Monumental Life Insurance Company

# EXPRESS ISSUE COVER SHEET

*(Please submit completed sheet with every application)*

| **Agent Information** | | |
|---|---|---|
| Agent ID | Agent Name (Print) | Agent Phone<br>( ) |
| Agent Email | | Agent Fax<br>( ) |
| **Proposed Insured Information** | | |
| Insured's name (Print) | | Last 4 digits of Insured's social security # |

Required Disclosures with Application:

❑ HIPAA Authorization Form ❑ Bank Draft Form

Other Disclosures (if applicable):

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

How are you paying the Initial Premium?

❑ 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

❑ Draft initial premium upon receipt

❑ Draft initial premium at future date, please indicate the month and day (mm/dd): _____ / _____

**Month** **Day (1st thru 28th only)**

- If you choose a specific Initial Premium draft date (in the future), the recurring draft date will be the same as the initial premium draft date and may not be greater than 30 days after the application 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.**

**(See 'Draft Date Procedures & Scenarios' on Web site)**

Submitting Application to Monumental: ***(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:

**Monumental Life, 4333 Edgewood Road NE, Cedar Rapids, IA 52499**

Monumental Life INSURANCE COMPANY

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

# LIFE APPLICATION

| Agent ID # | State Application Taken | Policy # (H.O. Use Only) |
|---|---|---|
| | | |

## Part A1 - Proposed Insured

| Name (First, M.I., Last) | | | Address, City, State, Zip Code (cannot be a P.O. Box) | | |
|---|---|---|---|---|---|
| SSN | Gender | D.O.B. (MM/DD/YYYY) | Age | U.S. State or Country of Birth | Phone Number ( ) |
| | | | | | |

1) Within the last 12 months has the proposed Insured used tobacco products in any form? ❑ Yes ❑ No
2) Life Insurance Face Amount $ _____
   a) Plan: _____
   b) Accidental Death Benefit Rider Face Amount $ _____
   c) Total Premium $ _____
   d) If a policy cannot be issued as applied for, would you accept a rated policy if available? ❑ Yes ❑ No
   e) If 'yes,' adjust face amount to premium? ❑ Yes ❑ No
3) Does the applicant have any existing life insurance or annuity contracts with the company or any other company? ❑ Yes ❑ No
4) Is this insurance intended to replace or change any life insurance or annuity contract in force with the company or any other company? (If yes, submit the state required forms) ❑ Yes ❑ No

## Part A2 - Owner (If Other Than Proposed Insured)

| Name (First, MI, Last) | SSN | Gender | Relationship to Insured | 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.? If not, what country? ❑ Yes ❑ No |
|---|---|
| | |

## Part A3 - Beneficiary

| Primary Name (First, MI, Last) | SSN | Gender | Relationship to Insured | D.O.B. (MM/DD/YYYY) |
|---|---|---|---|---|
| | | | | |
| Contingent Name (First, MI, Last) | SSN | Gender | Relationship to Insured | D.O.B. (MM/DD/YYYY) |
| | | | | |

## Part B1 - If Any Question In This Section Is Answered "Yes", The Proposed Insured Is Not Eligible For Any Coverage.

1) Is the proposed Insured hospitalized, bedridden, residing in a nursing home or long term care facility, receiving hospice or home health care, confined to a wheelchair, been advised by a medical doctor or planning to have inpatient surgery or currently waiting for an organ transplant? ❑ Yes ❑ No
2) Has the proposed Insured ever:
   a) Been diagnosed with, been treated for or advised by a medical doctor to receive treatment for Alzheimer's disease, senile dementia, organic brain disease, mental incapacity, Lou Gehrig's disease (ALS), Downs Syndrome, Huntington's disease, sickle cell anemia, Spina Bifida not surgically corrected, cystic fibrosis, cerebral palsy or any terminal medical condition? ❑ Yes ❑ No
   b) Been diagnosed as having or been told by a medical doctor that you have AIDS, HIV, or ARC disorders? ❑ Yes ❑ No
   c) Been in a diabetic coma or had or been advised by a medical doctor to have an amputation due to disease or disorder? ❑ Yes ❑ No
3) Within the past **2 years** has the proposed Insured:
   a) Been diagnosed with, been treated for or advised by a medical doctor to receive treatment for cancer (other than basal cell carcinoma)? ❑ Yes ❑ No
   b) Undergone testing by a medical doctor for which the results have not been received? ❑ Yes ❑ No

## Part B2

4) Has the proposed Insured been diagnosed with, been treated for or advised by a medical doctor to receive treatment for diabetes (other than gestational diabetes) before the age of 18? ❑ Yes ❑ No
5) Within the past **4 years** has the proposed Insured been diagnosed with, been treated for or advised by a medical doctor to receive treatment for cancer (other than basal cell carcinoma)? ❑ Yes ❑ No
6) Within the past **1 year** has the proposed Insured:
   a) Used illegal drugs or been diagnosed with, been treated for or advised by a medical doctor to receive treatment for alcohol abuse, drug abuse or muscular dystrophy? ❑ Yes ❑ No
   b) Had more than 12 seizures or been diagnosed with, been treated for or advised by a medical doctor to receive treatment for congestive heart failure, cirrhosis, hepatitis B or C or other liver disease? ❑ Yes ❑ No
   c) Been diagnosed with, been treated for or advised by a medical doctor to receive treatment for heart attack, stroke (CVA), transient ischemic attack (TIA), aneurysm, angina, or had or been advised to have heart surgery of any kind including bypass surgery or pacemaker implant? ❑ Yes ❑ No
   d) Used oxygen to assist in breathing due to a disease or disorder, received kidney dialysis or been diagnosed with, been treated for or advised by a medical doctor to receive treatment for kidney failure due to a disease or disorder? ❑ Yes ❑ No

- If All Questions in Part B2 Are Answered "No", Proceed to Part B3.
- If One Question in Part B2 Is Answered "Yes", The proposed Insured Is Eligible For The Graded Death Benefit Product. Proceed to Part C1.
- If Two Or More Questions in Part B2 Are Answered "Yes", The proposed Insured Is Not Eligible For Any Coverage.

Last Name and Last 4 Digits of SSN: _____

## Part B3

7) Within the past **2 years** has the proposed Insured:
   a) Had or been treated by a medical doctor for a heart attack, angina (chest pain), stroke (CVA), transient ischemic attack (TIA), aneurysm, circulatory or blood disorder, heart surgery including bypass or irregular heart rhythm such as atrial fibrillation? ❑ Yes ❑ No
   b) Had more than 12 seizures, taken insulin shots or been diagnosed with, been treated for or advised by a medical doctor to receive treatment for congestive heart failure, cirrhosis, hepatitis B or C or other liver disease? ❑ Yes ❑ No
   c) Used illegal drugs or been diagnosed with, been treated for or advised by a medical doctor to receive treatment for alcohol abuse or drug abuse? ❑ Yes ❑ No
8) Within the past **4 years** has the proposed Insured been diagnosed with, been treated for or advised by a medical doctor to receive treatment for kidney disease? ❑ Yes ❑ No
9) Has the proposed Insured **ever** been diagnosed with, been treated for or advised by a medical doctor to receive treatment for Parkinson's disease, multiple sclerosis, chronic obstructive pulmonary disease (COPD) including emphysema, chronic asthma, black lung or other chronic respiratory disease? ❑ Yes ❑ No
10) Is the proposed Insured currently under the age of 50 **and** if so, has the proposed Insured within the past **5 years** been diagnosed with, been treated for or advised by a medical doctor to receive treatment for any mental disorder such as manic or clinical depression, schizophrenia, bipolar disease or post traumatic stress syndrome? ❑ Yes ❑ No

- If All Questions in Part B3 Are Answered "No," The proposed Insured Is Eligible For The Preferred Product. Please Check The Appropriate Box And Proceed to B4:
  ❑ Preferred LP99 ❑ Preferred 10PL ❑ Preferred Other: _____
- If One Question in Part B3 Is Answered "Yes," The proposed Insured Is Eligible For The Standard Product. Please Check The Appropriate Box And Proceed to B4:
  ❑ Standard LP99 ❑ Standard 10PL ❑ Standard Other: _____
- If Two Or More "Yes" Answers in Part B3, The proposed Insured Is Eligible For The Graded Death Benefit Product. Proceed To C1.

## Part B4 - Nursing Home Option - If The Following Question Is Answered "Yes", The Proposed Insured Is Not Eligible For The Nursing Home Option On The Accelerated Death Benefit Rider.

Does the proposed Insured need any assistance from other persons in performing any Activities of Daily Living such as eating, bathing, toileting, dressing, taking medications, walking or moving in and out of bed or chair or does the proposed Insured have ongoing incontinence or, in the 2 years prior to the application, has a medical professional recommended that the proposed Insured be confined to a Nursing Home? ❑ Yes ❑ No

## Part C1 - Face Amount & Payment Method

Face Amount: | Payment Method: ❑ Monthly EFT ❑ Quarterly ❑ Semi-Annual ❑ Annual

Full Modal Premium Included or Authorized With Application Is:

## Part C2 - Payor Information

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

| Name (First, MI, Last) | SSN | Gender | Relationship to Insured |
|---|---|---|---|
| | | | |

Address, City, State, Zip Code (cannot be a P.O. Box)

Are you a citizen of the U.S.? ❑ Yes ❑ No
If not, what country?

## Part C3 - 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.

Draft Date (1st-28th):_____ If no date selected, the draft date will be the policy date.

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

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

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

Last Name and Last 4 Digits of SSN: _____

**Agent's Report**

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 _____

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

Best time to call for a Personal History Interview _____ a.m. _____ p.m.

Home or work phone number _____

Agent Signature _____

## AGREEMENT / AUTHORIZATION

This application consists of all Parts A, B, and C, and is not a contract of insurance. A contract of insurance shall take effect only if a policy is issued on this application and the first premium is paid in full (a) during the lifetime of the proposed Insured and (b) while there is no change in the insurability and health of the proposed Insured from that stated in this application. It is represented that all statements and answers in this application are true, full and complete and bind all parties in interest under any policy applied for. Only an authorized officer of our Company can make void, waive or change any of the conditions or provisions of any application, policy or receipt or accept risks or pass on insurability. Acceptance of any policy issued on this application shall mean acceptance of any change, correction, addition or amendment noted by any amendments and corrections. The proposed Insured shall be the policyowner unless another owner is named above.

I have received the MIB Disclosure Notification, Notice to Persons Applying For Insurance, Accelerated Death Benefit Disclosure and Conditional Receipt. I hereby authorize any licensed physician, medical practitioner, or the Medical Information Bureau or other institution that has any records or knowledge of the proposed Insured to give any such information, including medical information, to the life insurance company. A photocopy or facsimile of this authorization shall be made as valid as the original.

**FRAUD WARNING:** Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Signed at City _____ State _____ Proposed Insured Signature _____

Date _____ Owner Signature _____

(If Owner other than Insured)

Witness _____ _____

(Agent Signature) (Print Agent's Name and I.D. Number)

**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 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 the MIB, Inc., formerly known as Medical Information Bureau, 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 about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 or (TTY 866-346-3642). If you question the accuracy of information in the 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, Suite 400, Braintree, Massachusetts 02184-8734.

Monumental Life Insurance Company, or its reinsurers may also release information from its file to other life 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.

7/08

**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;
2. An amount equal to the first full premium required is paid on the plan and any check, money order, or Authorization for Electronic Funds Transfer (EFT) given in payment is 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 of rates or amount of coverage.

**Effective Date**

If all of the above conditions are met, insurance in the amount applied for or $25,000, whichever is lower, will become effective on the date the application is completed. If any of the above conditions are not met, or the application contains a material misrepresentation, 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**

RESET

*Monumental Life Insurance Company*
Administrative Office, 4333 Edgewood Road NE, Cedar Rapids, IA 52499

# 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 |
|---|---|---|
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**ADDITIONAL INFORMATION**



Dated at _____ (City) _____ (State) this _____ day of _____ (Month), _____ (Year)

_____
Signature of Proposed Insured

_____
Signature of Proposed Owner (if other than Proposed Insured)

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

_____
Signature of Additional Insured

_____
Signature of Agent

SA-ADINFO 0805

**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:

- 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.**

# PRE-AUTHORIZED WITHDRAWAL PLAN

I/we, the undersigned, hereby authorize and request _____ to initiate electronic debit entries or effect a charge by any other commercially accepted practice to my/our account indicated on the attached check (or the information provided below) for premiums and other such payments that may become due in any amount under this policy. I/we request that this Authorization, unless previously revoked, continue to apply to any conversion, renewal, or change later made in the policy. I/we agree that this Authorization in no way affects the terms of the policy, other than the mode of payment and I/we understand that if premiums are not paid within the grace period allowed by the policy, as in the event of withdrawals being dishonored, or for any other reason, then the policy shall terminate subject to any nonforfeiture provision of the policy. No debit, check or other charge shall constitute payment until the Company actually receives payment from the financial institution within the period provided in the policy. This Authorization may be terminated by either party by giving written notice to the other.

## INITIAL PAYMENT (MUST CHECK ONE BOX)

☐ CHECK: Check this box if you are attaching a check for the initial modal premium. The check will be deposited upon receipt of the application by the Company.

☐ AUTOMATIC WITHDRAWAL: Check this box to have the initial modal premium withdrawn from the account listed below. By checking this box, I/we agree that I/we want an amount sufficient to pay the initial premium due for the insurance policy withdrawn from the account. This initial premium amount may not equal the amount reflected below. I/we further understand that no insurance will be provided except under the terms of a conditional receipt which may be given at the time the application is taken, and then only if and when all conditions and requirements of the conditional receipt have been satisfied.

**Initial premium will be withdrawn upon receipt of the application by the Company and not on the day of the future recurring monthly payment stated below.**

## ACCOUNT INFORMATION

**TAPE VOIDED CHECK HERE**
**(Place tape along TOP of check)**

**If not attaching void check or if withdrawing from Savings Account, complete the following information**

_____
Bank Name, Office or Branch

_____
Bank Address | City | State | Zip Code

Check one: ☐ Checking ☐ Savings

_____
Payor Name(s)

_____ _____
Transit Routing Number | Account Number

## COMPLETE THE FOLLOWING INFORMATION FOR FUTURE RECURRING PAYMENTS

| **Premium to Withdraw** | |
|---|---|
| $ _____ | ☐ Withdraw on day of the month matching the policy's effective date (this will be elected if no box is checked) |
| | ☐ Withdraw on a different day of the month; choose a day between 1 and 28 _____ |

## SIGNATURE

**Payor Signature(s)** – as on financial institution's records. A copy is as valid as the original.

**X**_____ **Date:** _____

# 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**

☐ **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.

❑ **Monumental Life Insurance Company**

❑ **Stonebridge Life Insurance Company**

❑ **Transamerica Life Insurance Company**

❑ **Western Reserve Life Assurance Co. of Ohio**

## Terminal Illness Accelerated Death Benefit Disclosure Form

The owner may apply for the single sum accelerated benefit when the insured has been diagnosed with a terminal illness. A terminal illness is a condition resulting from injury or illness which, as determined by a physician, has reduced life expectancy to not more than 24 months from the date of the physician's statement. The company requires proof of a terminal condition, including an attending physician's statement and any other proof that we may require. We reserve the right to seek a second medical opinion or have you examined at our expense by a physician we choose.

This benefit cannot be exercised:

1. if the policy is not in force;
2. is only in force as extended term insurance;
3. if the policy is within two years of endowment; or
4. if any eligible rider is within two years of expiration.

The single sum benefit may only be requested once. If there is an irrevocable beneficiary or assignee, they must consent in writing to payment of this benefit.

The policy's specified amount, policy value, surrender charge and indebtedness, if any, will be reduced by the election percentage. We will provide you with revised policy specification pages.

Receipt of accelerated benefits may be taxable and you should consult your personal tax advisor.

By signing below, you agree that you have read the above and received a copy of this summary and disclosure statement upon delivery of your policy.



_____
Date

_____
Owner's (Applicant's) Signature

_____
Agent's Signature

**IMPORTANT: The signed original must be submitted with the application for life insurance. The copy is to be left with the applicant.**

Monumental Life Insurance Company

# ACCELERATED DEATH BENEFIT RIDER DISCLOSURE

**The acceleration-of-life-insurance benefits offered under this rider may or may not qualify for favorable tax treatment under the Internal Revenue Code of 1986. Whether such benefits qualify depends on factors such as your life expectancy at the time benefits are accelerated or whether you use the benefits to pay for necessary long-term care expenses, such as nursing home care. If the acceleration-of-life-insurance benefits qualify for favorable tax treatment, the benefits will be excludable from your income and not subject to federal taxation. Tax laws relating to acceleration-of-life-insurance benefits are complex. You are advised to consult with a qualified tax advisor about circumstances under which you could receive acceleration-of-life-insurance benefits excludable from income under federal law.**

**Receipt of acceleration-of-life-insurance benefits may affect your, your spouse or your family's eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children (AFDC), supplementary social security income (SSI), and drug assistance programs. You are advised to consult with a qualified tax advisor and with social service agencies concerning how receipt of such a payment will affect you, your spouse and your family's eligibility for public assistance.**

**Description of Benefit:** Upon receipt of proof acceptable to us of the Insured's Qualifying Event, the Owner may choose to receive the Accelerated Death Benefit while the Insured is alive and the Rider is In Force.

**Qualifying Event:** An event defined in the Rider, which allows for payment of the Accelerated Death Benefit.

**Accelerated Death Benefit Amount:** The Accelerated Death Benefit shall be equal to:

1. the Policy Death Benefit that would be In Force at the end of the 12 month period following the Acceleration Date, before deduction of any outstanding Loan Balance; less
2. a discount on the Accelerated Death Benefit calculated for the 12 month period using the current interest rate; less
3. any outstanding policy loans, including accrued interest until the end of the 12 months following the Acceleration Date; less
4. any premiums which would be required to keep the Policy In Force for the 12 month period following the Acceleration Date for the Policy Amount of Insurance reduced by an appropriate discount using the current interest rate.

**Termination of Coverage:** The Accelerated Death Benefit Rider will automatically terminate when the Policy to which it is attached terminates or lapses or matures or is continued under one of the nonforfeiture options; or when the Accelerated Death Benefit is paid; whichever occurs first.

**Impact on the Policy's Death Benefit:** The Policy to which the Rider is attached will terminate on the date the Accelerated Death Benefit is paid.

By signing below, you agree that you have read and received a copy of this summary and disclosure statement at the time of application.

| | |
|---|---|
| Date | Owner's (Applicant's) Signature |
| Date | Agent's Signature |