

APPLICATION FOR LIFE INSURANCE

This packet includes an application for all plans of life insurance. Also included are the Notice of Insurance Information Practices, Authorization form, and PreAuthorized Bank form.

Forward this packet to the Home Office intact. Do not separate.

A separate AIDS Informed Consent/Questionnaire form is required. Always utilize the appropriate form for your state.

Please be sure:

- (1) The Notice of Insurance Information Practices is delivered to the proposed insured before completion of the application.
- (2) The Temporary Life Insurance Agreement Receipt is given to the premium payor whenever settlement is collected in advance.
Do not accept settlement if the proposed insured has been treated for heart disease, stroke or cancer within the past 2 years.
Do not accept settlement if the application is not completed in its entirety.
- (3) The proposed insured, and applicant if a different person, sign the form where indicated.
- (4) If the proposed insured is under age 15, the application is signed by a parent or guardian.
- (5) All sections of the application required for the coverage requested are completed.
- (6) The signed authorization remains attached to the application when forwarded to the Home Office.
- (7) Taxpayer Identification number and Certification form is completed and remains with the application when sent to the Home Office.
- (8) To complete the Personal History Interview form included herein. The information portion is to remain with the application. The notice portion is to be detached and given to the proposed insured.

NON MEDICAL AND PARAMEDICAL LIMITS

In all instances non medical and paramedical limits must be observed. Do not initiate paramedicals or medicals when lesser requirements suffice.



A Member of THE MONY GROUP

A Stock Insurance Company

10290 Alliance Road

P.O. Box 429560

Cincinnati, OH 45242

www.usfli.com

(Including Medical Information Bureau Notice and Fair Credit Reporting Act Notice)

In considering your application, information from various sources will be considered. These include your statements, the results of your physical examination (if required), and reports we get from doctors or medical facilities which have attended you. Information about your insurability will be treated as confidential. We, or our reinsurers, may, however, make a brief report of this to the Medical Information Bureau, a nonprofit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file. Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is P.O. Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660.

We, or our reinsurers, may also release information to other life insurance companies to whom you apply for life insurance, or to whom a claim is submitted.

In addition, we may get an investigative report from a consumer reporting agency. This report requires personal interviews with your neighbors, friends, or other acquaintances for information as to your general reputation, personal characteristics and mode of living. As part of your application, you have authorized us to do this. You have the right to be personally interviewed and to make a written request within a reasonable period about the nature and scope of this investigation. Upon written request you will be told if such a report has actually been ordered, and if it has, we will give you the name and address of the consumer reporting agency. You may contact this consumer reporting agency and ask for a copy of such report.

Unless a legitimate business need exists or we are required to do so by law, the information we get in this report, as well as any other information which we later acquire, will not be disclosed to anyone else without your consent. You may request a copy of all information acquired by us and have a right to correct any personal information which you feel is inaccurate. We will, if required by law, give you a more detailed notice of the types of personal information which we get in considering your application, as well as any additional rights which you may have.

**U.S. Financial Life Insurance Company
Cincinnati, Ohio 45202**

PART 1 - Application For Life Insurance

Application No. _____

Please Print Using Dark Ink

Policy No. _____

Section I

Proposed Insured #1

Name (Last First M)		Date of Birth M D Y			Place of Birth	Social Security No.
Home Address		City	State	Zip	How Long?	
Sex	Marital Status	Occupation	Employer			
Business Address		City	State	Zip	How Long?	

Section II

Proposed Insured #2

Name (Last First M)		Date of Birth M D Y			Place of Birth	Social Security No.
Home Address		City	State	Zip	How Long?	
Sex	Marital Status	Occupation	Employer			
Business Address		City	State	Zip	How Long?	

Section IIA

Dependent Children

Name (Last First M)	Sex	Date of Birth			Place of Birth	Height		Weight
		M	D	Y		ft	in	

Section III

Applicant Owner or Payor

Name of Applicant/Owner (if other than Proposed Insured) (Applicant must sign Page 6)		Relationship	Social Security No. or Taxpayer I.D. No.
Address		City	State Zip

If Proposed is a minor, ownership will pass to Proposed Insured at age, _____. (If no designation is made, ownership will pass to Proposed Insured at age 21)

All notices and reports will be sent to the Owner unless otherwise specified in Special Requests section, Page 2

Section IV

Policy Specifications

Plan of Insurance	Face Amount	If UL, indicate	<input type="checkbox"/> Option 1- Specified Amount
			<input type="checkbox"/> Option 2- Specified Amount in addition to Cash Value Death Benefit.
Additional Benefits			
<input type="checkbox"/> Waiver of Premium	<input type="checkbox"/> Children's Insurance Benefit		
<input type="checkbox"/> Waiver of State Monthly Amount (UL)	<input type="checkbox"/> Additional Insured Person Rider		
<input type="checkbox"/> Waiver of Monthly Deduction (UL)	<input type="checkbox"/> Other: _____		
<input type="checkbox"/> Accidental Death			

Section V

Premium Frequency: Annual Semiannual Quarterly PAC Single Cash with Application \$ _____

Premium Send premium notices to: Home Business (Give any specific address here.)

Name _____

Address _____ City _____ State _____ Zip _____

Section VI	PRIMARY BENEFICIARY: Full Name	Percent	Relationship
		%	
Beneficiary For Proposed Insured #1	CONTINGENT BENEFICIARY: Full Name	Percent	Relationship
		%	

If more than one, then equally to the survivors unless otherwise stated.

Section VI-A	PRIMARY BENEFICIARY: Full Name	Percent	Relationship
		%	
Beneficiary For Proposed Insured #2	CONTINGENT BENEFICIARY: Full Name	Percent	Relationship
		%	

If more than one, then equally to the survivors unless otherwise stated.

Section VII Life Insurance In Force and Pending on All Proposed Insureds, Including Business Insurance: (If none insert "None.")

Existing and Pending Insurance	Name of Insured	Company	Type of Coverage	Life Amount	Accidental		Year Issued
					Death		
				\$	\$		

- Regarding all Proposed Insureds:** (If any "Yes," give name, date and details in Remarks below.)
- | | | |
|---|--------------------------|--------------------------|
| | Yes | No |
| (a) Has any life or health insurance been applied for without it being received exactly as requested? | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) Is the policy applied for to replace any existing insurance or annuity in this or any other company? (If "Yes," forward Replacement Forms.) | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) Has any life insurance lapsed, been surrendered or otherwise terminated in the last 24 months? | <input type="checkbox"/> | <input type="checkbox"/> |

Section VIII	Has any Proposed Insured:	Yes	No
Special Activities	(a) Flown as a Student, Private, Commercial or Military pilot in the past two years, or are any such flights planned in the future? (If "Yes," complete Aviation Questionnaire, Page 9.)	<input type="checkbox"/>	<input type="checkbox"/>
	(b) Engaged in any form of racing, sky diving, underwater diving, or other hazardous activity in the past two years? (If "Yes," complete Avocation Questionnaire, Page 10)	<input type="checkbox"/>	<input type="checkbox"/>
	(c) Belong to or intend joining any active military, naval or aeronautic organization?	<input type="checkbox"/>	<input type="checkbox"/>
	(d) Contemplate travel or residence outside the United States or Canada?	<input type="checkbox"/>	<input type="checkbox"/>

Section IX	Has Primary or Additional Proposed Insured:	Yes	No
Tobacco Use	(a) Smoked tobacco within the past 12 months? If "Yes," and not presently smoking, when did Primary Proposed Insured quit? _____ When did additional Proposed Insured quit? _____	<input type="checkbox"/>	<input type="checkbox"/>
	(b) Used tobacco in any other form? If "Yes," what type? _____	<input type="checkbox"/>	<input type="checkbox"/>

Section X		Yes	No
Driving	(a) Has Primary Proposed Insured and/or Additional Proposed Insured had their driver's license restricted or revoked, or been cited for more than 3 moving violations within the last 3 years?	<input type="checkbox"/>	<input type="checkbox"/>

Special Requests and Remarks:

PART II -- NON-MEDICAL SECTION

Application No. _____

- 1 (a) Proposed Insured #1: Height ft in Weight lbs Weight change in past year none loss gain lbs
 (b) Do you have a personal doctor? Yes No (If "Yes," give name, address and telephone number.)

- 2 (a) Proposed Insured #2: Height ft in Weight lbs Weight change in past year none loss gain lbs
 (b) Do you have a personal doctor? Yes No (If "Yes," give name, address and telephone number.)

Please answer all Questions for Each person to be insured

3. To the best of your knowledge have you or has any other Proposed Insured had or been told by a doctor that he or she had: (Circle conditions to which "Yes" answer applies and give details below.)
- (a) Convulsions, epilepsy, paralysis, mental or nervous disorders?
 - (b) Chest pain, high blood pressure, heart murmur, heart attack, stroke, or other disorder of the heart or circulatory system?
 - (c) Asthma, emphysema, bronchitis, tuberculosis, or chronic respiratory disease?
 - (d) Jaundice, intestinal bleeding, ulcer, chronic colitis, diverticulitis, or other liver or gastrointestinal disorder?
 - (e) Complicated pregnancy, hysterectomy, disorder of breast or female organs?
 - (f) Disease of kidney, bladder, prostate, or sugar or protein in urine?
 - (g) Loss of vision, amputation, deformity, arthritis or any disorder of muscles, bones or joints?
 - (h) Cancer, tumor, diabetes or glandular disorder?

Proposed Insured #1		Proposed Insured #2		Children	
yes	no	yes	no	yes	no
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. To the best of your knowledge have you or has any other Proposed Insured: (Circle conditions to which "Yes" answer applies and give details below.)
- (a) Other than above, had examination, treatment or consultation with a doctor, or been hospital confined during the past 5 years?
 - (b) Been on, or are now on, any medication or prescribed diet?
 - (c) Been treated for drug addiction, alcoholism or been a member of Alcoholics Anonymous?
 - (d) Ever used narcotics, hallucinogens, barbituates, heroin or any other drug not prescribed by a physician?
 - (e) In the past 10 years have you been treated for or been diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS)?
 - (f) Ever received disability benefits?
 - (g) Been advised to have any diagnostic test, hospitalization or surgery which has not been completed?
 - (h) Had a parent, brother, or sister who had cancer, diabetes, heart disease, or who committed suicide? (Please show age at onset and /or date of death).....

yes	no	yes	no	yes	no
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Person's Name	Question Number	Details or Reasons	Duration	Name, Address and Telephone # of Attending Doctor or Hospital (if applicable)

HOME OFFICE ENDORSEMENTS

(Not to be used where prohibited by Statute or Insurance Department ruling)

DECLARATIONS

I (We) represent that all statements and answers made in all parts of this application are full, complete and true to the best of my (our) knowledge and belief. It is agreed that:

- (1) All such statements and answers shall be the basis for and a part of any policy issued on this application.
- (2) No agent or medical examiner can accept risks or make or change contracts or waive U.S. Financial's rights or requirements.
- (3a) Any prepayment made with this application will be subject to the provisions of the Temporary Life Insurance Agreement;
- (3b) If there is no prepayment made with this application, the policy will not take effect until both:
 - (I) the first premium is paid during the lifetime of the proposed insured and while his/her health and the facts and other conditions affecting his/her insurability are as described in Part I and Part II of this application;
 - (II) and until the policy is delivered to the proposed owner.
- (4) No one except the President, Vice President or the Secretary can make, alter or discharge contracts or waive any of the Company's rights or requirements.
- (5) Acceptance of the policy by the Owner shall constitute ratification of any changes made by U.S. Financial under "Home Office Endorsements."

NOTICE - Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Dated _____

Signature or Proposed Insured #1

Signed At _____
City and State

Signature of Proposed Insured #2

Witnessed by Agent

Signature of Applicant/Owner,
if Other than Proposed Insured
(If a corporation, state name)

By _____
Signature of Corporate Officer

**U.S. Financial Life Insurance Company
Cincinnati, Ohio 45202**

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I authorize U.S. Financial Life Insurance Company and/or its reinsurer(s) to obtain medical and other information on me or my minor children. This includes information about drugs and alcohol and about diagnosis, treatment and prognosis of any physical or mental condition, as well as any other non-medical information.

I authorize the release of this information to U.S. Financial Life Insurance Company and/or its reinsurers. This information can be released by doctors including medical practitioners and pharmacists. It can also be released by any hospital, clinic or other medical or medically related facility, including facilities run by the Veteran's Administration. Information can also be released by insurers, reinsurers, the Medical Information Bureau (MIB), employers and consumer reporting agencies.

I also authorize all the above sources (except the MIB) to give such records or information to any consumer reporting agencies employed by U.S. Financial to collect and transmit such information.

I acknowledge that the information obtained by this authorization will be used by U.S. Financial to determine eligibility for insurance applied for, and may be used to determine eligibility for benefits under an existing policy. Any information obtained will only be released by U.S. Financial to reinsurers, the MIB, or other persons or organizations performing business or legal services in connection with my application or a claim. The information may also be released if U.S. Financial is required to do so by law, or if I authorize its release.

This authorization shall be valid for 30 months from the date shown below. I may obtain a copy of this if I ask for it. A photographic copy shall be as valid as the original.

I authorize U.S. Financial Life Insurance Company to obtain one or more investigative consumer report(s) on me.

I have received a copy of the Notice of Information Practices.

Date: _____

Signature of Proposed Insured #1

Signature of Proposed Insured #2

Signature of Parent or Legal Guardian,
(if minor child(ren) proposed for insurance)

THIS AUTHORIZATION MUST BE SIGNED BEFORE APPLICATION CAN BE PROCESSED

AGENT'S REPORT - PLEASE COMPLETE IN FULL

SECTION A - General Information

1. Do you have knowledge of or reason to believe that replacement or change of existing life insurance or annuities may be involved? yes no
 (If "Yes," supply details Section VII, Page 4.)
2. What is purpose of insurance applied for? _____
3. a. How long and how well have you known each proposed insured? _____
 b. Are you related?
4. Were you present with the Proposed Insured and Other Insured(s) when this application was completed?
 (If "No," Explain) _____
5. If Proposed Insured's name was changed for any reason, state previous name and date changed _____
6. Is a paramed or medical Examination required for:
 If "Yes," fill in below
- | Name of Insured | Date of Exam | Type of Exam | Examiner Paramedical Service Name | Special Studies |
|-----------------|--------------|--------------|-----------------------------------|-----------------|
| | | | | |
| | | | | |
7. Have you any information about health, character, habits, residence, mode of life, contemplated travel, or occupation affecting this risk which is not fully explained in this report or in the application? (If "Yes," give details in Remarks section)
8. If the Proposed Insured or Other Insured is Under age 15:
 (a) Applicant's relationship to the child: _____
 (b) Amount of insurance on life of : Father \$ Mother \$
 (c) Did you see the child?
 (d) Age of brothers and sisters of the child and amount of insurance in force on each of their lives:
- | Age | Insurance | Age | Insurance | Age | Insurance | Age | Insurance |
|-----|-----------|-----|-----------|-----|-----------|-----|-----------|
| | | | | | | | |
9. Primary Insured: Earned Income: \$ _____ Unearned Income: \$ _____ Net Worth: \$ _____
 Other Insured: Earned Income: \$ _____ Unearned Income: \$ _____ Net Worth: \$ _____

SECTION B Business Information (Complete only if insurance is for business purposes)

- | <p>1. (a) What is approximate net worth of business? \$ _____
 (b) What is approx. net yearly business income? \$ _____
 (c) What is Market Value of business? \$ _____</p> <p>2. (a) Is it a <input type="checkbox"/> partnership <input type="checkbox"/> corporation <input type="checkbox"/> sole proprietorship
 (b) What percentage of business does Proposed Insured own or control; _____ %</p> | <p>3. Business insurance applied for and in force on any proposed insured and any Partners, Officers, or Key Person: (If "None," explain in Remarks Section).</p> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:30%;">Name</th> <th style="width:30%;">Title & Interest</th> <th style="width:15%;">Amount</th> <th style="width:25%;">Company</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </tbody> </table> | Name | Title & Interest | Amount | Company | | | | | | | | |
|---|--|--------|------------------|--------|---------|--|--|--|--|--|--|--|--|
| Name | Title & Interest | Amount | Company | | | | | | | | | | |
| | | | | | | | | | | | | | |
| | | | | | | | | | | | | | |

SECTION C - Agent's Remarks Section

Except as set forth below, I hereby represent that I know nothing affecting the insurability of any person applying for insurance which is not fully set forth in these papers.

Signature of Soliciting Agent _____
 Print full name as signed above _____

COMPLETE FOR PROPER PRODUCTION CREDIT

Agency	Code Number	Address	Phone Number
Agent	Code Number	Address	Phone Number
Agent	Code Number	Address	Phone Number

U.S. Financial Life Insurance Company
Cincinnati, Ohio 45202

AVIATION QUESTIONNAIRE

Name of Proposed Insured Date of Birth

Section I For Pilots, Students and Crew Members:

Hours Flown Total of Solo Hours Flown Total Hours Flown In Past 12 Months: Estimated Hours Flying In Next 12 Months:

Section II

Pilot Certificate Private Student Airline Transportation Rating (ATR) Instrument Flight Rating (IFR) Commercial Flight Instructor

Have you ever been grounded or had your license revoked? Yes No (If Yes, give details in Remarks below.)

Section III

Type of Flying Pleasure Flying Personal Business Crop Dusting Employer Aircraft or Employee Transportation Freight Carrying or Passenger Service Instructor Other (Give details in Remarks below.)

Section IV

(a) Military Branch or Organization
(b) Type Aircraft Date of Last Flight
(c) If not pilot, specify in which you fly

Section V

(a) Have you ever flown or do you intend to fly:
Ultralight, Biplane, Prototype, experimental or personally built or assembled aircraft? Yes No
(b) Have you within the past 12 months, or do you contemplate flying in the Civil Air Patrol? Yes No
(c) Do you contemplate a change from your present flying to commercial or military flying?
(If Yes, give details in Remarks below.) Yes No

Section VI

Should you not qualify for full coverage at standard rates, do you desire:
(a) Full coverage with extra premium, if available? Yes No
(b) Restricted aviation coverage without extra premium, if available? Yes No

Remarks:

The above statements and answers are complete and true to the best of my knowledge and belief and will be the basis for and a part of any policy issued based on them.

Signed at _____
City and State

Signature of Proposed Insured

Date

AVOCATION QUESTIONNAIRE

Name of Proposed Insured: _____ Date of Birth _____ m d y

Section I Auto, Motorcycle, Snowmobile, Motorboat:

Type: midget stock hotrod drag sportscar snowmobile cycle boat other

Racing Vehicle or boat: make & model _____ Class & category _____

Sports Displacement _____ Horsepower _____

Timing 1/2 "of": vehicle vs. vehicle vehicle vs. clock Maximum speed attained _____ mph

Location: oval track closed circuit drag strip hill climb other

Have you ever had a racing accident? Yes No (If "Yes," explain details in Remarks below)

Racing Organizations affiliated with _____

Races supervised by _____

Frequency (Number of Races) Last 12 Months _____ 1 to 2 Years Ago _____ Estimate Next 12 Months _____

Section II

Type: scuba skin snorkel Purpose: recreation rescue salvage

Locations: oceans lakes rivers pools quarries caves other

Underwater Have you received formal diving training? Yes No (If "Yes," give details in Remarks below)

Sports Do you use the "buddy system"? Yes No

Depth.	Average Time	Number of Dives		
		Last 12 Months	1 to 2 Years Ago	Est. Next 12 Months
0-75 ft.	Mins.	_____	_____	_____
75-125 ft.	Mins.	_____	_____	_____
Over 125 ft.	Mins.	_____	_____	_____

Section III Please Identify Which of the Activities You Participate In:

sky diving hang gliding ultralights biplaning parachuting ballooning other _____

Sky If sky diving: Yes No If ballooning: Yes No

Sports Delayed jumping done? Yes No Gas ballooning? Yes No

Any stunting or baton passing? Yes No Hot air ballooning? Yes No

Are you a member of a club? Yes No

What class of license do you hold? _____

Usual location or type of terrain? _____

Have you been in an accident connected with this avocation? Yes No

(If "Yes," give details in Remarks below 1

Number or flights or jumps: Last 12 Mos. _____ 1 to 2 Years ago _____ Est Next 12 Mos. _____

Average height _____ Maximum height _____

Average distance _____ Maximum distance _____

Average duration _____ Maximum duration _____

Remarks or Other Avocations (Include details regarding nature, location, frequency, and degree of participation.)

The above statements and answers are complete and true to the best of my knowledge and belief and will be the basis for and a part of any policy issued based on them.

Signed at _____
City and State

Signature of Proposed Insured

Date _____

PERSONAL HISTORY INTERVIEW TELEPHONE INFORMATION

Insured's Name _____

Telephone number you would like us to call:

Home _____ Business _____
(Area) (Number) (Area) (Number) (Ext.)

The best time for us to call you is: _____ a.m. _____ p.m. Time Zone

(Agent's Name)

(Agency or Office)

PLEASE DETACH HERE AND GIVE THIS PART TO THE PROPOSED INSURED,
PERSONAL HISTORY INTERVIEW NOTICE

As part of your application you have been given and acknowledged receipt of the "Notice of Insurance Information Practices". This "Notice" has informed you of the necessity of information required about you and other persons who may be proposed for insurance. The "Notice" also informed you about the Medical Information Bureau and any investigative consumer report which may be requested.

In order to offer insurance at the lowest possible cost U.S. Financial Life Insurance Company has specially trained employees that may call you to discuss information contained in your application or to ask questions related to the underwriting of your insurance. Whether they call depends upon the amount of insurance applied for. We will attempt to conduct this telephone interview at your convenience and at a number you designate. The information portion of this form contains the data needed to complete such a call. Your cooperation in supplying this information is appreciated and will greatly assist in the prompt underwriting of the insurance applied for.



A Member of THE MONY GROUP

A Stock Insurance Company
10290 Alliance Road
P.O. Box 429560
Cincinnati, OH 45242
www.usfli.com

REQUEST FOR PAYORS' TAXPAYER IDENTIFICATION NUMBER AND CERTIFICATION

Enter your taxpayer identification number in the appropriate box. For most individuals, this is your Social Security Number.

SS#

Tax I.D.#

Certification-Under penalties of perjury, I certify that:

1. The number shown on this form is my correct Taxpayer Identification Number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding either because I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of failure to report all interest or dividends, or the IRS has notified me that I am no longer subject to backup withholding.

Certification Instructions:

You must cross out item (2) above if you have been notified by IRS that you are subject to backup withholding because of underreporting interest or dividends on your tax return. However, if after being notified by IRS that you were subject to backup withholding you received another notification from IRS that you are no longer subject to backup withholding, do not cross out item (2).

Please sign here _____
(Signature of applicant, Trustee/Employer) (Date)

TEMPORARY LIFE INSURANCE AGREEMENT (TIA)

This Agreement provides a Limited Amount of Life Insurance Protection, for a Limited Period of time, subject to the terms of this agreement.

Advance payment in the Amount of \$ _____ in connection with Application # _____ is made for

Life Insurance on _____

Name of Proposed Insured(s)

Has the person(s) listed above as Proposed Insured(s):

- 1. Within the past 90 days, been admitted to a hospital or other medical facility, been advised to be admitted, or had surgery performed or recommended? _____ Yes _____ No
- 2. Within the past 2 years, been treated for heart trouble, chest pain, stroke, or cancer, or had such treatment recommended by a physician or other medical practitioner? _____ Yes _____ No

If either of the above questions is answered YES or LEFT BLANK, no representative of the Company is authorized to accept money; and NO COVERAGE will take effect under the Agreement.

TERMS AND CONDITIONS

AMOUNT OF COVERAGE \$100,000 MAXIMUM FOR ALL APPLICATIONS OR AGREEMENTS

If money has been accepted by the Company as advance payment for an application for Life Insurance and a Proposed Insured dies while this temporary insurance is in effect, the Company will pay to the beneficiary designated in the Application the lesser of (a) the amount of all death benefits applied for in the Application, including any accidental or supplemental death benefits, if applicable, or (b) \$100,000. In no event shall the total benefit payable under this Agreement and under any other Temporary Insurance Agreement with the Company exceed \$100,000 with respect to ALL Proposed Insured(s).

In order for all or any part of any Accidental Death Benefit amount to be included in the Temporary Insurance Agreement Death Benefit for a Proposed Insured, the Accidental Death Benefit Rider must be applied for with respect to such Proposed Insured, and the death of such Proposed Insured must have been such that the Accidental Death Benefit would be payable if the Accidental Death Benefit Rider of the policy applied for were in force.

DATE COVERAGE BEGINS

Temporary Life Insurance under this Agreement will begin on the date of this Agreement but only if Part I and Part II of the Application have been completed on the same date or prior to the date of this Agreement and at least one month's premium for the policy applied for, but not less than \$20.00, is received on the date of this Agreement.

DATE COVERAGE TERMINATES -- 60 DAYS MAXIMUM

Temporary Life Insurance under this Agreement will terminate automatically on the earliest of:

- (a) 60 days from the date of this Agreement, or
- (b) the date that insurance takes effect under the policy applied for, or
- (c) the date a policy, other than as applied for, is offered to the Applicant, or
- (d) the date the Company mails notice of termination of coverage to the premium notice address designated in the Application. The Company may terminate coverage at any time.

SPECIAL LIMITATIONS

- *In no event will a death benefit be paid under both the Agreement and the policy applied for on the application.
- *Fraud or material misrepresentations in the Application or if the answers to the Health questions of this Agreement invalidate this Agreement and the Company's only liability is for refund of any payment made.
- *No one is authorized to accept money on Proposed Insureds under 15 days of age or over age 70 (nearest birthday) on the date of this Agreement, nor will any coverage take effect.
- *If the Proposed Insured dies by suicide, the Company's liability under this Agreement is limited to a refund of the payment made.
- *There is no coverage under this Agreement if the check or draft submitted as payment is not honored by the bank.
- *No one is authorized to waive or modify any of the provisions of this Agreement.

I (WE) HAVE RECEIVED A COPY OF AND HAVE READ THIS AGREEMENT AND DECLARE THAT THE ANSWERS ARE TRUE TO THE BEST OF MY (OUR) KNOWLEDGE AND BELIEF. I (WE) UNDERSTAND AND AGREE TO ALL ITS TERMS.

Date of this Agreement is _____ 19 _____

Applicant (if other than proposed insured)

Signature of Proposed Insured
(If below age 15, parent or guardian must sign)

Signature of Agent

Signature of Additional Proposed Insured

NOTICE: ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE INSURANCE COMPANY-DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK. The Applicant should retain a copy of this Agreement; the original will be retained by the Company. If you do not hear from the Company regarding the insurance applied for within 70 days from the date of this Agreement, notify the Company at 201 East Fourth Street, P.O. Box 2347, Cincinnati, Ohio 45201.

AGENT: Do Not Separate FORM MUST BE COMPLETED IN FULL AND ACCOMPANIED BY A PERSONAL CHECK MARKED "VOID".

AUTHORIZATION TO U.S. FINANCIAL LIFE INSURANCE COMPANY TO INITIATE DEBIT ENTRIES ON BANK ACCOUNT

For the purpose of paying premiums on insurance on the life of

issued under Application No. _____ or, in force under Policy No. _____

I hereby authorize U.S. Financial Life Insurance Company to initiate debit entries, whether by electronic or paper means, on my account at the _____ Bank No. _____

(Bank)

_____ (Address or Branch)

_____ (City)

_____ (State)

_____ (Zip)

Such authorization to be revocable only upon receipt by U.S. Financial Life Insurance Company of a written revocation.

I agree that the intitiation of such debit entries to such bank shall constitute due notice of premiums being due upon the policy.

My Debit Date is the same as the Policy Date unless indicated below

Date _____, 19 _____

Other Date _____

_____ (Signature)

AUTHORIZATION TO MY BANK TO HONOR DEBIT ENTRIES ON BANK ACCOUNT

As a convenience to me, I hereby request and authorize you to honor debit entries, whether by electronic or paper means, with said debits made to my account and drawn by U. S. Financial Life Insurance Company, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to such debit shall be the same as if it were a check drawn on you and signed personally by me. I hereby agree that if any debit is not paid by you for any reason, with or without cause or whether such nonpayment is intentional, inadvertent or otherwise, you shall be under no liability whatsoever, even though such nonpayment results in the forfeiture of insurance. This authorization is to remain in full force and effect until revoked by me upon 30 days written notice, and until you actually receive such notice I agree that you shall be fully protected in honoring any such debit to my account.

Date _____

Signature _____

(As it appears on bank records)

