more than seven years old, or bankruptcies that are more than 10 years old.
- **Access to your file is limited.** A consumer reporting agency may provide information about you only to people with a valid need -- usually to consider an application with a creditor, insurer, employer, landlord, or other business. The FCRA specifies those with a valid need for access.
- **You must give your consent for reports to be provided to employers.** A consumer reporting agency may not give out information about you to your employer, or a potential employer, without your written consent given to the employer. Written consent generally is not required in the trucking industry. For more information, go to [www.ftc.gov/credit](http://www.ftc.gov/credit).

GIVE COPY TO THE APPLICANT

- **You may limit “prescreened” offers of credit and insurance you get based on information in your credit report.** Unsolicited “prescreened” offers for credit and insurance must include a toll-free phone number you can call if you choose to remove your name and address from the lists these offers are based on. You may opt-out with the nationwide credit bureaus at 1-888-5-OPTOUT (1-888-567-8688).
- **You may seek damages from violators.** If a consumer reporting agency, or, in some cases, a user of consumer reports or a furnisher of information to a consumer reporting agency violates the FCRA, you may be able to sue in state or federal court.
- **Identity theft victims and active duty military personnel have additional rights.** For more information, visit [www.ftc.gov/credit](http://www.ftc.gov/credit).

**States may enforce the FCRA, and many states have their own consumer reporting laws. In some cases, you may have more rights under state law. For more information, contact your state or local consumer protection agency or your state Attorney General. Federal enforcers are:**

**TYPE OF BUSINESS:**

**CONTACT:**

Consumer reporting agencies, creditors and others not listed below

Federal Trade Commission: Consumer Response Center - FCRA  
Washington, DC 20580  
1-877-382-4357

National banks, federal branches/agencies of foreign banks (word “National” or initials “N.A.” appear in or after bank’s name)

Office of the Comptroller of the Currency  
Compliance Management, Mail Stop 6-6  
Washington, DC 20219  
800-613-6743

Federal Reserve System member banks (except national banks, and federal branches/ agencies of foreign banks)

Federal Reserve Board  
Division of Consumer & Community Affairs  
Washington, DC 20551  
1-202-452-3693

Savings associations and federally chartered savings banks (word “Federal” or initials “F.S.B.” appear in federal institution’s name)

Office of Thrift Supervision  
Consumer Complaints  
Washington, DC 20552  
1-800-842-6929

Federal credit unions (words “Federal Credit Union” appear in institution’s name)

National Credit Union Administration  
1775 Duke Street  
Alexandria, VA 22314  
1-703-519-4600

State-chartered banks that are not members of the Federal Reserve System

Federal Deposit Insurance Corporation  
Consumer Response Center, 2345 Grand Avenue, Suite 100  
Kansas City, Missouri 64108-2638  
1-877-275-3342

Air, surface, or rail common carriers regulated by former Civil Aeronautics Board or Interstate Commerce Commission

Department of Transportation , Office of Financial Management  
Washington, DC 20590  
1-202-366-1306

Activities subject to the Packers and Stockyards Act, 1921

Department of Agriculture  
Office of Deputy Administrator - GIPSA  
Washington, DC 20250  
1-202-720-7051

**GIVE COPY TO THE APPLICANT**

# Conditional Receipt

Companion Life Insurance Company ("Companion"), 303 Merrick Road, Lynbrook, NY 11563-2515

All checks for premiums must be made payable to Companion Life Insurance Company. Do not make checks payable to the agent or leave the payee blank.

**The terms of this receipt apply to life insurance only. If an annuity is being applied for, this form will serve only as a receipt for the amount of annuity premium paid with the application.**

This receipt is furnished in connection with an application for insurance bearing the same date and number as this receipt and will provide insurance prior to the delivery date of the policy, but only if **all** conditions below have been completely met:

- (1) The amount received is sufficient to pay: (a) the first premium of a fixed premium plan, at the mode applied for; or (b) the first planned periodic premium on a flexible premium plan.
- (2) The first medical examination (and if required by Companion's rules for age of the person and amount of insurance applied for, a second medical examination) must be completed within 60 days from the date of the application.
- (3) The exact insurance applied for by the Proposed Insured is or would be acceptable to the Company's underwriting department in accordance with its underwriting procedures and practices on the effective date indicated below, without modification of plan, premium rate or amount.
- (4) That to the best knowledge and belief of those signing the application, all the statements and answers in this application are true and complete when made.

**Effective Date:** If all the conditions above are met, then insurance, subject to all the terms and conditions of the policy applied for and as if the policy applied for had already been issued and delivered, will become effective on the latest of: (a) the date of application; (b) the date of completion of all underwriting requirements stated in (2) above; or (c) the special policy date requested in the application, if any.

**The amount of insurance which may become effective prior to the delivery of the policy applied for will not exceed \$500,000 including any accidental death benefit and will not be effective if, in the past 60 days, the proposed insured has been hospitalized or advised to have a surgical operation or medical test.**

If any of the above conditions is not met, the liability of the Company will be limited to the return of the amount submitted.

I understand and agree to the terms, conditions and limits of the Conditional Receipt and the Agreements in the application. These have been fully explained to me by the Agent or Broker.

Date \_\_\_\_\_ Signature of Applicant \_\_\_\_\_

This receipt is furnished in connection with an application for insurance bearing the same date and number as this receipt.

Amount Received \_\_\_\_\_ Received From \_\_\_\_\_ Proposed Insured \_\_\_\_\_

Signed at \_\_\_\_\_, on \_\_\_\_\_  
City, State Date

\_\_\_\_\_  
Agent

# Conditional Receipt

Companion Life Insurance Company ("Companion"), 303 Merrick Road, Lynbrook, NY 11563-2515

All checks for premiums must be made payable to Companion Life Insurance Company. Do not make checks payable to the agent or leave the payee blank.

**The terms of this receipt apply to life insurance only. If an annuity is being applied for, this form will serve only as a receipt for the amount of annuity premium paid with the application.**

This receipt is furnished in connection with an application for insurance bearing the same date and number as this receipt and will provide insurance prior to the delivery date of the policy, but only if **all** conditions below have been completely met:

- (1) The amount received is sufficient to pay: (a) the first premium of a fixed premium plan, at the mode applied for; or (b) the first planned periodic premium on a flexible premium plan.
- (2) The first medical examination (and if required by Companion's rules for age of the person and amount of insurance applied for, a second medical examination) must be completed within 60 days from the date of the application.
- (3) The exact insurance applied for by the Proposed Insured is or would be acceptable to the Company's underwriting department in accordance with its underwriting procedures and practices on the effective date indicated below, without modification of plan, premium rate or amount.
- (4) That to the best knowledge and belief of those signing the application, all the statements and answers in this application are true and complete when made.

**Effective Date:** If all the conditions above are met, then insurance, subject to all the terms and conditions of the policy applied for and as if the policy applied for had already been issued and delivered, will become effective on the latest of: (a) the date of application; (b) the date of completion of all underwriting requirements stated in (2) above; or (c) the special policy date requested in the application, if any.

**The amount of insurance which may become effective prior to the delivery of the policy applied for will not exceed \$500,000 including any accidental death benefit and will not be effective if, in the past 60 days, the proposed insured has been hospitalized or advised to have a surgical operation or medical test.**

If any of the above conditions is not met, the liability of the Company will be limited to the return of the amount submitted.

I understand and agree to the terms, conditions and limits of the Conditional Receipt and the Agreements in the application. These have been fully explained to me by the Agent or Broker.

Date \_\_\_\_\_ Signature of Applicant \_\_\_\_\_

This receipt is furnished in connection with an application for insurance bearing the same date and number as this receipt.

Amount Received \_\_\_\_\_ Received From \_\_\_\_\_ Proposed Insured \_\_\_\_\_

Signed at \_\_\_\_\_, on \_\_\_\_\_  
City, State Date

\_\_\_\_\_  
Agent

# Notice and Consent for Testing Which May Include AIDS Virus (HIV) Antibody/Antigen Testing

Mutual of Omaha Insurance Company

- ATTN: Health:  
Mutual of Omaha Plaza, Omaha, NE 68175
- ATTN: True Group:  
Mutual of Omaha Plaza, Omaha, NE 68175

Companion Life Insurance Company

- ATTN: Life Agency:  
Mutual of Omaha Plaza, Omaha, NE 68175
- ATTN: Life Brokerage:  
P.O. Box 2476, Omaha, NE 68103-2476

To determine your insurability, the Insurer named above (the Insurer) has requested that you provide a sample of your blood and/or other bodily fluid for testing and analysis. All tests will be performed by a licensed laboratory.

Unless precluded by law, tests may be performed to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. The HIV antibody test that we perform is actually a series of tests done by a medically accepted procedure. The HIV antigen test directly identifies AIDS viral particles. These tests are extremely reliable. Other tests which may be performed include determinations of blood cholesterol and related lipids (fats) and screening for liver or kidney disorders, diabetes and immune disorders.

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 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 nonspecific test abnormality. If your HIV test is normal, no report will be made about it to the MIB, Inc. Other test results may be reported to the MIB, Inc., in a more specific manner. 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.

If your HIV test results are normal, no routine notification will be sent to you. If the HIV test results are other than normal, the Insurer will contact you. The Insurer may also contact you if there are other abnormal test results which, in the Insurer's opinion, are significant. The Insurer may ask you for the name of a physician or other health care provider to whom you may authorize disclosure and with whom you may wish to discuss the results.

Positive HIV antibody/antigen test results do not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others. For those reasons, a person with a positive test result may wish to consider further independent testing.

Positive HIV antibody or antigen test results or other significant blood abnormalities 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.

## Notification of Test Results

A positive test result will be disclosed to a physician or other individual you designate. If you do not designate anyone, a positive test result will be disclosed to you. However, because a trained person should deliver that information so that you can understand clearly what the test result means, please 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 or other designee for reporting a positive test result \_\_\_\_\_

Address \_\_\_\_\_

If you desire further information about AIDS, the meaning or HIV-related test results and the availability and location of HIV-related counseling services, you may call the New York State Department of Health on their toll-free number 1-800-541-AIDS.

## Consent

I have read and I understand this Notice and Consent for AIDS-related Testing. I voluntarily consent to the withdrawal of blood and/or other bodily fluids from me, the testing of that blood and/or other bodily fluids, and the disclosure of the test results as described herein.

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 \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_  
Signature of Proposed Insured or Parent/Guardian

\_\_\_\_\_  
Date Signed

# Notice and Consent for Testing Which May Include AIDS Virus (HIV) Antibody/Antigen Testing

Mutual of Omaha Insurance Company

- ATTN: Health:  
Mutual of Omaha Plaza, Omaha, NE 68175
- ATTN: True Group:  
Mutual of Omaha Plaza, Omaha, NE 68175

Companion Life Insurance Company

- ATTN: Life Agency:  
Mutual of Omaha Plaza, Omaha, NE 68175
- ATTN: Life Brokerage:  
P.O. Box 2476, Omaha, NE 68103-2476

To determine your insurability, the Insurer named above (the Insurer) has requested that you provide a sample of your blood and/or other bodily fluid for testing and analysis. All tests will be performed by a licensed laboratory.

Unless precluded by law, tests may be performed to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. The HIV antibody test that we perform is actually a series of tests done by a medically accepted procedure. The HIV antigen test directly identifies AIDS viral particles. These tests are extremely reliable. Other tests which may be performed include determinations of blood cholesterol and related lipids (fats) and screening for liver or kidney disorders, diabetes and immune disorders.

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 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 nonspecific test abnormality. If your HIV test is normal, no report will be made about it to the MIB, Inc. Other test results may be reported to the MIB, Inc., in a more specific manner. 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.

If your HIV test results are normal, no routine notification will be sent to you. If the HIV test results are other than normal, the Insurer will contact you. The Insurer may also contact you if there are other abnormal test results which, in the Insurer's opinion, are significant. The Insurer may ask you for the name of a physician or other health care provider to whom you may authorize disclosure and with whom you may wish to discuss the results.

Positive HIV antibody/antigen test results do not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others. For those reasons, a person with a positive test result may wish to consider further independent testing.

Positive HIV antibody or antigen test results or other significant blood abnormalities 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.

## Notification of Test Results

A positive test result will be disclosed to a physician or other individual you designate. If you do not designate anyone, a positive test result will be disclosed to you. However, because a trained person should deliver that information so that you can understand clearly what the test result means, please 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 or other designee for reporting a positive test result \_\_\_\_\_

Address \_\_\_\_\_

If you desire further information about AIDS, the meaning or HIV-related test results and the availability and location of HIV-related counseling services, you may call the New York State Department of Health on their toll-free number 1-800-541-AIDS.

## Consent

I have read and I understand this Notice and Consent for AIDS-related Testing. I voluntarily consent to the withdrawal of blood and/or other bodily fluids from me, the testing of that blood and/or other bodily fluids, and the disclosure of the test results as described herein.

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 \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_  
Signature of Proposed Insured or Parent/Guardian

\_\_\_\_\_  
Date Signed

## Insurance Department of the State of New York Definition of Replacement

---

In order to determine whether you are replacing or otherwise changing the status of existing life insurance policies or annuity contracts, and in order to receive the valuable information necessary to make a careful comparison if you are contemplating replacement, the agent or broker is required to ask you the following questions and explain any items that you do not understand.

As part of your purchase of a new life insurance policy or a new annuity contract, has existing coverage been, or is it likely to be:

- (1) Lapsed, surrendered, partially surrendered, forfeited, assigned to the insurer replacing the life insurance policy or annuity contract, or otherwise terminated?  
Yes \_\_\_\_\_ No \_\_\_\_\_
- (2) Changed or modified into paid-up insurance; continued as extended term insurance or under another form of nonforfeiture benefit; or otherwise reduced in value by the use of nonforfeiture benefits, dividend accumulations, dividend cash values or other cash values?  
Yes \_\_\_\_\_ No \_\_\_\_\_
- (3) Changed or modified so as to effect a reduction either in the amount of the existing life insurance or annuity benefit or in the period of time the existing life insurance or annuity benefit will continue in force?  
Yes \_\_\_\_\_ No \_\_\_\_\_
- (4) Reissued with a reduction in amount such that any cash values are released, including all transactions wherein an amount of dividend accumulations or paid-up additions is to be released on one or more of the existing policies?  
Yes \_\_\_\_\_ No \_\_\_\_\_
- (5) Assigned as collateral for a loan or made subject to borrowing or withdrawal of any portion of the loan value, including all transactions wherein any amount of dividend accumulations or paid-up additions is to be borrowed or withdrawn on one or more existing policies?  
Yes \_\_\_\_\_ No \_\_\_\_\_
- (6) Continued with a stoppage of premium payments or reduction in the amount of premium paid?  
Yes \_\_\_\_\_ No \_\_\_\_\_

If you have answered yes to any of the above questions, a replacement as defined by New York Insurance Department Regulation No. 60 has occurred or is likely to occur and your agent or broker is required to provide you with a completed Disclosure Statement and the **Important** Notice Regarding Replacement or Change of Life Insurance Policies or Annuity Contracts.

Date: \_\_\_\_\_ Signature of Applicant: \_\_\_\_\_

Date: \_\_\_\_\_ Signature of Applicant: \_\_\_\_\_

To the best of my knowledge, a replacement is involved in this transaction: Yes \_\_\_ No \_\_\_

Date: \_\_\_\_\_ Signature of Agent/Broker: \_\_\_\_\_

## Insurance Department of the State of New York Definition of Replacement

---

In order to determine whether you are replacing or otherwise changing the status of existing life insurance policies or annuity contracts, and in order to receive the valuable information necessary to make a careful comparison if you are contemplating replacement, the agent or broker is required to ask you the following questions and explain any items that you do not understand.

As part of your purchase of a new life insurance policy or a new annuity contract, has existing coverage been, or is it likely to be:

- (1) Lapsed, surrendered, partially surrendered, forfeited, assigned to the insurer replacing the life insurance policy or annuity contract, or otherwise terminated?  
Yes \_\_\_\_\_ No \_\_\_\_\_
- (2) Changed or modified into paid-up insurance; continued as extended term insurance or under another form of nonforfeiture benefit; or otherwise reduced in value by the use of nonforfeiture benefits, dividend accumulations, dividend cash values or other cash values?  
Yes \_\_\_\_\_ No \_\_\_\_\_
- (3) Changed or modified so as to effect a reduction either in the amount of the existing life insurance or annuity benefit or in the period of time the existing life insurance or annuity benefit will continue in force?  
Yes \_\_\_\_\_ No \_\_\_\_\_
- (4) Reissued with a reduction in amount such that any cash values are released, including all transactions wherein an amount of dividend accumulations or paid-up additions is to be released on one or more of the existing policies?  
Yes \_\_\_\_\_ No \_\_\_\_\_
- (5) Assigned as collateral for a loan or made subject to borrowing or withdrawal of any portion of the loan value, including all transactions wherein any amount of dividend accumulations or paid-up additions is to be borrowed or withdrawn on one or more existing policies?  
Yes \_\_\_\_\_ No \_\_\_\_\_
- (6) Continued with a stoppage of premium payments or reduction in the amount of premium paid?  
Yes \_\_\_\_\_ No \_\_\_\_\_

If you have answered yes to any of the above questions, a replacement as defined by New York Insurance Department Regulation No. 60 has occurred or is likely to occur and your agent or broker is required to provide you with a completed Disclosure Statement and the **Important** Notice Regarding Replacement or Change of Life Insurance Policies or Annuity Contracts.

Date: \_\_\_\_\_ Signature of Applicant: \_\_\_\_\_

Date: \_\_\_\_\_ Signature of Applicant: \_\_\_\_\_

To the best of my knowledge, a replacement is involved in this transaction: Yes \_\_\_ No \_\_\_

Date: \_\_\_\_\_ Signature of Agent/Broker: \_\_\_\_\_

## Insurance Department of the State of New York Definition of Replacement

---

In order to determine whether you are replacing or otherwise changing the status of existing life insurance policies or annuity contracts, and in order to receive the valuable information necessary to make a careful comparison if you are contemplating replacement, the agent or broker is required to ask you the following questions and explain any items that you do not understand.

As part of your purchase of a new life insurance policy or a new annuity contract, has existing coverage been, or is it likely to be:

- (1) Lapsed, surrendered, partially surrendered, forfeited, assigned to the insurer replacing the life insurance policy or annuity contract, or otherwise terminated?  
Yes \_\_\_\_\_ No \_\_\_\_\_
- (2) Changed or modified into paid-up insurance; continued as extended term insurance or under another form of nonforfeiture benefit; or otherwise reduced in value by the use of nonforfeiture benefits, dividend accumulations, dividend cash values or other cash values?  
Yes \_\_\_\_\_ No \_\_\_\_\_
- (3) Changed or modified so as to effect a reduction either in the amount of the existing life insurance or annuity benefit or in the period of time the existing life insurance or annuity benefit will continue in force?  
Yes \_\_\_\_\_ No \_\_\_\_\_
- (4) Reissued with a reduction in amount such that any cash values are released, including all transactions wherein an amount of dividend accumulations or paid-up additions is to be released on one or more of the existing policies?  
Yes \_\_\_\_\_ No \_\_\_\_\_
- (5) Assigned as collateral for a loan or made subject to borrowing or withdrawal of any portion of the loan value, including all transactions wherein any amount of dividend accumulations or paid-up additions is to be borrowed or withdrawn on one or more existing policies?  
Yes \_\_\_\_\_ No \_\_\_\_\_
- (6) Continued with a stoppage of premium payments or reduction in the amount of premium paid?  
Yes \_\_\_\_\_ No \_\_\_\_\_

If you have answered yes to any of the above questions, a replacement as defined by New York Insurance Department Regulation No. 60 has occurred or is likely to occur and your agent or broker is required to provide you with a completed Disclosure Statement and the **Important** Notice Regarding Replacement or Change of Life Insurance Policies or Annuity Contracts.

Date: \_\_\_\_\_ Signature of Applicant: \_\_\_\_\_

Date: \_\_\_\_\_ Signature of Applicant: \_\_\_\_\_

To the best of my knowledge, a replacement is involved in this transaction: Yes \_\_\_ No \_\_\_

Date: \_\_\_\_\_ Signature of Agent/Broker: \_\_\_\_\_

## Replacement Sales Material Checklist

**Required for all replacement sales.**

Applicant Name: \_\_\_\_\_

Agent Name: \_\_\_\_\_

Date: \_\_\_\_\_

For all replacement sales, please enter the form's series number in the "Form Number –" Column and place a check mark in the "Check Box" Column next to each piece of sales material which was presented to the applicant. Copies of these materials must also be left with the applicant at the time the application is completed. Electronically presented sales material must be provided to the policyowner in printed form not later than at the time of policy delivery.

Item	Description	Form Number – list series # if applicable	Check Box
Financial Overview	Brochure	YC1518	
Life Product Line	Brochure	YC1792	
Guaranteed Universal Life Express & Complete	POS Brochure	YC1989_	
Guaranteed Universal Life Express	Trifold Brochure	YC1988	
Guaranteed Universal Life Express	Highlight Sheet	YC1986	
Guaranteed Universal Life Complete	Highlight Sheet	YC1987	
Term Life	Highlight Sheet	YC1748	
Bonus Flexible Annuity	Highlight Sheet	YC1598	
Income Access Annuity	Highlight Sheet	YC1809	
Ultra Income Annuity	Highlight Sheet	YC1677	
<b>*All Other Materials Used:</b> Please list item, description and form number (if any).			

\*NOTE: Copies of materials listed in the "All Other Materials Used" section must be attached to this document.

## **Insurance Department of the State of New York Important Notice Regarding Replacement or Change of Life Insurance Policies or Annuity Contracts**

---

### **This Notice is for Your Benefit and Required by Regulation No. 60**

You are contemplating the purchase of a life insurance policy or annuity contract in connection with the surrender, lapse or change of existing life insurance policies or annuity contracts. The agent or broker is required to give you this notice together with a signed disclosure statement containing the summary result comparison for the new life insurance policy or annuity contract and any life insurance policies or annuity contracts to be changed that sets forth the facts of the transaction and its advantages and disadvantages to you. Your decision could be a good one – or a mistake – so make sure you understand the facts. You should:

1. Carefully study the Disclosure Statement, which includes a Summary Result Comparison, until you are sure you understand fully the effect of the transaction.
2. Ask the agent or broker from whom you bought your existing life insurance policies or annuity contracts to review with you the transaction and the Disclosure Statement. You may be able to effect the changes you desire more advantageously with them. Their customer service telephone number is contained in the Disclosure Statement.
3. Consult your tax advisor. There may be unfavorable tax implications associated with the contemplated changes to your existing life insurance policies or annuity contracts.

As a general rule, it is often not advantageous to drop or change existing coverage in favor of new coverage, whether issued by the same or a different insurance company. Some of the reasons it may be disadvantageous are:

1. The amount of the annual premium under an existing life insurance policy may be lower than that called for by a new life insurance policy having the same or similar benefits. Any replacement of the same type of policy will normally be at a higher premium rate based upon the insured's then attained age.
2. Since the initial costs of a life insurance policy are charged against the cash value increases in the earlier life insurance policy years, the replacement of an old life insurance policy by a new one results in the policyholder sustaining the burden of these costs twice. Annuity contracts usually contain provision for surrender charges, therefore, a replacement involving annuity contracts may result in the imposition of surrender charges.
3. The incontestable and suicide clauses begin anew in a new life insurance policy. This could result in a claim being denied under the new life insurance policy that would have been paid under the life insurance policy that was replaced.
4. An existing life insurance policy or annuity contract often has more favorable provisions than a new life insurance policy or annuity contract in areas such as loan interest rate, settlement options, disability benefits and tax treatment.
5. There may have been changes in your health since the purchase of the existing coverage.
6. The insurance company with which you have existing coverage can often make a desired change on terms that would be more favorable than if you replaced existing coverage with new coverage.

You have the right, within 60 days from the date of delivery of a new life insurance policy or annuity contract, to return it to the insurer and receive an unconditional full refund of all premiums or considerations paid on it, or in the case of a variable or market value adjustment policy or contract, a payment of the cash surrender benefits provided under the policy or contract, plus the amount of all fees and other charges deducted from gross considerations or imposed under the life insurance policy or annuity contract, and may have the right to reinstate or restore any life insurance policies and annuity contracts that were surrendered, lapsed or changed in the transaction to their former status to the extent possible and in accordance with the insurer's published reinstatement rules to the extent such rules are not inconsistent with the provisions of this part.

## **Insurance Department of the State of New York Important Notice Regarding Replacement or Change of Life Insurance Policies or Annuity Contracts**

---

### **This Notice is for Your Benefit and Required by Regulation No. 60**

You are contemplating the purchase of a life insurance policy or annuity contract in connection with the surrender, lapse or change of existing life insurance policies or annuity contracts. The agent or broker is required to give you this notice together with a signed disclosure statement containing the summary result comparison for the new life insurance policy or annuity contract and any life insurance policies or annuity contracts to be changed that sets forth the facts of the transaction and its advantages and disadvantages to you. Your decision could be a good one – or a mistake – so make sure you understand the facts. You should:

1. Carefully study the Disclosure Statement, which includes a Summary Result Comparison, until you are sure you understand fully the effect of the transaction.
2. Ask the agent or broker from whom you bought your existing life insurance policies or annuity contracts to review with you the transaction and the Disclosure Statement. You may be able to effect the changes you desire more advantageously with them. Their customer service telephone number is contained in the Disclosure Statement.
3. Consult your tax advisor. There may be unfavorable tax implications associated with the contemplated changes to your existing life insurance policies or annuity contracts.

As a general rule, it is often not advantageous to drop or change existing coverage in favor of new coverage, whether issued by the same or a different insurance company. Some of the reasons it may be disadvantageous are:

1. The amount of the annual premium under an existing life insurance policy may be lower than that called for by a new life insurance policy having the same or similar benefits. Any replacement of the same type of policy will normally be at a higher premium rate based upon the insured's then attained age.
2. Since the initial costs of a life insurance policy are charged against the cash value increases in the earlier life insurance policy years, the replacement of an old life insurance policy by a new one results in the policyholder sustaining the burden of these costs twice. Annuity contracts usually contain provision for surrender charges, therefore, a replacement involving annuity contracts may result in the imposition of surrender charges.
3. The incontestable and suicide clauses begin anew in a new life insurance policy. This could result in a claim being denied under the new life insurance policy that would have been paid under the life insurance policy that was replaced.
4. An existing life insurance policy or annuity contract often has more favorable provisions than a new life insurance policy or annuity contract in areas such as loan interest rate, settlement options, disability benefits and tax treatment.
5. There may have been changes in your health since the purchase of the existing coverage.
6. The insurance company with which you have existing coverage can often make a desired change on terms that would be more favorable than if you replaced existing coverage with new coverage.

You have the right, within 60 days from the date of delivery of a new life insurance policy or annuity contract, to return it to the insurer and receive an unconditional full refund of all premiums or considerations paid on it, or in the case of a variable or market value adjustment policy or contract, a payment of the cash surrender benefits provided under the policy or contract, plus the amount of all fees and other charges deducted from gross considerations or imposed under the life insurance policy or annuity contract, and may have the right to reinstate or restore any life insurance policies and annuity contracts that were surrendered, lapsed or changed in the transaction to their former status to the extent possible and in accordance with the insurer's published reinstatement rules to the extent such rules are not inconsistent with the provisions of this part.

## **Insurance Department of the State of New York Important Notice Regarding Replacement or Change of Life Insurance Policies or Annuity Contracts**

---

### **This Notice is for Your Benefit and Required by Regulation No. 60**

You are contemplating the purchase of a life insurance policy or annuity contract in connection with the surrender, lapse or change of existing life insurance policies or annuity contracts. The agent or broker is required to give you this notice together with a signed disclosure statement containing the summary result comparison for the new life insurance policy or annuity contract and any life insurance policies or annuity contracts to be changed that sets forth the facts of the transaction and its advantages and disadvantages to you. Your decision could be a good one – or a mistake – so make sure you understand the facts. You should:

1. Carefully study the Disclosure Statement, which includes a Summary Result Comparison, until you are sure you understand fully the effect of the transaction.
2. Ask the agent or broker from whom you bought your existing life insurance policies or annuity contracts to review with you the transaction and the Disclosure Statement. You may be able to effect the changes you desire more advantageously with them. Their customer service telephone number is contained in the Disclosure Statement.
3. Consult your tax advisor. There may be unfavorable tax implications associated with the contemplated changes to your existing life insurance policies or annuity contracts.

As a general rule, it is often not advantageous to drop or change existing coverage in favor of new coverage, whether issued by the same or a different insurance company. Some of the reasons it may be disadvantageous are:

1. The amount of the annual premium under an existing life insurance policy may be lower than that called for by a new life insurance policy having the same or similar benefits. Any replacement of the same type of policy will normally be at a higher premium rate based upon the insured's then attained age.
2. Since the initial costs of a life insurance policy are charged against the cash value increases in the earlier life insurance policy years, the replacement of an old life insurance policy by a new one results in the policyholder sustaining the burden of these costs twice. Annuity contracts usually contain provision for surrender charges, therefore, a replacement involving annuity contracts may result in the imposition of surrender charges.
3. The incontestable and suicide clauses begin anew in a new life insurance policy. This could result in a claim being denied under the new life insurance policy that would have been paid under the life insurance policy that was replaced.
4. An existing life insurance policy or annuity contract often has more favorable provisions than a new life insurance policy or annuity contract in areas such as loan interest rate, settlement options, disability benefits and tax treatment.
5. There may have been changes in your health since the purchase of the existing coverage.
6. The insurance company with which you have existing coverage can often make a desired change on terms that would be more favorable than if you replaced existing coverage with new coverage.

You have the right, within 60 days from the date of delivery of a new life insurance policy or annuity contract, to return it to the insurer and receive an unconditional full refund of all premiums or considerations paid on it, or in the case of a variable or market value adjustment policy or contract, a payment of the cash surrender benefits provided under the policy or contract, plus the amount of all fees and other charges deducted from gross considerations or imposed under the life insurance policy or annuity contract, and may have the right to reinstate or restore any life insurance policies and annuity contracts that were surrendered, lapsed or changed in the transaction to their former status to the extent possible and in accordance with the insurer's published reinstatement rules to the extent such rules are not inconsistent with the provisions of this part.

**IMPORTANT:** This right should not be viewed as reinstating or restoring your life insurance policy or annuity contract to the same condition as if it had never been replaced. There may be consequences in reinstating or restoring your life insurance policy or annuity contract, including but not limited to:

- The right to reinstate or restore your life insurance policy or annuity contract applies only to companies subject to New York insurance laws;
- Your life insurance policy or annuity contract is subject to your specific company’s reinstatement rules, which may vary from company to company. These rules may require payment of both premium and interest; however, you will not be subject to evidence of insurability, or a new contestable or suicide period;
- You may not receive the interest or investment performance during the period the life insurance policy or annuity contract was replaced; and
- There may be unfavorable Federal Income Tax consequences as a result of the reinstatement of your life insurance policy or annuity contract.

**IMPORTANT:** In the case of a variable or market value adjustment policy or contract, the value of the policy or contract may increase or decrease during the 60-day period depending on the performance of the underlying investments, which may affect the value of the refund you receive.

**I hereby acknowledge that I read the above “IMPORTANT NOTICE” and have received a copy of same.**

**DATE:** \_\_\_\_\_ **SIGNATURE OF APPLICANT:** \_\_\_\_\_

**DATE:** \_\_\_\_\_ **SIGNATURE OF APPLICANT:** \_\_\_\_\_

**IMPORTANT:** This right should not be viewed as reinstating or restoring your life insurance policy or annuity contract to the same condition as if it had never been replaced. There may be consequences in reinstating or restoring your life insurance policy or annuity contract, including but not limited to:

- The right to reinstate or restore your life insurance policy or annuity contract applies only to companies subject to New York insurance laws;
- Your life insurance policy or annuity contract is subject to your specific company’s reinstatement rules, which may vary from company to company. These rules may require payment of both premium and interest; however, you will not be subject to evidence of insurability, or a new contestable or suicide period;
- You may not receive the interest or investment performance during the period the life insurance policy or annuity contract was replaced; and
- There may be unfavorable Federal Income Tax consequences as a result of the reinstatement of your life insurance policy or annuity contract.

**IMPORTANT:** In the case of a variable or market value adjustment policy or contract, the value of the policy or contract may increase or decrease during the 60-day period depending on the performance of the underlying investments, which may affect the value of the refund you receive.

**I hereby acknowledge that I read the above “IMPORTANT NOTICE” and have received a copy of same.**

**DATE:** \_\_\_\_\_ **SIGNATURE OF APPLICANT:** \_\_\_\_\_

**DATE:** \_\_\_\_\_ **SIGNATURE OF APPLICANT:** \_\_\_\_\_

**IMPORTANT:** This right should not be viewed as reinstating or restoring your life insurance policy or annuity contract to the same condition as if it had never been replaced. There may be consequences in reinstating or restoring your life insurance policy or annuity contract, including but not limited to:

- The right to reinstate or restore your life insurance policy or annuity contract applies only to companies subject to New York insurance laws;
- Your life insurance policy or annuity contract is subject to your specific company’s reinstatement rules, which may vary from company to company. These rules may require payment of both premium and interest; however, you will not be subject to evidence of insurability, or a new contestable or suicide period;
- You may not receive the interest or investment performance during the period the life insurance policy or annuity contract was replaced; and
- There may be unfavorable Federal Income Tax consequences as a result of the reinstatement of your life insurance policy or annuity contract.

**IMPORTANT:** In the case of a variable or market value adjustment policy or contract, the value of the policy or contract may increase or decrease during the 60-day period depending on the performance of the underlying investments, which may affect the value of the refund you receive.

**I hereby acknowledge that I read the above “IMPORTANT NOTICE” and have received a copy of same.**

**DATE:** \_\_\_\_\_ **SIGNATURE OF APPLICANT:** \_\_\_\_\_

**DATE:** \_\_\_\_\_ **SIGNATURE OF APPLICANT:** \_\_\_\_\_

## NEW YORK Regulation 60 Replacement Submission Guidelines

Please submit this form with application

**ALL FORMS AND SUPPORTING DOCUMENTS THAT ARE  
CHECKED MUST BE SUBMITTED WITH THE APPLICATION.**

- Y5415\_0403 – Definition of Replacement – Submit with every application.**

If any question on Y5415 is answered “yes,” Submit the following:

- Y5416\_0706 – Authorization to Disclose Policy or Contract Information**
- Need a copy prepared for each existing insurer.
  - Include all policy / contract numbers on the form.
  - Include the date when the form was sent to the existing insurer in the space provided at the bottom of the form.
- Y5414\_0403 – Important Notice Regarding Replacement**
- Remember to submit both page 1 and 2 of the Y5414.
- Y5412\_0406 – Disclosure Statement (for Cash Value Policies)**
- Verify the form is signed and dated appropriately.
  - Verify that one of the boxes at the bottom of Page 1 is check marked.
  - Verify that one of the check boxes for sales materials / proposals is marked on the Disclosure Statement on Page 4.
- Y6541\_1205 – Disclosure Statement (for Term to Term Policies)**
- Verify the form is signed and dated appropriately.
  - Verify that one of the check boxes for sales materials / proposals is marked on the Disclosure Statement on Page 1.
  - Verify one of the boxes on page 1 is checked whether approximations or information from the other company was used.
- Y5413\_0704 – Disclosure Statement (for Annuity to Annuity Policies)**
- Verify the form is signed and dated appropriately.
  - Verify that one of the check boxes for sales materials / proposals is marked on the Disclosure Statement.
- A copy of the Other Company’s proposal or any documentation used in preparing the disclosure statements or approximations.**

If the Y5412, Y5413, or Y6541 indicates that a Proposal, Illustration, or Sales Materials were used, please submit the following:

- Y6626\_1005 – Sales Materials Checklist (indicate which sales materials were used).**
- A copy of the Sales proposal or illustration used in selling the new plan.**

**By submitting the required forms or supporting documentation with the application:**

- The Underwriting process will proceed without delays or files being closed within 10 days due to missing requirements
- Policies will be issued more quickly
- Notification to the existing insurer will be done within the acceptable timeframe

## Insurance Department of the State of New York Disclosure Statement

---

### For Use With Replacement of Term Policy to Term Policy (with no Cash Value) Only

**IMPORTANT - it may not be in your best interest to surrender, lapse, change or borrow from existing life insurance policies or annuity contracts in connection with the purchase of a new life insurance policy or annuity contract whether issued by the same or a different insurance company. You are urged to contact your existing agent or insurance company prior to completing the transaction. They can help you decide whether the replacement is in your best interest.**

FOR YOUR PROTECTION, the Insurance Department of the State of New York requires that you be given this Disclosure Statement, the **IMPORTANT** Notice Regarding Replacement or Change of Life Insurance Policies or Annuity Contracts and the Definition of Replacement, together with policy information on all proposed and existing coverage affected.

Name of Applicant(s) \_\_\_\_\_ Telephone Number \_\_\_\_\_

Address \_\_\_\_\_

Name of Agent \_\_\_\_\_ Telephone Number \_\_\_\_\_

Address \_\_\_\_\_

The Information On Existing Coverage on This Form Was Obtained From:

The following replaced company(ies): \_\_\_\_\_

Approximations if the following replaced company(ies) failed to provide information in the prescribed time:  
\_\_\_\_\_

### Agent's Statement:

1. The primary reason(s) for recommending the new life insurance policy is (are):  
\_\_\_\_\_

2. The existing life insurance policy cannot meet the applicant's objectives because:  
\_\_\_\_\_

3. The advantages of continuing the existing life insurance policy without changes are:  
\_\_\_\_\_

Remarks: \_\_\_\_\_

The sales material shown on the attached checklist were used in this sale.

The attached proposal was used in this sale.

No proposal or sales material were used in this sale.

If more than three existing life insurance policies are to be affected by this transaction or if more than one new life insurance policy is proposed, Section 1 of this Disclosure Statement must be completed for such additional life insurance policies. In addition, a composite comparison shall be completed of all existing life insurance to all proposed life insurance policies. The proposal, including sales material used in the sale of the proposed life insurance policy, must accompany the submission of this form to the insurer. Copies must be given to the applicant.

I have personally completed this form and certify that it is correct to the best of my knowledge and ability.

Date: \_\_\_\_\_ Signature of Agent \_\_\_\_\_

## Insurance Department of the State of New York Disclosure Statement

---

### For Use With Replacement of Term Policy to Term Policy (with no Cash Value) Only

**IMPORTANT** - it may not be in your best interest to surrender, lapse, change or borrow from existing life insurance policies or annuity contracts in connection with the purchase of a new life insurance policy or annuity contract whether issued by the same or a different insurance company. You are urged to contact your existing agent or insurance company prior to completing the transaction. They can help you decide whether the replacement is in your best interest.

FOR YOUR PROTECTION, the Insurance Department of the State of New York requires that you be given this Disclosure Statement, the **IMPORTANT** Notice Regarding Replacement or Change of Life Insurance Policies or Annuity Contracts and the Definition of Replacement, together with policy information on all proposed and existing coverage affected.

Name of Applicant(s) \_\_\_\_\_ Telephone Number \_\_\_\_\_

Address \_\_\_\_\_

Name of Agent \_\_\_\_\_ Telephone Number \_\_\_\_\_

Address \_\_\_\_\_

The Information On Existing Coverage on This Form Was Obtained From:

The following replaced company(ies): \_\_\_\_\_

Approximations if the following replaced company(ies) failed to provide information in the prescribed time:  
\_\_\_\_\_

### Agent's Statement:

1. The primary reason(s) for recommending the new life insurance policy is (are):  
\_\_\_\_\_

2. The existing life insurance policy cannot meet the applicant's objectives because:  
\_\_\_\_\_

3. The advantages of continuing the existing life insurance policy without changes are:  
\_\_\_\_\_

Remarks: \_\_\_\_\_

The sales material shown on the attached checklist were used in this sale.

The attached proposal was used in this sale.

No proposal or sales material were used in this sale.

If more than three existing life insurance policies are to be affected by this transaction or if more than one new life insurance policy is proposed, Section 1 of this Disclosure Statement must be completed for such additional life insurance policies. In addition, a composite comparison shall be completed of all existing life insurance to all proposed life insurance policies. The proposal, including sales material used in the sale of the proposed life insurance policy, must accompany the submission of this form to the insurer. Copies must be given to the applicant.

I have personally completed this form and certify that it is correct to the best of my knowledge and ability.

Date: \_\_\_\_\_ Signature of Agent \_\_\_\_\_

## Insurance Department of the State of New York Disclosure Statement

---

### For Use With Replacement of Term Policy to Term Policy (with no Cash Value) Only

**IMPORTANT** - it may not be in your best interest to surrender, lapse, change or borrow from existing life insurance policies or annuity contracts in connection with the purchase of a new life insurance policy or annuity contract whether issued by the same or a different insurance company. You are urged to contact your existing agent or insurance company prior to completing the transaction. They can help you decide whether the replacement is in your best interest.

FOR YOUR PROTECTION, the Insurance Department of the State of New York requires that you be given this Disclosure Statement, the **IMPORTANT** Notice Regarding Replacement or Change of Life Insurance Policies or Annuity Contracts and the Definition of Replacement, together with policy information on all proposed and existing coverage affected.

Name of Applicant(s) \_\_\_\_\_ Telephone Number \_\_\_\_\_

Address \_\_\_\_\_

Name of Agent \_\_\_\_\_ Telephone Number \_\_\_\_\_

Address \_\_\_\_\_

The Information On Existing Coverage on This Form Was Obtained From:

The following replaced company(ies): \_\_\_\_\_

Approximations if the following replaced company(ies) failed to provide information in the prescribed time:  
\_\_\_\_\_

### Agent's Statement:

1. The primary reason(s) for recommending the new life insurance policy is (are):  
\_\_\_\_\_

2. The existing life insurance policy cannot meet the applicant's objectives because:  
\_\_\_\_\_

3. The advantages of continuing the existing life insurance policy without changes are:  
\_\_\_\_\_

Remarks: \_\_\_\_\_

The sales material shown on the attached checklist were used in this sale.

The attached proposal was used in this sale.

No proposal or sales material were used in this sale.

If more than three existing life insurance policies are to be affected by this transaction or if more than one new life insurance policy is proposed, Section 1 of this Disclosure Statement must be completed for such additional life insurance policies. In addition, a composite comparison shall be completed of all existing life insurance to all proposed life insurance policies. The proposal, including sales material used in the sale of the proposed life insurance policy, must accompany the submission of this form to the insurer. Copies must be given to the applicant.

I have personally completed this form and certify that it is correct to the best of my knowledge and ability.

Date: \_\_\_\_\_ Signature of Agent \_\_\_\_\_

**DISCLOSURE STATEMENT CONTINUED:**

**1. Description of Transaction:**

Proposed Policy		Existing Policies Affected		
		(1) As of	(2) As of	(3) As of
	Company Name			
	Customer Service Phone No.			
	Policy Number	#	#	#
	Issue Date			
	Type of Term Insurance			
\$	Base Policy Face Amount	\$	\$	\$
	Rider			
	Rider			
	Rider			
	Rider			
	Rider			
\$	Total Annualized Premium	\$	\$	\$
	Contestable Expiry Date			
	Suicide Expiry Date			
<b>Existing coverage to be changed by:</b>				
		(1)	(2)	(3)
	Lapse	[ ]	[ ]	[ ]
	Amendment or Reissue	[ ]	[ ]	[ ]
	Other			
	Cash released by change	\$	\$	\$

Use of cash released: \_\_\_\_\_

**2. Summary Result Comparison:**

Proposed With Existing Coverage Changed		Existing Coverage Unchanged		
Guaranteed	Non-Guaranteed		Guaranteed	Non-Guaranteed
		<b>Annualized Premium</b>		
\$	\$	Current Year	\$	\$
\$	\$	5 Years Hence	\$	\$
\$	\$	10 Years Hence	\$	\$
		<b>Death Benefit</b>		
\$	\$	End of 1st Year	\$	\$
\$	\$	5 Years Hence	\$	\$
\$	\$	10 Years Hence	\$	\$
		<b>Dividends</b>		
\$	\$	End of 1st Year	\$	\$
\$	\$	5 Years Hence	\$	\$
\$	\$	10 Years Hence	\$	\$

I hereby acknowledge that I received and read the above Disclosure Statement before I signed the application for the new coverage.

Date: \_\_\_\_\_ Signature of Applicant: \_\_\_\_\_

Date: \_\_\_\_\_ Signature of Applicant: \_\_\_\_\_

**DISCLOSURE STATEMENT CONTINUED:**

**1. Description of Transaction:**

Proposed Policy		Existing Policies Affected		
		(1) As of	(2) As of	(3) As of
	Company Name			
	Customer Service Phone No.			
	Policy Number	#	#	#
	Issue Date			
	Type of Term Insurance			
\$	Base Policy Face Amount	\$	\$	\$
	Rider			
	Rider			
	Rider			
	Rider			
	Rider			
\$	Total Annualized Premium	\$	\$	\$
	Contestable Expiry Date			
	Suicide Expiry Date			
<b>Existing coverage to be changed by:</b>				
		(1)	(2)	(3)
	Lapse	[ ]	[ ]	[ ]
	Amendment or Reissue	[ ]	[ ]	[ ]
	Other			
	Cash released by change	\$	\$	\$

Use of cash released: \_\_\_\_\_

**2. Summary Result Comparison:**

Proposed With Existing Coverage Changed		Existing Coverage Unchanged		
Guaranteed	Non-Guaranteed		Guaranteed	Non-Guaranteed
		<b>Annualized Premium</b>		
\$	\$	Current Year	\$	\$
\$	\$	5 Years Hence	\$	\$
\$	\$	10 Years Hence	\$	\$
		<b>Death Benefit</b>		
\$	\$	End of 1st Year	\$	\$
\$	\$	5 Years Hence	\$	\$
\$	\$	10 Years Hence	\$	\$
		<b>Dividends</b>		
\$	\$	End of 1st Year	\$	\$
\$	\$	5 Years Hence	\$	\$
\$	\$	10 Years Hence	\$	\$

I hereby acknowledge that I received and read the above Disclosure Statement before I signed the application for the new coverage.

Date: \_\_\_\_\_ Signature of Applicant: \_\_\_\_\_

Date: \_\_\_\_\_ Signature of Applicant: \_\_\_\_\_

**DISCLOSURE STATEMENT CONTINUED:**

**1. Description of Transaction:**

Proposed Policy		Existing Policies Affected		
		(1) As of	(2) As of	(3) As of
	Company Name			
	Customer Service Phone No.			
	Policy Number	#	#	#
	Issue Date			
	Type of Term Insurance			
\$	Base Policy Face Amount	\$	\$	\$
	Rider			
	Rider			
	Rider			
	Rider			
	Rider			
\$	Total Annualized Premium	\$	\$	\$
	Contestable Expiry Date			
	Suicide Expiry Date			
<b>Existing coverage to be changed by:</b>				
		(1)	(2)	(3)
	Lapse	[ ]	[ ]	[ ]
	Amendment or Reissue	[ ]	[ ]	[ ]
	Other			
	Cash released by change	\$	\$	\$

Use of cash released: \_\_\_\_\_

**2. Summary Result Comparison:**

Proposed With Existing Coverage Changed		Existing Coverage Unchanged		
Guaranteed	Non-Guaranteed		Guaranteed	Non-Guaranteed
		<b>Annualized Premium</b>		
\$	\$	Current Year	\$	\$
\$	\$	5 Years Hence	\$	\$
\$	\$	10 Years Hence	\$	\$
		<b>Death Benefit</b>		
\$	\$	End of 1st Year	\$	\$
\$	\$	5 Years Hence	\$	\$
\$	\$	10 Years Hence	\$	\$
		<b>Dividends</b>		
\$	\$	End of 1st Year	\$	\$
\$	\$	5 Years Hence	\$	\$
\$	\$	10 Years Hence	\$	\$

I hereby acknowledge that I received and read the above Disclosure Statement before I signed the application for the new coverage.

Date: \_\_\_\_\_ Signature of Applicant: \_\_\_\_\_

Date: \_\_\_\_\_ Signature of Applicant: \_\_\_\_\_

## Authorization to Disclose Policy or Contract Information

To: \_\_\_\_\_ Policyowner: \_\_\_\_\_  
\_\_\_\_\_  
Your Policy(s): \_\_\_\_\_  
\_\_\_\_\_  
or Contract(s): \_\_\_\_\_

Attention\*: \_\_\_\_\_  
\_\_\_\_\_

(\*You must list the appropriate contact person provided by each licensed insurer or society and posted on the following website: [www.ins.state.ny.us/reg60/reg60contacts.htm](http://www.ins.state.ny.us/reg60/reg60contacts.htm). Please note: some companies have provided more than one contact, so it is important you use the appropriate contact for the type of policy or contract that is proposed to be replaced.)

We are requesting your assistance in accordance with New York State Insurance Department Regulation No. 60 11NYCRR 51 in providing the required information for completing the enclosed New York State Disclosure Statement. We would like to thank you in advance for your cooperation.

Please forward the requested information directly to our representative at the address shown below:

Attention:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

This authorization is for the purpose shown above, and valid until revoked in writing by the policyowner. A photocopy of this authorization is as valid as the original.

\_\_\_\_\_  
Policyowner's Signature

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
ZIP Code

\_\_\_\_\_  
Date

**Date this form was sent to existing insurer:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
month day year