Issue ages 0 - 44

EXPRESS ISSUE COVER SHEET

(Please submit completed sheet with <u>every</u> application)

Agent Information		
Agent ID	Agent Name (Print)	Agent Phone ( )
Agent Email		Agent Fax ( )
Case Manager Name	Case Manager Phone ( )	
Case Manager Email Address		
Proposed Insured Information		
Insured's name (Print)		Last 4 digits of Insured's social security #

Required Disclosures with Application:

❑ HIPAA Authorization Form

Other Disclosures (if applicable):

❑ Accelerated Death Benefit Disclosure Form ❑ Replacement Form(s)

Submitting Applications: ***(Faxing is the preferred method)***

If faxing, fax to **1-866-834-0437** and enter date faxed_____ . **Do Not** mail originals if faxing.

If mailing the application and/or check for initial premium please send with cover sheet to:

4333 Edgewood Road NE, Cedar Rapids, IA 52499

If a case manager is listed, please follow your General Agency's submission process with sending the signed application packet.

Monumental Life Insurance Company
Home Office: 4333 Edgewood Road NE, Cedar Rapids, Iowa 52499

LIFE APPLICATION

Part A1 – Producer

Name	Producer ID	Split %	Profile
Name	Producer ID	Split %	Profile
Name	Producer ID	Split %	Profile

Part A2 – Plan & Rider Information

Plan	Face Amount	Total Premium
	$	$

Rate Class applied for:

❑ Preferred Non-Tobacco ❑ Preferred Tobacco ❑ Preferred Juvenile
❑ Standard Non-Tobacco ❑ Standard Tobacco ❑ Standard Juvenile
❑ Graded

Accidental Death Benefit Rider? (If yes, Accidental Death Benefit Rider will equal base amount) ❑ Yes ❑ No

Child / Grandchild Rider? $_____ (Add Child / Grandchild information to the Supplemental Information to the Application for Life Insurance) ❑ Yes ❑ No

Part A3 – Proposed Insured

Name (First, M.I., Last, Suffix)	Address, City, State, Zip Code (cannot be a P.O. Box)

D.O.B. (MM/DD/YYYY)	U.S. State or Country of Birth	Are you a citizen of the United States? ❑ Yes ❑ No If "NO," what Country? _____ If "NO," are you a legal U.S. Resident? ❑ Yes ❑ No If "YES," VISA type and number _____ If "NO," you are not eligible for coverage.

Gender	Height	Weight	SSN

Driver's License Number State	Phone Number for Interview	Best time to call	Occupation
	( )	a.m. p.m.	

Part A4 – Owner (If Other Than Proposed Insured)

Name (First, M.I., Last, Suffix)	Address, City, State, Zip Code (cannot be a P.O. Box)

Phone Number	D.O.B. (MM/DD/YYYY)	Gender	Are you a citizen of the United States? ❑ Yes ❑ No If "NO," what Country? _____ If "NO," are you a legal U.S. Resident? ❑ Yes ❑ No If "YES," VISA type and number _____ If "NO," you are not eligible for coverage.
( )			

SSN	Relationship to Insured

Part A5 – Beneficiary (Please use the Supplemental Information form if additional room is needed)

Primary Name (First, M.I., Last, Suffix)	D.O.B. (MM/DD/YYYY)	SSN	Percentage	Relationship to Insured
Contingent Name (First, M.I., Last, Suffix)	D.O.B. (MM/DD/YYYY)	SSN	Percentage	Relationship to Insured

Part A6 – Existing Insurance

Does the proposed Insured have any existing life insurance or annuity contracts with the company or any other company? ❑ Yes ❑ No

Is this insurance intended to replace or change any life insurance or annuity contract in force with the company or any other company? ❑ Yes ❑ No

If yes, submit the state required forms and please provide company name and policy number. _____

Is this to be a 1035 exchange? ❑ Yes ❑ No

Last Name and Last 4 Digits of SSN: _____

Part B1 – Initial Premium Payment Method

❑ By check: Available with all methods, but must be used if subsequent payments are quarterly, semi-annual or annual.
Is the check for initial premium payment on the same account as monthly EFT payments? ❑ Yes ❑ No

❑ By payroll deduction or allotment.

❑ Draft initial premium upon receipt from the account below.

❑ Draft initial premium at future date from the account below. Please indicate the month and day (mm/dd): _____/_____
Month **Day (1st thru 28th only)**

If you select an initial premium draft date in the future, it may not be greater than 30 days after the application date and the recurring draft date below must be the same day of the month as the initial premium draft date. If you select an initial premium draft date in the future, you will not have potential coverage until that date under the Conditional Receipt.

Part B2 – Premium Payment Authorization For Electronic Funds Transfer (EFT): Payor's Authorization To Insurance Company

As a convenience to myself, I hereby authorize Monumental Life Insurance Company to draft premium payments from my financial institution account.

It is understood that credit for payment is conditioned upon the draft being honored when presented for payment. Furthermore, this authorization may be terminated (a) at the option of the Company if any draft is not honored when presented for payment; or (b) by the Company, financial institution or the undersigned upon 30 days written notice to the parties hereto.

If this authorization is terminated, the amount due on the policy involved will be billed on a quarterly basis.

❑ Checking ❑ Savings Financial Institution Name: _____ City/State: _____

Account #: | | | | | | | | | | | | | | | | | | |

Routing #: | | | | | | | | | |

No debit card numbers please

Recurring Draft Date (1st-28th):_____ If no recurring draft date is selected, the draft date will be the same day of the month as the Policy Date.

Payor Signature (if other than proposed Insured or Owner)_____ Date:_____

Part B3 – Recurring Payment Method

EFT

❑ Monthly ❑ Quarterly ❑ Semi-Annual ❑ Annual

Payroll Deduction

Special Frequency _____

❑ List Bill ❑ Civil Service Allotment ❑ Military Allotment

Requested Effective Date _____

Automatic Premium Loan provision (if available)? ❑ Yes ❑ No

Part B4 – Payor Information

The Payor is the ❑ Proposed Insured ❑ Owner ❑ Other (If Other, please provide the following information:)

Name (First, M.I., Last, Suffix)	Address, City, State, Zip Code (cannot be a P.O. Box)	
SSN	Relationship to Insured	Are you a citizen of the U.S.? ❑ Yes ❑ No If not, what country?

Part B5 – Secondary Addressee

Name (First, M.I., Last, Suffix)	Address, City, State, Zip Code (cannot be a P.O. Box)

Last Name and Last 4 Digits of SSN: _____

Part C1

Within the last 12 months has the proposed Insured used tobacco products in any form? ❑ Yes ❑ No

If a policy cannot be issued as applied for, would you accept a rated policy if available? ❑ Yes ❑ No

If 'yes,' adjust face amount to premium? ❑ Yes ❑ No

Part C2 – If Any Question In This Section Is Answered "Yes", The Proposed Insured Is Not Eligible For Any Coverage.

1) Is the proposed insured currently:
   a. Hospitalized or bedridden? ❑ Yes ❑ No
   b. On parole or probation? ❑ Yes ❑ No

2) Within the **past 2 years** has the proposed insured:
   a. Had, been diagnosed with, been treated for or advised by a member of the medical profession to receive treatment for cancer (other than Basal Cell carcinoma)? ❑ Yes ❑ No
   b. Had a stroke (CVA), transient ischemic attack (TIA), heart attack, cardiovascular surgery including bypass, angioplasty, stent implant or pacemaker implant; or had, been diagnosed with, been treated for or advised by a member of the medical profession to receive treatment for congestive heart failure? ❑ Yes ❑ No
   c. Used a wheelchair or electric scooter? If answering yes to this question and the reason(s) for the wheelchair or scooter use was/is for a reason that is expected to resolve, please provide details on the Supplemental Information to the Application for Life Insurance. ❑ Yes ❑ No
   d. Used oxygen to assist in breathing (including oxygen use for Sleep Apnea)? ❑ Yes ❑ No
   e. Used illegal drugs (other than marijuana); or been diagnosed with, been treated for or advised by a member of the medical profession to receive treatment for alcoholism, alcohol use/abuse or drug use/abuse (including prescription drugs)? ❑ Yes ❑ No
   f. Undergone testing by a medical professional for which the results have not been received; or been advised by a member of the medical profession to have any surgical operation, diagnostic testing (other than for routine screening purposes), treatment, hospitalization or other procedure that has not been completed? ❑ Yes ❑ No
   g. Resided in a nursing home, assisted or long term care facility; or received hospice or home health care? ❑ Yes ❑ No
   h. Been diagnosed with Crohn's disease, Multiple Sclerosis or Parkinson's disease? ❑ Yes ❑ No
   i. Had, been diagnosed with, been treated for or advised by a member of the medical profession to receive treatment for Hepatitis C, Tuberculosis (TB) or Lupus? ❑ Yes ❑ No
   j. Been incarcerated; or been convicted of a felony or misdemeanor; or been convicted of 2 or more DUI's/DWI's or 3 or more moving violations? ❑ Yes ❑ No

3) To the best of your knowledge and belief has the proposed insured **ever**:
   a. Had, been diagnosed with, been treated for or been advised by a member of the medical profession to receive treatment for Alzheimer's, dementia, memory loss, any cognitive disorder, organic brain disease, mental incapacity, Lou Gehrig's (ALS), Downs Syndrome, Huntington's, Spina Bifida not surgically corrected, Sickle Cell anemia, Cystic Fibrosis or Cerebral Palsy? ❑ Yes ❑ No
   b. Been diagnosed by a medical professional as having a terminal medical condition that is expected to result in death within the next 18 months? ❑ Yes ❑ No
   c. Tested positive for the antibodies to the AIDS (HIV) virus or been medically diagnosed with or received treatment for HIV, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? ❑ Yes ❑ No
   d. Been in a diabetic coma or had or been advised by a member of the medical profession to have an amputation due to disease or disorder? ❑ Yes ❑ No
   e. Received or been advised by a member of the medical profession to receive an implanted defibrillator or an organ transplant (other than corneal)? ❑ Yes ❑ No

Part C3 - For All Questions Answered "Yes" In This Section Give Details On The Supplemental Information To The Application.

1) Does the proposed Insured take any prescription medication? ❑ Yes ❑ No

2) Within the last **10 years**, has the proposed Insured had or received medical treatment for any of the following conditions:

Any disease or disorder of the blood, heart or circulatory system such as heart attack, stroke or transient ischemic attack (TIA) ❑ Yes ❑ No

Respiratory Disease ❑ Yes ❑ No

Kidney/Liver/Digestive Disorder ❑ Yes ❑ No

Epilepsy/Seizures ❑ Yes ❑ No

Mental/Nervous Disorder ❑ Yes ❑ No

Cancer/Leukemia ❑ Yes ❑ No

High Blood Pressure ❑ Yes ❑ No

If yes, last reading: _____/_____ Medication: _____

Diabetes ❑ Yes ❑ No

If yes, age at onset: _____ Medication: _____ Avg. blood sugar reading: _____

3) Within the last **5 years**, has the proposed Insured:

a) Had one or more DUI(s), been charged with, or convicted of a felony OR been on probation/parole? ❑ Yes ❑ No

b) Illegally used any drug or controlled substance or been treated/counseled for drug or alcohol abuse? ❑ Yes ❑ No

Last Name and Last 4 Digits of SSN: _____

AGREEMENT / AUTHORIZATION

ACKNOWLEDGMENT OF PROPOSED OWNER AND INSURED(S) –Each of the undersigned hereby certifies and represents as follows: The statements and answers given on this application are true and correct to the best of my knowledge and belief. I acknowledge and agree (A) that this application and any amendments shall be the basis for any insurance issued; (B) that the agent does not have the authority to waive any question on this application, to decide if insurance will be issued, or to modify any term or provision of any insurance which may be issued based on this application, only a writing signed by an officer of the Company can change the terms of this application or the terms of any insurance issued by the Company; (C) except as provided in the Conditional Receipt, if issued with the same proposed Insured(s) as on this application, no policy applied for shall take effect until after all of the following conditions have been met: 1) the minimum initial premium must be received by the Company; 2) the proposed Owner must have personally received and accepted the policy during the lifetime of all proposed Insured(s) and while all proposed Insured(s) are in good health; and 3) on the date of the later of either 1) or 2) above, all of the statements and answers given in this application must be true and complete, and the insurance will not take effect if the facts have changed. Unless otherwise stated the proposed insured is the premium payor and Owner of the policy applied for.

I have received the MIB Disclosure Notification, Notice to Persons Applying For Insurance and Conditional Receipt.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, MIB, Inc. ("MIB") or other organization, institution or person, that has any records or knowledge of me or my health, to give to the Company, or its reinsurers, any such information. I authorize the Company, or its reinsurers, to make a brief report of my personal/protected health information to MIB. A photographic copy of this authorization shall be as valid as the original.

This authorization will be valid for 30 months, but I understand that I may revoke it at any time by giving written notice to the Company at the above address. I understand that there are limitations on my right to revoke this authorization. Any action taken in reliance on this authorization will be valid if such action has been taken prior to receipt of notice of revocation. If this authorization is used to collect information in connection with a claim for benefits, it will be valid for the duration of the claim. If the law of my state so provides, my authorization may not be revoked during a contestable investigation. I also understand that my revocation of this authorization will not result in the deletion of codes in the MIB database if such codes are reported by the Company (or the Company becomes obligated to report such codes to MIB) while this authorization is in force.

If I have qualified for the graded death benefit policy, I understand that I may qualify for a full death benefit policy, which provides full benefits from inception from another life insurance company.

I understand that any omissions or misstatements in this application could cause an otherwise valid claim to be denied under any insurance issued from this application.

FRAUD WARNING: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Signed Date _____ Signed at City _____ State _____

_____
Proposed Insured Signature
(Insured age 15 and over must sign)

_____
Signature of Parent or Legal Guardian
(if Proposed Insured is Under 18 years of age)

_____
Owner Signature (If Owner other than Insured)

_____
Producer Signature

If the EFT premium payment method is chosen, please tape a voided check in this box.

NOTICE TO PERSONS APPLYING FOR INSURANCE

As part of the Company's procedure for processing your insurance application, an investigative consumer report may be prepared whereby information is obtained through personal interviews made by a consumer reporting agency with you, physicians, hospitals, clinics, and other medically-related facilities, who may be contacted using your signed authorization, to obtain details of your past medical treatment.

You have the right to be interviewed as part of any investigative consumer report that may be prepared. If you desire to be interviewed, you must indicate this to the Company. You also have the right to request access to, and correction and amendment of, any personal information collected. Additionally, you are entitled to receive a description of procedures which allow access to and correction of personal information which may be obtained, the nature and scope of the investigation requested, and a description of the circumstances under which personal information may be disclosed without prior authorization. Your written request should be addressed to the Company.

MONUMENTAL LIFE INSURANCE COMPANY
Home Office: 4333 Edgewood Road NE, Cedar Rapids, IA 52499

MIB DISCLOSURE NOTIFICATION

Information regarding your insurability will be treated as confidential. Monumental Life Insurance Company or its reinsurers may, however, make a brief report thereon to MIB, Inc., 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 office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734.

Monumental 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. Information for consumers about MIB may be obtained on its website at www.mib.com.

01/13

CONDITIONAL RECEIPT

No coverage will be effective prior to delivery of the policy applied for unless and until all the following conditions are met:

Conditions of Coverage

1. On the Effective Date indicated below, the state of health and all factors affecting insurability of each person proposed for coverage must be stated in the application required by the Company and the application must not contain a material misrepresentation;
2. An amount equal to the first full premium required must be paid and any check, Authorization for Electronic Funds Transfer (EFT), payroll deduction or allotment given in payment must be honored when first presented; and,
3. Each person proposed for coverage is on the Effective Date insurable and acceptable to the Company under its rules, limits and underwriting standards for the plan and for the amount applied for, without modification of plan, premium rates or amount of coverage.

Effective Date

If all of the above conditions are met, insurance in the amount applied for or $50,000, whichever is lower, will become effective on the date the application is completed. If any of the above conditions are not met, or if the proposed Insured dies prior to a future date selected for draft of the initial premium or if the proposed Insured dies by suicide, this receipt provides no coverage, and the liability of the Company is the return of the amount remitted with this receipt. Coverage which takes effect through this receipt will terminate at the EARLIEST of the following: (a) the effective date of the policy; (b) thirty (30) days after the date of the application; (c) three (3) days after the date the Company sends written notice that the receipt is terminated.

Agent Instructions: Please leave this page with the Proposed Insured/Owner

Supplemental Information to the Application for Life Insurance

Proposed Primary Insured Name:______________________ Social Security Number: ______________

Additional Information

Question Number	Name of Proposed Insured	Details to General and Medical Questions (Diagnosis, Dates, Durations, and Medications, Dosages, Frequency) Medical Facilities & Physicians Names, Addresses, Phone Numbers

Additional Information

Child / Grandchild Rider Information

Name (First, M.I., Last, Suffix)	D.O.B. (MM/DD/YYYY)	Gender	Relationship to Insured	SSN
Name (First, M.I., Last, Suffix)	D.O.B. (MM/DD/YYYY)	Gender	Relationship to Insured	SSN
Name (First, M.I., Last, Suffix)	D.O.B. (MM/DD/YYYY)	Gender	Relationship to Insured	SSN
Name (First, M.I., Last, Suffix)	D.O.B. (MM/DD/YYYY)	Gender	Relationship to Insured	SSN
Name (First, M.I., Last, Suffix)	D.O.B. (MM/DD/YYYY)	Gender	Relationship to Insured	SSN
Name (First, M.I., Last, Suffix)	D.O.B. (MM/DD/YYYY)	Gender	Relationship to Insured	SSN
Name (First, M.I., Last, Suffix)	D.O.B. (MM/DD/YYYY)	Gender	Relationship to Insured	SSN
Name (First, M.I., Last, Suffix)	D.O.B. (MM/DD/YYYY)	Gender	Relationship to Insured	SSN
Name (First, M.I., Last, Suffix)	D.O.B. (MM/DD/YYYY)	Gender	Relationship to Insured	SSN

Contingent Owner

Name (First, M.I., Last, Suffix)	SSN	Gender	Relationship to Insured	Phone Number ( )	D.O.B. (MM/DD/YYYY)

Address, City, State, Zip Code (If different from Insured) (cannot be a P.O. Box)	Are you a citizen of the U.S.? ❑ Yes ❑ No If not, what country?

Signed Date______________ Signed at City______________ State ______________

____
Proposed Insured Signature
(Insured age 15 and over must sign)

____
Signature of Parent or Legal Guardian
(if Proposed Insured is Under 18 years of age)

____
Owner Signature (If Owner other than Insured)

____
Producer Signature

Last Name and Last 4 Digits of SSN: _____

Agent's Report

Existing insurance? ❑ Yes ❑ No

Is the policy applied for in this application intended to replace any insurance or annuity now in force? ❑ Yes ❑ No

I represent that:

1) I have personally seen the proposed Insured. ❑ Yes ❑ No

2) I have truly and accurately recorded on this application the information as supplied by the Owner and the proposed Insured. ❑ Yes ❑ No

Is the person proposed for insurance related to you? ❑ Yes ❑ No Relationship _____

_____

Producer Signature

Monumental Life Insurance Company
Stonebridge Life Insurance Company
Transamerica Life Insurance Company
Western Reserve Life Assurance Co. of Ohio
4333 Edgewood Road NE, Cedar Rapids, IA 52499

HIPAA Authorization for Release of Health-Related Information

This authorization complies with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

Name of Primary Proposed Insured/Patient	Date of birth	Last four digits of SSN
Name of Secondary Proposed Insured/Patient	Date of birth	Last four digits of SSN
Name(s) of Unemancipated Minors	Date(s) of birth	Last four digits of SSN(s)

I hereby authorize the use or disclosure of health information, as described below, about me or my above-named unemancipated minor children and revoke any previous restrictions concerning access to such information:

1. **Person(s) or group(s) of persons authorized to use and/or disclose the information:** Any health plan, physician, health care professional, hospital, clinic, long-term care facility, medical or medically-related facility, laboratory, pharmacy, pharmacy benefit manager, insurance company [including the Companies noted above (the "Companies")], insurance support organization such as MIB Group, Inc., or other medical practitioner or health care provider that has provided payment, treatment or services to me or on my behalf or to or on behalf of my unemancipated minor children.
2. **Person(s) or group(s) of persons authorized to collect or otherwise receive and use the information:** The Companies, their affiliates and reinsurers, and their agents, employees, or other representatives. I further authorize the Companies and their affiliates and reinsurers to redisclose the information to MIB Group, Inc., which operates an information exchange on behalf of life and health insurance companies.
3. **Description of the information that may be used or disclosed:** This authorization specifically includes the release of all information related to my health or that of my unemancipated minor children and my or my unemancipated minor children's insurance policies and claims, including, but not limited to, information on the diagnoses, prognoses, treatments, prescription drug information, and information regarding diagnosis, prognosis and treatment of mental illness, communicable or infectious conditions, such as HIV or AIDS, and use of alcohol, drugs and tobacco. **This Authorization excludes psychotherapy notes that are separated from the rest of my medical records.**
4. **The information will be used or disclosed only for the following purpose(s):** For the purpose of underwriting my insurance application with the Companies, to support the operations of our business, and, if a policy is issued, for evaluating contestability and eligibility for benefits, for the continuation or replacement of the policy, for reinstatement of the policy or to contest a claim under the policy.

STATEMENTS OF UNDERSTANDING & ACKNOWLEDGMENT:

- I understand that health information about me provided to the Companies may be protected by state and federal privacy regulations including the HIPAA Privacy Rule and that the Companies will only use and disclose such information as permitted by applicable regulations and as described in their privacy notices. However, I also understand that any information disclosed under this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal regulations such as the HIPAA Privacy Rule governing privacy and confidentiality of health information.
- I understand that if I refuse to sign this authorization to release my health information or that of my unemancipated minor children, the Companies may not be able to process my application, or if coverage is issued may not be able to make any benefit payments.
- I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on it, or to the extent that other law provides the Companies with the right to contest a claim under the policy or the policy itself, by sending a written revocation to the Companies' Privacy Official at the address at the top of this form. I also understand that the revocation of this authorization will not affect uses and disclosures of my health information for purposes of treatment, payment and business operations, including agent commission statements.
- This authorization shall remain in force for 24 months (12 months in Kansas) from the date signed, regardless of my condition and whether living or deceased.
- I acknowledge I have received a copy of this authorization.

Signature of Primary Proposed Insured/Patient or Personal Representative	Date
Signature of Secondary Proposed Insured/Patient or Personal Representative	Date

If signed by an individual's personal representative or the parent or guardian of an unemancipated minor, describe authority to sign on behalf of the individual:

❑ Parent ❑ Legal guardian ❑ Power of Attorney ❑ Other (please describe): _____

(NOTE: If more than one individual is named above, please specify the individual(s) to which the personal representative applies.)

Policy or contract number (if known): _____

A copy of this authorization will be considered as valid as the original.

Monumental Life Insurance Company
Stonebridge Life Insurance Company
Transamerica Life Insurance Company
Western Reserve Life Assurance Co. of Ohio
4333 Edgewood Road NE, Cedar Rapids, IA 52499

HIPAA Authorization for Release of Health-Related Information

This authorization complies with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

Name of Primary Proposed Insured/Patient	Date of birth	Last four digits of SSN
Name of Secondary Proposed Insured/Patient	Date of birth	Last four digits of SSN
Name(s) of Unemancipated Minors	Date(s) of birth	Last four digits of SSN(s)

I hereby authorize the use or disclosure of health information, as described below, about me or my above-named unemancipated minor children and revoke any previous restrictions concerning access to such information:

1. **Person(s) or group(s) of persons authorized to use and/or disclose the information:** Any health plan, physician, health care professional, hospital, clinic, long-term care facility, medical or medically-related facility, laboratory, pharmacy, pharmacy benefit manager, insurance company [including the Companies noted above (the "Companies")], insurance support organization such as MIB Group, Inc., or other medical practitioner or health care provider that has provided payment, treatment or services to me or on my behalf or to or on behalf of my unemancipated minor children.
2. **Person(s) or group(s) of persons authorized to collect or otherwise receive and use the information:** The Companies, their affiliates and reinsurers, and their agents, employees, or other representatives. I further authorize the Companies and their affiliates and reinsurers to redisclose the information to MIB Group, Inc., which operates an information exchange on behalf of life and health insurance companies.
3. **Description of the information that may be used or disclosed:** This authorization specifically includes the release of all information related to my health or that of my unemancipated minor children and my or my unemancipated minor children's insurance policies and claims, including, but not limited to, information on the diagnoses, prognoses, treatments, prescription drug information, and information regarding diagnosis, prognosis and treatment of mental illness, communicable or infectious conditions, such as HIV or AIDS, and use of alcohol, drugs and tobacco. **This Authorization excludes psychotherapy notes that are separated from the rest of my medical records.**
4. **The information will be used or disclosed only for the following purpose(s):** For the purpose of underwriting my insurance application with the Companies, to support the operations of our business, and, if a policy is issued, for evaluating contestability and eligibility for benefits, for the continuation or replacement of the policy, for reinstatement of the policy or to contest a claim under the policy.

STATEMENTS OF UNDERSTANDING & ACKNOWLEDGMENT:

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- I understand that if I refuse to sign this authorization to release my health information or that of my unemancipated minor children, the Companies may not be able to process my application, or if coverage is issued may not be able to make any benefit payments.
- I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on it, or to the extent that other law provides the Companies with the right to contest a claim under the policy or the policy itself, by sending a written revocation to the Companies' Privacy Official at the address at the top of this form. I also understand that the revocation of this authorization will not affect uses and disclosures of my health information for purposes of treatment, payment and business operations, including agent commission statements.
- This authorization shall remain in force for 24 months (12 months in Kansas) from the date signed, regardless of my condition and whether living or deceased.
- I acknowledge I have received a copy of this authorization.

_____ _____
Signature of Primary Proposed Insured/Patient or Personal Representative — Date

_____ _____
Signature of Secondary Proposed Insured/Patient or Personal Representative — Date

If signed by an individual's personal representative or the parent or guardian of an unemancipated minor, describe authority to sign on behalf of the individual:

❑ Parent ❑ Legal guardian ❑ Power of Attorney ❑ Other (please describe): _____

(NOTE: If more than one individual is named above, please specify the individual(s) to which the personal representative applies.)

Policy or contract number (if known): _____

A copy of this authorization will be considered as valid as the original.

☐ **Monumental Life Insurance Company** ☐ **Transamerica Life Insurance Company**

☐ **Stonebridge Life Insurance Company** ☐ **Western Reserve Life Assurance Co. of Ohio**

Administrative Office located at: 4333 Edgewood Road N.E., Cedar Rapids, Iowa 52499. Telephone: (319) 355-8511

IMPORTANT NOTICE:
REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy, to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interest. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1. **Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? ___ YES ___ NO**

2. **Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ___ YES ___NO**

If you answered "yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy number or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

INSURER NAME	CONTRACT OR POLICY #	INSURED	REPLACED (R) OR FINANCING (F)
1.			
2.			
3.			

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. [If you request one, an in-force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer.] Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because _____.
I certify that the responses herein are, to the best of my knowledge, accurate:

_____ _____
Applicant's Signature and Printed Name Date

_____ _____
Producer's Signature and Printed Name Date

_____ I do not want this notice read aloud to me. (Applicants must initial only if they do not want the notice read aloud.)

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

PREMIUMS:

Are they affordable?
Could they change?
You're older – are premiums higher for the proposed new policy?
How long will you have to pay premiums on the new policy? On the old policy?

POLICY VALUES:

New policies usually take longer to build cash values and to pay dividends.
Acquisition costs for the old policy may have been paid; you will incur costs for the new one.
What surrender charges do the policies have?
What expenses and sales charges will you pay on the new policy?
Does the new policy provide more insurance coverage?

INSURABILITY:

If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.
You may need a medical exam for a new policy.
[Claims on most new policies for up to the first two years can be denied based on inaccurate statements.
Suicide limitations may begin anew on the new coverage.]

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:

How are premiums for both policies being paid?
How will the premiums on your existing policy be affected?
Will a loan be deducted from death benefits?
What values from the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:

Will you pay surrender charges on your old contract?
What are the interest rate guarantees for the new contract?
Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:

What are the tax consequences of buying the new policy?
Is this a tax-free exchange? (See your tax advisor)
Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?
Will the existing insurer be willing to modify the old policy?
How does the quality and financial stability of the new company compare with your existing company?

30 DAY RIGHT TO CANCEL

In the event of a replacement transaction, you may cancel this policy by delivering or mailing a written request to the Company. You must return the policy to the Company before midnight of the thirtieth day after the day you receive it. You will receive an unconditional full refund of all premiums or considerations paid on it, less any withdrawals and indebtedness, including any policy fees or charges or, in the case of a variable or market value adjustment policy, payment of the cash surrender value provided under the policy plus the fees and other charges deducted from the gross premiums or considerations or imposed under the policy. Your written request given by mail and return of the policy by mail are effective on being postmarked, properly addressed and postage prepaid.

REPLACEMENT ADVERTISING
AGENT STATEMENT

I, _____, have complied with the following in connection with the replacement sales transaction:

a. I have used only company approved sales advertising.

b. I have given a copy of all sales advertising used during the presentation to the applicant, including printed copies of any electronically presented sales materials.

_____ _____

DATE **AGENT SIGNATURE**

You're prepared for the possible...
Now prepare for the* INEVITABLE *with Legacy Safeguard.

Legacy Safeguard provides members with legacy planning and end of life planning assistance, support and guidance.

LEGACY
Safeguard®

Protecting Your Family. Protecting Your Legacy.

Leave a Lasting Legacy with Legacy Safeguard

We believe it is important to leave a legacy, and part of that legacy is to be remembered long after we are gone.

With this in mind, Legacy Safeguard was created to help you leave a lasting legacy and assist your family through some of the most difficult times in their life. Legacy Safeguard offers many legacy planning and end of life planning benefits designed to help protect your legacy. And for a limited time you can become a member in Legacy Safeguard, free of charge, by simply completing the attached Legacy Safeguard Enrollment Form!

LEGACY SAFEGUARD

Membership Benefits

Legacy Planning Services

- Legacy Planning Guide™ Software — A one-of-a-kind legacy planning software that will help you share with your loved ones your historical information, the lessons you've learned, and the family values you hope they keep. This planning software is easy to use and will help you leave a lasting legacy.
- Legacy Planning Archive™ — Outlines the important information that will be needed to complete the Death Certificate and Obituary. The Legacy Planning Archive also helps you record your final wishes to reduce stress and confusion among your family during a difficult time.

Estate Planning Support

- Estate Planning Attorney Locator — Assists you in locating local Estate Planning & Elder Law Attorneys.
- Free Living Will — You can also create a Free Living Will online. This allows you to communicate your wishes for your end of life plans to your family.
- Discounts on Estate Planning Legal Documents — Members receive discounts on personalized estate planning legal documents that include a Last Will and Testament, a Power of Attorney and other important documents.

End of Life Planning, Guidance & Assistance

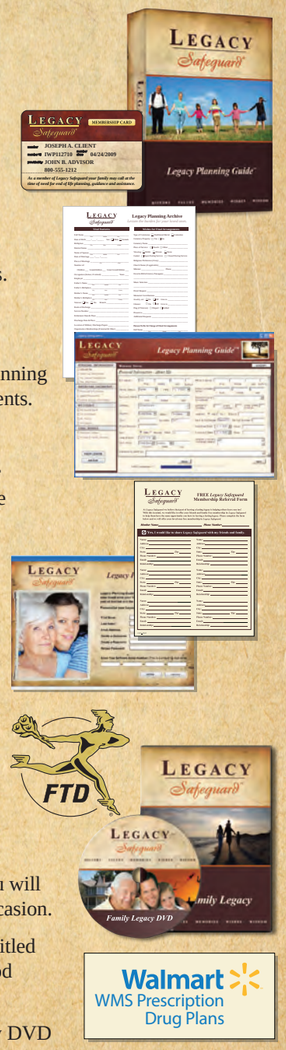
- Legacy Safeguard Advisors — At the time of need, *Legacy Safeguard* advisors are on call to guide your family through the entire planning process. This will help your family evaluate all of the options that are available to them.
- Funeral Home Locator — Can help you in locating several funeral homes and cemeteries in your area.
- End of Life Planning — Our advisors can help your family create a dignified memorial service that celebrates your life. *Legacy Safeguard* can also help your family make informed decisions about how to use the funds that you have set aside to pay for your final arrangements.

Support for Survivors

- Bereavement Travel Assistance — Our advisors can inform your family about bereavement travel options and discounts available to them.
- Grief Counseling Support — We can also recommend grief counseling programs to help your family through the loss of a loved one.

Celebrating Life Events

- Discounts on Flowers, Gift Baskets & Other Celebration Items — As a member of Legacy Safeguard you will also enjoy a 20% discount on flowers, gift baskets, and other items from FTD to celebrate life for any occasion.
- Superior RxCard Walmart Prescription Drug Program — You and any member of your household are entitled to special negotiated pricing on prescription drugs at any Walmart, SAM's Club or Walmart Neighborhood Market Pharmacy.
- Free Family Legacy DVD — Members also receive an exclusive professionally produced Family Legacy DVD that combines your photos with your favorite music.



***Legacy Safeguard is not an insurance policy. Actual fees and charges associated with a funeral or other related services offered are not covered by Legacy Safeguard. This is a free benefit and provided to the recipient at no additional cost; this offer is subject to change without notice.**

Don't Leave a Burden for Your Family

Many Americans believe that Social Security will pay for their final expense needs, however, the government only pays a lump sum of $255 for those who qualify. (Source: U.S. Social Security Administration May 2012)

At Legacy Safeguard we believe that an important part of legacy planning is protecting your family from the unexpected cost of your final expenses. With this in mind, we are proud to introduce Monumental Solution, a final expense life insurance plan underwritten by Monumental Life Insurance Company. These policies have been designed to help you and your family ***peace of mind*** and assistance with covering your final expenses.

Monumental Solutions for Your Final Expenses

Monumental Life Insurance Company

- **Coverage can never be canceled** as long as you pay your premiums.
- **Coverage builds cash value** over time that is tax deferred and can be borrowed against.
- **You may be able to receive the Accelerated Death Benefit Rider alone or with Nursing Home Benefit.***
- **Competitive premiums that can fit any budget** and If you're not satisfied **for any reason,** you can return your policy (for a period of 10, 20 or 30 days depending on your state). You'll receive a **full refund of any premiums paid – no questions asked.**

Immediate Solution LP121, 10-Pay Solution and Easy Solution are whole life insurance policies issued by Monumental Life Insurance Company, Cedar Rapids, IA. Policy Form Nos. WL08 and WL09. Policy form and numbers may vary, and these products may not be available in all jurisdictions. Insurance eligibility and premiums are subject to underwriting. In most states, in the event of suicide during the first two policy years, death benefits are limited only to the return of premiums paid.
**Available on the Immediate Solution and 10 Pay Solution policies Only. Availability may vary by state. Accelerated Death Benefits will be available when the Insured has been diagnosed with a Qualifying Event, as described in the rider, while the policy and the rider are in force. Benefits advanced under this rider may be subject to taxation. Limitations and Exclusions apply. Refer to the Rider for complete details.

Help Protect Your Family with Monumental Life Insurance Company

An important part of planning is helping to protect your family and loved ones from unexpected costs.

It's comforting to know that Final Expense Life Insurance from Monumental Life Insurance Company, may be able to help provide the benefits needed to help cover outstanding costs including final expenses and other expenses that may arise at the time of need.

No one knows what the future may hold, but we can take action today to help make sure that our loved ones are cared for in the event of death.

National Average Final Expense Costs

Funeral Cost Estimates	
• Professional services, embalming, visitation, etc.	$ 4,265
• Metal casket	$ 2,295
• Burial vault	$ 1,195
Cemetery Cost Estimates	
• Cemetery Plot ($1,000 and up in metro areas)	$ 800
• Monument ($500 to $2,000 and up)	$ 950
• Opening and Closing of the grave (varies by cemetery)	$ 1,295
TOTAL ESTIMATED FUNERAL EXPENSES	$ 10,800
Other Final Expense Estimates	
• Immediate household expenses, rent or mortgage payments, credit card debt, car loans, loss of income, hospital and medical bills not paid by medical insurance, attorney fees, court fees, taxes, etc.	$ 10,000
TOTAL ESTIMATED FINAL EXPENSES	$ 20,800

ML303 0713

Source: National Funeral Directors Association 2009 General Price List Survey. (Most recent available)

LEGACY Safeguard®

CLASSIC MEMBERSHIP ENROLLMENT FORM

Simple Enrollment Process

Legacy Safeguard can help you leave a lasting legacy and provide your family with end of life planning, guidance and assistance, at the time of need. To receive your complimentary membership in Legacy Safeguard please complete, sign and return the enrollment form below to take advantage of all the Legacy Safeguard Classic membership benefits.

Member Information

Member's Name | *Date of Birth (MM-DD-YYYY)* | ☐M ☐F *Gender*

Spouse's Name | *Date of Birth (MM-DD-YYYY)* | ☐M ☐F *Gender*

Address

City | *State* | *Zip Code*

Phone Number | *Email Address*

Acknowledgement of Terms & Conditions

Please sign below to acknowledge that you have read, understand and agree to the Terms & Conditions of the Legacy Safeguard Classic Membership.

Signature | *Date (MM-DD-YYYY)*

Provided By:

Agent's Name

Phone Number | *Email Address*

Insurance Company Name | *Agent Number*

Return by mail: Legacy Safeguard • P.O. Box 270523 • Flower Mound, TX • 75027 **Return by fax:** 214-224-0922

TERMS & CONDITIONS - Legacy Safeguard is a legacy and end of life planning consumer advocacy service provided by Legacy Safeguard, LLC. Member understands and agrees that by completing and returning this enrollment form the Member will receive a limited free online membership in the Legacy Safeguard service. Legacy Safeguard is not an insurance policy. Actual fees and charges associated with a funeral or other related services offered are not covered by Legacy Safeguard. This is a free benefit and provided to the recipient at no additional cost; this offer is subject to change without notice. Member may choose to purchase additional services, including but not limited to, additional membership opportunities in Legacy Safeguard. Member also agrees that they can be contacted by Legacy Safeguard at anytime to receive additional information about merchandise and services offered by Legacy Safeguard, its affiliates and other companies that Legacy Safeguard partners with. Member agrees to indemnify, defend, and hold harmless Legacy Safeguard, its affiliates, officers, agents, contractors, and employees, from any claim arising in any manner, directly or indirectly, out of or in connection with terms of this agreement or any other agreement between the parties to this agreement regardless of the cause of fault or failure to comply with any of the provisions of the aforementioned agreement, which includes, but is not limited to, the negligence of either party to this agreement. Member further agrees to indemnify, defend, and hold harmless Legacy Safeguard, its affiliates, officers, agents, contractors, and employees from any and all claims and/or causes of action set forth by or against Member and/or a third-party for the actions or omissions of Member and/or any third-party that arises out of or are any way connected with that which is addressed herein.

FREE *Legacy Safeguard* Member Sponsorship Form

At *Legacy Safeguard* we believe that part of leaving a lasting legacy is helping others leave one too! With this in mind, we would like to offer your friends and family free membership in *Legacy Safeguard* to help them have the same opportunity you have in leaving a lasting legacy. Please complete the form below and we will offer your loved ones free membership in *Legacy Safeguard*.

*Member Name:*______________________________ *Phone Number:* ____________________

☑ **Yes, I would like to sponsor my friends and family to become a member in *Legacy Safeguard*.**

Name: __________	Name: __________
Address: __________	Address: __________
City: __________	City: __________
State: ______ Zip: ____	State: ______ Zip: ____
Phone Number: __________	Phone Number: __________
Email: __________	Email: __________
Relationship: __________	Relationship: __________
Name: __________	Name: __________
Address: __________	Address: __________
City: __________	City: __________
State: ______ Zip: ____	State: ______ Zip: ____
Phone Number: __________	Phone Number: __________
Email: __________	Email: __________
Relationship: __________	Relationship: __________
Name: __________	Name: __________
Address: __________	Address: __________
City: __________	City: __________
State: ______ Zip: ____	State: ______ Zip: ____
Phone Number: __________	Phone Number: __________
Email: __________	Email: __________
Relationship: __________	Relationship: __________