WILLIAM PENN LIFE INSURANCE COMPANY OF NEW YORK
A Legal & General America Company
3275 Bennett Creek Avenue
Frederick, Maryland 21704
(800) 346-4773

LIFE INSURANCE APPLICATION

INSTRUCTIONS

As the Agent, you are responsible for completing the necessary forms required to process and underwrite this application. All forms must be completed in full and must be legible. Please follow these instructions carefully.

DO

- Print application in black ink.
- Verify identification of Proposed Insured.
- Obtain all of the necessary signatures.
- Give the Notice to Proposed Insured to your client.
- Have the Proposed Insured/Owner initial all changes. The Proposed Insured must initial all changes to questions involving insurability. Change an answer by putting a line through the incorrect answer and inserting the correct information.
- Complete Part 2, Medical History, if the Proposed Insured is to be considered without paramedical exam, if an exam on another company's form is being used or if an abbreviated exam will be done.
- Complete section K, Part 1 on all business cases and if required on non-business cases.
- Complete and obtain signature on Consent for HIV Testing Form for each Proposed Insured.
- If you accept payment with the application:
  - Complete the Temporary Insurance Application section of the Temporary Insurance Application and Agreement (TIAA), making sure that all questions are answered. If any are answered Yes, do not accept money.
  - Remit an amount equal to the first modal premium.
  - Explain the terms and conditions of the TIAA to the Owner and Proposed Insured and have them sign it.
  - Complete and sign the Licensed Insurance Agent's Statement on the TIAA.
  - Send the TIAA with the application, give the Owner a copy.
  - All checks collected must be made payable to William Penn Life Insurance Company of New York.
- If applicable, complete and obtain signature(s) on the Payment Options form.
- Complete and sign the Agent's Report on page 11. Please be sure to enter all agent information and your William Penn agent number.

DO NOT

- Do not accept money on applications now applied for or pending with William Penn Life Insurance Company of New York totaling over $1,000,000.
- Do not accept any payment if any question on the Temporary Insurance Application and Agreement is answered Yes or left blank.
- Do not accept cash or cash equivalents (money order, cashiers check) or "starter" checks.
- Do not accept money if the Proposed Insured is over age nearest 70.
- Do not use pencil or correction fluid.

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NOTICE TO PROPOSED INSURED

(Please give to the Proposed Insured)

Thank you for applying to William Penn Life Insurance Company of New York. The soliciting insurance broker (broker) should be able to answer any questions you may have. This broker is an independent broker, not an employee of William Penn Life Insurance Company of New York, and is not authorized to make or modify contracts or to waive any requirements or any information that we may request.

Underwriting

Once we receive your application, we will begin an evaluation process called underwriting to determine whether you are eligible for insurance and, if so, the rate you should pay for that insurance. We may find that we are unable to give you the insurance you have applied for or that we are able to give it to you only on a modified basis or at a rate greater than our lowest rate.

Your application will be our primary source of information; therefore, it must be true, complete and accurate. You must inform us of a change to any answer in any part of your application before accepting delivery of a policy; in fact, you agree to do so when you sign your application. We may seek information from other sources to help us evaluate the information you give us on your application.

Contestability

We strongly urge you to review the completed application closely for accuracy. A claim may be denied, the policy may be void or your coverage may be lost if the application is incomplete or if it contains false statements or material misrepresentations. Any policy that may be issued will indicate when and under what circumstances it may be contested. You must inform us of a change to any answer in any part of your application before accepting delivery of a policy; in fact, you agree to do so when you sign your application.

Replacement of Existing Coverage

If you intend to replace existing coverage, tell the broker of your intention and answer "Yes" to the replacement question in the application. State law may require the broker to give you information that will help you compare the policy you are applying for with the policy you intend to replace. If you are undecided about keeping existing coverage, indicating an intention to replace existing coverage may help you get the information you need to make a decision. If you do replace existing coverage, the new policy may contain new suicide and contestable periods. The following would be considered replacement: you stop paying premiums on an existing policy or surrender an existing policy before or shortly after applying to us or you borrow from an existing policy to pay premiums for the insurance for which you are applying. State law may define replacement to include other situations. Ask the broker if you are unsure.

Insurance Information Practices

We will rely primarily on information provided by you. We may supplement that information with information from other sources such as medical professionals who have treated you. In some cases, we may ask a consumer reporting agency to collect information and submit an investigative consumer report to us as explained in this Notice under Federal Fair Credit Reporting Notice. You may request to be interviewed in connection with the preparation of this report.

In certain limited situations, we are allowed by law to disclose necessary items of personal information to third parties without your specific authorization.

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

We will send you a more detailed explanation of our information practices if you send us a written request. You may send your request to the Director of Underwriting, William Penn Life Insurance Company of New York, 3275 Bennett Creek Avenue, Frederick, Maryland 21704.

Federal Fair Credit Reporting Notice

As part of our underwriting, we may ask that an investigative consumer report be prepared. An independent source known as a consumer reporting agency will prepare the report. The report will typically include information as to your character, general reputation, mode of living, and personal characteristics. The agency may conduct personal interviews with your family, friends, neighbors, business associates, financial sources or others with whom you are acquainted in order to get this information. If you write to us, we will tell you whether or not a report was requested. If a report was requested, we will tell you the name, address and telephone number of the agency to whom the request was made. Upon request, the agency will furnish information as to the nature and scope of its investigation. If you would like to inspect and to receive a copy of the report, you may do so by contacting the agency directly.

Continued on next page

NOTICE TO PROPOSED INSURED

(Please give to the Proposed Insured)

MIB (Medical Information Bureau) Pre-Notice Disclosure

Information regarding your insurability will be treated as confidential. William Penn Life Insurance Company of New York 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 each 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 (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.

William Penn Life Insurance Company of New York, or its reinsurers, may also release information from 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.

Continued from prior page

PART 1
(Please Print)

WILLIAM PENN LIFE INSURANCE COMPANY OF NEW YORK
A Legal & General America Company
3275 Bennett Creek Avenue
Frederick, Maryland 21704
(800) 346-4773

Policy # _____

SECTION A PROPOSED INSURED

1. Full Name (Include maiden name in parentheses)	2. Sex ☐ M ☐ F	3. Date of Birth Month / Day / Year	4. Social Security Number

5. a. Home Address	5. b. How Long
Street _____ City, State _____ Zip _____	

6. Phone Numbers	7. State/Country of Birth	8. U.S. Citizen ☐ Yes ☐ No Visa Type _____
Home ( )		If No, Date of Entry into U.S. _____
Work ( )		Country of Citizenship _____

9. Marital Status ☐ M ☐ S ☐ W ☐ D	10. Driver's License Number and State of Issue or State ID Number

11. Occupation (Include duties)	12. Annual Income	13. Total Net Worth

14. a. Employer's Name and Address and Nature of Business	14. b. How Long Employed

15. Have you ever used tobacco or nicotine products in any form? ☐ Yes - give details below ☐ No

Product	Date last used (month/year)	Amount / Frequency
Cigarettes		
Cigars		
Other		

SECTION B BENEFICIARY (Share percentage totals must equal 100%. If necessary, use Remarks section, Question 48. If Beneficiary is a trust, check box ☐ and complete Section D.)

16. Primary

Name _____ Relationship _____ % Share _____
SSN _____ Date of Birth _____
Name _____ Relationship _____ % Share _____
SSN _____ Date of Birth _____

17. Contingent

Name _____ Relationship _____ % Share _____
SSN _____ Date of Birth _____
Name _____ Relationship _____ % Share _____
SSN _____ Date of Birth _____

SECTION C OWNER

18. Owner is ☐ Proposed Insured ☐ Trust (also complete Section D) ☐ Other than Proposed Insured or Trust

Complete if the Proposed Insured is not the Owner. (If contingent Owner is required, use Remarks section, Question 48).

Name _____ SSN or Tax ID # _____ Date of Birth _____
Address _____ City, State _____ Zip _____
Contact Phone # _____ Relationship to Proposed Insured _____
If Owner is a business, web site address _____ Email address _____

SECTION D TRUST INFORMATION (If trust is Beneficiary and/or Owner).

19. Exact Name of Trust _____ Trust Tax ID# _____
Current Trustee(s) _____ Date of Trust _____

PART 1 (continued)

SECTION E PAYOR

20. Send premium notices to: ☐ Insured ☐ Owner ☐ Other - If Other, complete the information below

Name _____ Relationship to Insured/Owners _____

Address _____
Street City State Zip

Contact Phone # _____ Email address _____

SECTION F INSURANCE APPLIED FOR

21. Amount of Insurance $ _____ 22. Plan of Insurance _____

23. Death Benefit Option (if available with Plan): ☐ Level Death Benefit ☐ Increasing Death Benefit

24. Payment method: ☐ Direct Bill ☐ Electronic Funds Transfer (EFT)

25. Frequency of premium payment: ☐ Single ☐ Annual ☐ Semi-annual ☐ Quarterly ☐ Monthly (EFT only)

26. Planned periodic premium for universal life product: (Provide details in Remarks section, Question 48.)

a. ☐ 1st Year Only $_____ 2nd Year and Thereafter $_____ b. ☐ Premium For All Years $ _____

27. Will the premiums for this policy be loaned or otherwise financed by an individual(s) or entity other than the Proposed Insured or immediate family members of the Proposed Insured? ☐ Yes ☐ No

If Yes, please identify all parties involved and provide copies of all financing agreements or promissory notes and all related side agreements and schedules. (Provide details in Remarks section, Question 48.)

28. a. Date to Save Age? ☐ Yes ☐ No b. Specific Policy Date? ☐ Yes ☐ No Date _____

Additional Benefits (if available)

29. ☐ Waiver of Premium ☐ Other (description and amount) _____

SECTION G OTHER INSURANCE

30. a. **Excluding** this application, amount of insurance **currently pending** with other companies. If NONE state NONE. $ _____

b. Of the above pending amount in 30.a., how much do you intend to accept? $ _____

c. Provide information for each policy in force (except group insurance). (If necessary, use Remarks section, Question 48.) If NONE state NONE.

Company	Policy Number	Face Amount	Business? Yes	Business? No	Issue Date	Replacing? Yes	Replacing? No	Beneficiary
			☐	☐		☐	☐	
			☐	☐		☐	☐	
			☐	☐		☐	☐	
			☐	☐		☐	☐	
			☐	☐		☐	☐	

	Yes	No
31. Have you ever had an application for life or health insurance declined, postponed, modified, rated or offered with a reduced face amount? (If Yes, provide details in Remarks section, Question 48.)	☐	☐
32. Will you, or are you likely to, replace, end, or change existing insurance or annuity with any company or society with the insurance for which you are applying? (If Yes, the broker may be required to provide additional forms for your review and signature.)	☐	☐
33. Are there any plans to sell or permanently assign the policy to another person or entity, life settlement provider or an investor, or will it replace a policy that has already been sold to another life settlement company or investor? (If Yes, provide details in Remarks section, Question 48.)	☐	☐

PART 1 (continued)

SECTION H GENERAL QUESTIONS (Explain all Yes answers in Remarks section, Question 48.)

	Yes	No
34. Has any person promised or agreed to give or have they given to any party to the application, any inducement, fee or compensation as an incentive to purchase the policy?	☐	☐
35. Has any party to the application ever sold, transferred or assigned any life insurance policy to a third party, such as a viatical settlement entity, life settlement entity, insurance company, other secondary market provider, or premium financing entity?	☐	☐
36. Has any party to the application ever received inducement, fee or compensation as an incentive to purchase, sell, transfer or assign a policy?	☐	☐
37. In the past 5 years, have you requested or received a Worker's Compensation, Social Security, or disability income payment?	☐	☐
38. Have you ever been convicted of, or are you currently charged with, a felony or misdemeanor, or are you currently on parole or probation?	☐	☐
39. In the past 5 years, has your driver's license been suspended or revoked, or have you been convicted of 2 or more moving violations or accidents?	☐	☐
40. In the past 5 years, have you been convicted of, or plead guilty or no contest to, driving while impaired, intoxicated, or under the influence of alcohol or drugs? (If Yes, complete Alcohol/Drug Usage Questionnaire.)	☐	☐
41. Are you a member, or do you intend to become a member, of the armed forces, including the reserves?	☐	☐

SECTION I OTHER ACTIVITIES

	Yes	No
42. Do you hold a current pilot license, or have you in the past 5 years flown, or within the next 2 years do you intend to fly, other than as a passenger in any type of aircraft? (If Yes, complete Aviation Questionnaire.)	☐	☐
43. Have you in the past 2 years engaged in, or within the next 2 years do you intend to engage in, certain activities such as hang gliding, hot-air ballooning, ultra-light flying, heli-skiing, mountain, ice or rock climbing, cliff or base jumping, motor vehicle racing, motorcycle or any other motorized land or water vehicle racing, or scuba or sky diving? (If Yes, complete appropriate questionnaire.)	☐	☐
44. Do you intend to travel outside the U.S. or Canada, or change your country of residence in the next 12 months? (If Yes, list countries, cities, duration and purpose of travel in Remarks section, Question 48.)	☐	☐

SECTION J PROPOSED INSURED FINANCIAL INFORMATION

Complete this section when applying for face amount over $1,000,000 or when the Proposed Insured is over age 65:

45. a. What is the purpose of this insurance? (e.g. income replacement, buy-sell, keyperson, estate conservation)

_____

b. How was the need for the face amount determined? _____

	Yes	No
c. In the last 5 years, has the Proposed Insured filed for bankruptcy or had any charge off of bad debts?	☐	☐

If Yes, type of bankruptcy and discharge date or charge off date. _____

46. a. Gross annual earned income (salary, bonuses, etc. from W-2 forms) $ _____

b. Gross annual unearned income (dividends, interest, rental income, etc.) $ _____

	Yes	No
c. Is the Proposed Insured self-supporting?	☐	☐

If No, how much insurance is in-force on the life of the person providing the support? $ _____

What is that person's relationship to the Proposed Insured? _____

PART 1 (continued)

SECTION K BUSINESS FINANCIAL INFORMATION

Complete this section when applying for face amount over $1,000,000 and if Beneficiary or Owner is a business:

	Current YTD	Previous Year
47. a. Assets	$	$
b. Liabilities	$	$
c. Gross Sales	$	$
d. Net Income after Taxes	$	$
e. Fair Market Value of the business	$	$

f. How long has the business been established? _____

g. What percentage of the business does the Proposed Insured own? _____

	Yes	No
h. Are other partners/owners/executives being insured? (If Yes, use Remarks section, Question 48.)	☐	☐
i. In the last 5 years, has the business filed for bankruptcy or had any charge off of bad debts?	☐	☐

If Yes, type of bankruptcy and discharge date or charge off date. _____

j. Company web site address, if available _____

48. Remarks: Explanations and/or special requests. Use Part 1 Supplement to Application if necessary.

IN CONNECTION WITH THIS APPLICATION FOR INSURANCE, IT IS UNDERSTOOD AND AGREED THAT:

The statements contained here and in Part 2 of this application and any supplements thereto, copies of which shall be attached to and made a part of any policy to be issued, are true and correct and made to induce William Penn Life Insurance Company of New York (the Company) to issue an insurance policy. I agree to notify the Company of any changes to the statements and answers given in any part of the application before accepting delivery of any policy.

No agent or other person has power to: (a) make or modify contracts; (b) waive any Company rights or requirements; (c) waive any information the Company requests; (d) discharge any contract of insurance; or (e) bind the Company by making promises respecting benefits upon any policy to be issued.

For indeterminate premium policies: (a) the premium for the policy applied for may change after the initial guarantee period and (b) the premium then charged is not guaranteed and the Company may charge the full maximum guaranteed premium.

I agree that: **(1) I will notify the Insurer if any statement or answer given in any part of the application changes prior to policy delivery; and (2) except as provided in the Temporary Insurance Application and Agreement, if any, insurance will not begin unless all persons proposed for insurance are living and insurable as set forth in the application at the time a policy is delivered to the Owner and the first modal premium is paid.**

Changes or corrections made by the Company and noted in Part 1, Question 48 above are ratified by the Owner upon acceptance of a contract containing this application with the noted changes or corrections. In those states where written consent is required by statute or State Insurance Department regulation for amendments as to plan, amount, classification, age at issue or benefits, such changes will be made only with the Owner's written consent.

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I hereby authorize any physician, medical professional, hospital, clinic or medical care facility; pharmacy benefit manager, prescription database; any insurance or reinsurance company; any consumer reporting agency or insurance support organization; my employer; or the Medical Information Bureau (MIB), to provide the Company and its legal representatives or affiliated insurers, all information they have pertaining to: medical consultations; treatments; hospitalizations for physical and/or mental conditions, use of drugs or alcohol; drug prescriptions; or any other information pertaining to me. This information does not apply to records protected under 42 USC 290dd-2. Other information could include items such as: other insurance information; personal finances; habits; hazardous avocations; motor vehicle records; court records or foreign travel, etc.

I understand that the information obtained will be used by the Company to determine my eligibility for insurance. I authorize that any information gathered during the evaluation of my application may be disclosed to: reinsurers; the MIB; other persons or organizations performing business or legal services in connection with my application or claim; any physician designated by me; or any person or entity required to receive such information by law or as I may further consent.

I understand that this consent may be revoked at any time by sending a written request to the Director of Underwriting, William Penn Life Insurance Company of New York, 3275 Bennett Creek Avenue, Frederick, Maryland 21704.

The consent will be valid for 24 months from the date of this application. I agree that a copy of this consent will be as valid as the original. I authorize the Company to obtain an investigative consumer report on me. I understand that I may request to be interviewed for the report and receive, upon written request, a copy of such report.

If an investigative consumer report is prepared, I elect to be interviewed: ☐ Yes ☐ No

DECLARATION

I/we have carefully read the Temporary Insurance Application and Agreement (TIAA) and understand and agree to the terms thereof including the conditions under which a limited amount of insurance may become effective prior to policy delivery. I/we understand that all premium checks are to be made payable to **William Penn Life Insurance Company of New York** (payee should not be left blank); checks are not to be made payable to the agent, agency or other third party. I/we have received the Notice to Proposed Insured, which includes the Medical Information Bureau Pre-Notice Disclosure and the Federal Fair Credit Reporting Notice.

_____ Signed at_____ on _____/_____/_____
Signature of Proposed Insured City/State

_____ Signed at_____ on _____/_____/_____
Signature of Owner (if other than Proposed Insured) City/State
If Owner is a firm or corporation, include officers' title with signature

_____
Print Owner/Officer Name and Title (if applicable)

_____ Signed at_____ on _____/_____/_____
Signature of Licensed Insurance Agent City/State

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PART 2
Medical History

1. Name of Proposed Insured _____ Date of Birth _____

2. Height _____ft. _____in. 3. Weight _____ lbs.

If your weight has changed by over 10 lbs. in the last year, indicate amount and reason _____

_____

PHYSICIAN INFORMATION

4. **Primary Physician**

Name _____

Address _____

Telephone _____ Date last seen _____

Reason last seen and results of visit _____

5. **Physician Last Consulted**

Name _____ Specialty _____

Address _____

Telephone _____ Date last seen _____

Reason last seen and results of visit _____

	Yes	No
6. Has a parent or sibling ever been diagnosed or treated by a member of the medical profession for heart or kidney disease, stroke, diabetes, cancer, melanoma, suicide, Huntington's Disease, Sickle Cell Disease or Familial Adenomatous Polyposis (FAP)? If Yes, give details in the Family History chart below.	☐	☐

Family History: Include the age at onset/event for each medical condition.

	Medical Conditions	Age at Onset/Event	Age if Living	Cause of Death	Age at Death
Father					
Mother					
Brothers					
Sisters					

MEDICAL HISTORY - Provide details to Yes answers in the Remarks section. Include provider, date, symptoms, diagnosis and treatment. An additional sheet of paper may be attached if necessary.	Yes	No	**Remarks - Explain All Yes Answers** Enter question number before detailed response.
Questions 7-22, have you ever consulted a member of the medical profession regarding or have you been diagnosed or treated for:			
7. High blood pressure, high cholesterol, abnormal electrocardiogram, chest pain, irregular heart rhythm, palpitations, heart murmur, heart attack, angina, phlebitis, peripheral vascular disease, or any other disease or disorder of the heart or blood vessels?	☐	☐	
8. Hepatitis, ulcer, internal bleeding, colitis, acid reflux, GERD, or any other disease or disorder of the stomach, gall bladder, esophagus, liver, pancreas, spleen, intestines, colon, or rectum?	☐	☐	
9. A disorder of your blood or immune system including anemia, blood clots, bleeding, immune deficiency, leukemia, or lymphoma (excluding HIV)?	☐	☐	

PART 2 - Medical History (continued)

Name of Proposed Insured _____	Yes	No	Remarks - Explain All Yes Answers
10. Cancer, tumor, melanoma, or any other malignant disorder?	☐	☐	
11. Diabetes or high blood sugar or any other disease or disorder of the pituitary, thyroid, or endocrine glands?	☐	☐	
12. Albumin, protein, blood or sugar in the urine or any other disease or disorder of the kidney or bladder?	☐	☐	
13. Cyst, polyp, lump, or other growth, or any disease or disorder of the skin or lymph nodes?	☐	☐	
14. Any disease or disorder of the uterus, cervix, ovaries, or breasts?	☐	☐	
15. Any disease or disorder of the prostate or reproductive system?	☐	☐	
16. Any sexually transmitted disorders or diseases?	☐	☐	
17. Pregnancy, complications of pregnancy or infertility? If now pregnant, what is the expected date of delivery? _____	☐	☐	
18. Asthma, shortness of breath, chronic cough or hoarseness, bronchitis, emphysema, COPD (chronic obstructive pulmonary disease), sarcoidosis, pneumonia, TB (tuberculosis), sleep apnea, or any other disorder of the respiratory system?	☐	☐	
19. A disorder of the brain, spinal cord, or nervous system including chronic headaches, convulsions or loss of consciousness, seizures, tremors, paralysis, fainting, stroke, MS (multiple sclerosis), or TIA (transient ischemic attack)?	☐	☐	
20. Depression, anxiety, psychosis, suicidal thoughts or attempts of suicide, anorexia or bulimia, obsessive compulsive disorder, bipolar disorder, or other mental, nervous or emotional disorder?	☐	☐	
21. Arthritis or disorder of the bones, skin or muscles?	☐	☐	
22. Any disease or disorder of the eyes, ears, nose or throat?	☐	☐	
23. In the **last 5 years,** unless previously stated on this application, have you:			
a. Been treated by a member of the medical profession or at a medical facility?	☐	☐	
b. Had an electrocardiogram, x-ray, blood test, or other diagnostic test, excluding an HIV test?	☐	☐	
c. Had surgery or biopsy, or been an inpatient or outpatient in a hospital, clinic, or other medical or mental health facility?	☐	☐	
d. Been advised by a member of the medical profession to have surgery, medical treatment, biopsy, or diagnostic testing, excluding HIV testing, that has not yet been completed?	☐	☐	
e. Been referred to any other member of the medical profession or medical facility?	☐	☐	
f. Been unable to work, attend school or perform the normal activities of like age and gender, or been confined at home?	☐	☐	
24. a. Have you ever used amphetamines, barbiturates, cocaine, heroin, crack, marijuana, LSD, PCP, or other illegal, restricted or controlled substances, except as prescribed by a licensed physician?	☐	☐	
If Yes, please provide dates of use: From_____ To _____			
Name of drug used: _____			
Amount and frequency of use: _____			

PART 2 - Medical History (continued)

Name of Proposed Insured _____	Yes	No	Remarks - Explain All Yes Answers
24 b. Have you ever been addicted to prescription medication or been advised by a physician to discontinue using habit forming drugs?..... If Yes, provide dates of use, type and frequency.	☐	☐	
25. Have you ever:			
a. Consumed alcoholic beverages?..... If Yes, give type and number of drinks per day and/or per week. Date of last consumption: _____	☐	☐	
b. Been advised by a physician or other licensed medical practitioner to limit or cease the use of alcoholic beverages?	☐	☐	
c. Been counseled, sought help or treatment, or been advised by a physician or other licensed medical practitioner to undergo counseling or treatment for alcohol problems?.....	☐	☐	
d. Attended or joined any organization due to alcohol or related problems?	☐	☐	
26. Are you currently:			
a. Taking or have you been advised to take any prescribed medication (other than contraceptives)?.....	☐	☐	
b. Taking any herbal or non-prescription medication at least weekly?..... If Yes, give details. _____	☐	☐	
27. Have you taken any other medications in the **past 2 years**?..... If Yes, list in Remarks section at right.	☐	☐	
28. Has any person proposed for insurance been diagnosed by or received treatment from a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?.....	☐	☐	
29. In the past 5 years, have you been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for any disease or disorder not previously stated on this application? ..... If Yes, give details. _____	☐	☐	

30. Additional remarks (please indicate which question number remarks reference)

I have read the answers as written before signing, the answers are true and complete to the best of my knowledge and belief, and there are no exceptions to any answers other than written on this document.

_____ Signed at _____ on ____/____/_____

Signature of Proposed Insured | City/State | Date

WILLIAM PENN LIFE INSURANCE COMPANY OF NEW YORK
A Legal & General America Company
3275 Bennett Creek Avenue
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(800) 346-4773

TEMPORARY INSURANCE APPLICATION AND AGREEMENT (TIAA)

Name of Proposed Insured _____ Date of Birth _____

Notice to Proposed Insured and Owner. Payment of the Amount Remitted may only be made at the same time that both the Application - Part 1 and this TIAA are completed. If the Insurer does not respond to you within 90 days, notify the Insurer at the above address. **Make the Amount Remitted payable to William Penn Life Insurance Company of New York. Do not make it payable to the licensed insurance agent or leave the payee blank. We do not accept cash or cash equivalents (money orders, cashiers checks) or "starter" checks.**

TEMPORARY INSURANCE APPLICATION (Answer all questions.)

Insurer The Insurer is William Penn Life Insurance Company of New York.

Temporary insurance cannot begin and you should make no payment if any question below is answered "Yes" or left blank.

	Yes	No
1. Is the Proposed Insured less than 15 days old or more than 70 years old (age nearest birthday) on the date of this TIAA?.....	☐	☐
2. Does the total amount of insurance on the Proposed Insured's life now applied for or pending with William Penn Life Insurance Company of New York exceed $1,000,000?	☐	☐
3. In the past 90 days, has the Proposed Insured been admitted, or medically advised by a member of the medical profession to be admitted, to a hospital or other licensed health care facility, had surgery performed or recommended, or been medically advised to have any diagnostic test (excluding an AIDS-related test) that was not completed?.....	☐	☐
4. In the past 5 years, has the Proposed Insured been diagnosed, treated for, or been advised by a member of the medical profession to be treated for: heart disease; stroke; cancer; alcohol or drug dependence or abuse; or insulin dependent diabetes?...	☐	☐

THIS AGREEMENT PROVIDES A LIMITED AMOUNT OF LIFE INSURANCE COVERAGE FOR A LIMITED AMOUNT OF TIME, SUBJECT TO THE TERMS AND CONDITIONS SET FORTH BELOW.

TEMPORARY INSURANCE AGREEMENT

Agreement. Subject to the terms of the policy applied for and this TIAA, the Insurer agrees to pay the Limited Amount to the beneficiaries listed in the Application - Part 1 upon receipt of due proof that the Proposed Insured died, except due to suicide, and provided all eligibility requirements and conditions for coverage under this Agreement have been met. The consideration for temporary insurance is the Temporary Insurance Application and payment of an amount equal to the first modal premium for the plan applied for or completion of the payment options form.

Limited Amount. The Limited Amount is the lesser of: (1) the amount of insurance applied for in the Application or (2) $1,000,000 minus the amount of insurance on the Proposed Insured's life with the Insurer under any other applications for insurance now pending or other temporary insurance agreements.

Start Date. Temporary insurance equal to the Limited Amount will begin on the Start Date subject to the terms of this TIAA. The Start Date is the Date of this TIAA.

Stop Date. Temporary insurance automatically ends on the **earliest** of the following: (1) the date the Owner withdraws the application for insurance or refuses to accept any policy issued or offered; (2) the date the Insurer mails or otherwise provides notice to the Owner or his/her agent that it was unable to approve the requested coverage at the premium amount quoted and a counter offer is made by the Insurer; (3) the date the Insurer mails or otherwise provides notice to the Owner or his/her representative that it has declined or cancelled the application; (4) the date the Insurer mails or otherwise provides a premium refund to the Owner or his/her representative; (5) the date the policy is delivered to the Owner and delivery requirements have been completed.

Policy Date. The policy date of any policy issued will be the Start Date unless the policy is backdated at the Owner's request. The prepayment for this temporary insurance will be applied to the first premium due if the policy is issued.

Other Limitations. The Insurer's liability will be limited to a return of the Amount Remitted if: (1) any part of the life insurance application or this TIAA contains a misrepresentation material to the Insurer; or (2) the Proposed Insured dies by suicide.

TEMPORARY INSURANCE APPLICATION AND AGREEMENT (TIAA)
(continued)

I represent that: (1) I have read and received a copy of this TIAA and agree to all of its terms and conditions; (2) I understand and agree that temporary insurance will not begin if any question in this TIAA is answered Yes or left blank and any collection of premium will not activate coverage under this agreement; (3) the answers given in this TIAA are true and correct, and I understand that, if they are false, temporary insurance may be denied or declined; (4) I understand that completing this TIAA does not guarantee that the Insurer will issue a policy on the Proposed Insured's life; (5) I understand that the licensed insurance agent is not authorized to change or waive the terms of this TIAA or to collect premium if the Proposed Insured is ineligible for coverage under this Agreement; and (6) I understand that any premium submitted with this TIAA will be refunded if the Insurer does not approve the requested coverage.

_____	_____	_____
Signature of Proposed Insured	Date of this TIAA	Signature of Owner (if other than Proposed Insured)

LICENSED INSURANCE AGENT'S STATEMENT

Amount Remitted $ _____ Person from Whom Received _____

On the Date of this TIAA, I received the Amount Remitted in exchange for this TIAA. The TIAA bears the same date as the Application - Part 1. I agree that I am not authorized to change or waive the terms of this TIAA and represent that I have not attempted to do so. I have read and explained the terms of this TIAA to the Proposed Insured and Owner. I have left a copy with the Owner.

_____	_____
Signature of Licensed Insurance Agent	Licensed Insurance Agent Number

WILLIAM PENN LIFE INSURANCE COMPANY OF NEW YORK
A Legal & General America Company
3275 Bennett Creek Avenue
Frederick, Maryland 21704
(800) 346-4773

TEMPORARY INSURANCE APPLICATION AND AGREEMENT (TIAA)

Name of Proposed Insured _____ Date of Birth _____

Notice to Proposed Insured and Owner. Payment of the Amount Remitted may only be made at the same time that both the Application - Part 1 and this TIAA are completed. If the Insurer does not respond to you within 90 days, notify the Insurer at the above address. **Make the Amount Remitted payable to William Penn Life Insurance Company of New York. Do not make it payable to the licensed insurance agent or leave the payee blank. We do not accept cash or cash equivalents (money orders, cashiers checks) or "starter" checks.**

TEMPORARY INSURANCE APPLICATION (Answer all questions.)

Insurer The Insurer is William Penn Life Insurance Company of New York.

Temporary insurance cannot begin and you should make no payment if any question below is answered "Yes" or left blank.

	Yes	No
1. Is the Proposed Insured less than 15 days old or more than 70 years old (age nearest birthday) on the date of this TIAA?.....	☐	☐
2. Does the total amount of insurance on the Proposed Insured's life now applied for or pending with William Penn Life Insurance Company of New York exceed $1,000,000?	☐	☐
3. In the past 90 days, has the Proposed Insured been admitted, or medically advised by a member of the medical profession to be admitted, to a hospital or other licensed health care facility, had surgery performed or recommended, or been medically advised to have any diagnostic test (excluding an AIDS-related test) that was not completed?.....	☐	☐
4. In the past 5 years, has the Proposed Insured been diagnosed, treated for, or been advised by a member of the medical profession to be treated for: heart disease; stroke; cancer; alcohol or drug dependence or abuse; or insulin dependent diabetes?...	☐	☐

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TEMPORARY INSURANCE AGREEMENT

Agreement. Subject to the terms of the policy applied for and this TIAA, the Insurer agrees to pay the Limited Amount to the beneficiaries listed in the Application - Part 1 upon receipt of due proof that the Proposed Insured died, except due to suicide, and provided all eligibility requirements and conditions for coverage under this Agreement have been met. The consideration for temporary insurance is the Temporary Insurance Application and payment of an amount equal to the first modal premium for the plan applied for or completion of the payment options form.

Limited Amount. The Limited Amount is the lesser of: (1) the amount of insurance applied for in the Application or (2) $1,000,000 minus the amount of insurance on the Proposed Insured's life with the Insurer under any other applications for insurance now pending or other temporary insurance agreements.

Start Date. Temporary insurance equal to the Limited Amount will begin on the Start Date subject to the terms of this TIAA. The Start Date is the Date of this TIAA.

Stop Date. Temporary insurance automatically ends on the **earliest** of the following: (1) the date the Owner withdraws the application for insurance or refuses to accept any policy issued or offered; (2) the date the Insurer mails or otherwise provides notice to the Owner or his/her agent that it was unable to approve the requested coverage at the premium amount quoted and a counter offer is made by the Insurer; (3) the date the Insurer mails or otherwise provides notice to the Owner or his/her representative that it has declined or cancelled the application; (4) the date the Insurer mails or otherwise provides a premium refund to the Owner or his/her representative; (5) the date the policy is delivered to the Owner and delivery requirements have been completed.

Policy Date. The policy date of any policy issued will be the Start Date unless the policy is backdated at the Owner's request. The prepayment for this temporary insurance will be applied to the first premium due if the policy is issued.

Other Limitations. The Insurer's liability will be limited to a return of the Amount Remitted if: (1) any part of the life insurance application or this TIAA contains a misrepresentation material to the Insurer; or (2) the Proposed Insured dies by suicide.

TEMPORARY INSURANCE APPLICATION AND AGREEMENT (TIAA)
(continued)

I represent that: (1) I have read and received a copy of this TIAA and agree to all of its terms and conditions; (2) I understand and agree that temporary insurance will not begin if any question in this TIAA is answered Yes or left blank and any collection of premium will not activate coverage under this agreement; (3) the answers given in this TIAA are true and correct, and I understand that, if they are false, temporary insurance may be denied or declined; (4) I understand that completing this TIAA does not guarantee that the Insurer will issue a policy on the Proposed Insured's life; (5) I understand that the licensed insurance agent is not authorized to change or waive the terms of this TIAA or to collect premium if the Proposed Insured is ineligible for coverage under this Agreement; and (6) I understand that any premium submitted with this TIAA will be refunded if the Insurer does not approve the requested coverage.

_____	_____	_____
Signature of Proposed Insured	Date of this TIAA	Signature of Owner (if other than Proposed Insured)

LICENSED INSURANCE AGENT'S STATEMENT

Amount Remitted $ _____ Person from Whom Received _____

On the Date of this TIAA, I received the Amount Remitted in exchange for this TIAA. The TIAA bears the same date as the Application - Part 1. I agree that I am not authorized to change or waive the terms of this TIAA and represent that I have not attempted to do so. I have read and explained the terms of this TIAA to the Proposed Insured and Owner. I have left a copy with the Owner.

_____	_____
Signature of Licensed Insurance Agent	Licensed Insurance Agent Number

AGENT'S REPORT

1. Name of Proposed Insured _____ Date of Birth _____
2. Number of years you have known the primary Proposed Insured _____
3. Who first suggested the purchase of this insurance? ☐ Agent ☐ Owner/Applicant ☐ Proposed Insured ☐ Other _____

	Yes	No
4. Was the application signed after all questions were answered?	☐	☐
5. Did you personally see the Proposed Insured?	☐	☐
6. Did anyone sign or assist in the completion of Part 1 or Part 2 of the Application for or on behalf of the Proposed Insured?	☐	☐
7. Are you aware of any information that would adversely affect any Proposed Insured's eligibility, acceptability, or insurability? If Yes, please provide details in the Remarks section below, and do not provide limited temporary life insurance.	☐	☐
8. Did you provide the client with the Temporary Life Insurance Application and Agreement (TIAA) form?	☐	☐
9. Premium Class Quoted _____		
10. Are there any personal or business companion applications? If Yes, please provide name and date of birth in the Remarks section below.	☐	☐
11. a. To the best of your knowledge, does the policy applied for involve the replacement of existing insurance?	☐	☐
b. If Yes, has the Proposed Insured replaced other life insurance policies in the past 2 years?	☐	☐
12. Are there any plans to sell or assign this policy to another person or entity, life settlement provider or investor, or will it replace a policy that has already been sold to a life settlement company or investor?	☐	☐
13. Will the premium for this policy be loaned or otherwise financed by an individual(s) or entity other than the Proposed Insured or immediate family members of the Proposed Insured? If Yes, please identify all parties involved and provide copies of all financing agreements or promissory notes and all related side agreements and schedules.	☐	☐

Remarks _____

_____

_____

STATEMENTS BY AGENT

I certify that:

- I asked and carefully explained each question to the Proposed Insured and Owner/applicant before recording each answer prior to the application being signed;
- The answers given in this application and Agent's Report are complete and accurate to the best of my knowledge and belief;
- The Proposed Insured and applicant know that any fraudulent statement or material misrepresentation in the application may result in loss of coverage under the policy;
- I have given the Notice to Proposed Insured attached to this application to the Proposed Insured;
- If the insurance applied for will or may replace any existing life insurance policy or annuity contract, I have completed any and all proper state required replacement form(s);
- I have explained to the Proposed Insured that if money is submitted with this application, conditions of the Temporary Insurance Application and Agreement must be met.
- If I become aware of a change in the health or habits of the Proposed Insured occurring after the date of the application but before the policy is delivered, I promise to inform the Company of the change and agree to withhold delivery of the policy until instructed by the Company to do so.

_____ Phone No. ( ) _____
Signature of Licensed Insurance Agent Date

_____ Agent # _____ SSN _____
Print Name of Above Signature

_____ Share of commission _____
Print Name of Agency, if different from above

_____ Phone No. ( ) _____
Signature of Additional Licensed Insurance Agent Date

_____ Agent # _____ SSN _____
Print Name for Above Additional Signature

_____ Share of commission _____
Print Name of Additional Agency, if different from above

GENERAL AGENT INFORMATION

GA name _____ GA # _____ Case Manager _____

WILLIAM PENN LIFE INSURANCE COMPANY OF NEW YORK
A Legal & General America Company
3275 Bennett Creek Avenue
Frederick, MD 21704-7608
(800) 346-4773

DEPARTMENT OF FINANCIAL SERVICES OF THE STATE OF NEW YORK

DEFINITION OF REPLACEMENT

IN ORDER TO DETERMINE WHETHER YOU ARE REPLACING OR OTHERWISE CHANGING THE STATUS OF EXISTING LIFE INSURANCE POLICIES OR ANNUITY CONTRACTS, AND IN ORDER TO RECEIVE THE VALUABLE INFORMATION NECESSARY TO MAKE A CAREFUL COMPARISON IF YOU ARE CONTEMPLATING REPLACEMENT, THE AGENT OR BROKER IS REQUIRED TO ASK YOU THE FOLLOWING QUESTIONS AND EXPLAIN ANY ITEMS THAT YOU DO NOT UNDERSTAND.

AS PART OF YOUR PURCHASE OF A NEW LIFE INSURANCE POLICY OR A NEW ANNUITY CONTRACT, HAS EXISTING COVERAGE BEEN, OR IS IT LIKELY TO BE:

1. LAPSED, SURRENDERED, PARTIALLY SURRENDERED, FORFEITED, ASSIGNED TO THE INSURER REPLACING THE LIFE INSURANCE POLICY OR ANNUITY CONTRACT, OR OTHERWISE TERMINATED? YES☐ NO☐
2. CHANGED OR MODIFIED INTO PAID-UP INSURANCE; CONTINUED AS EXTENDED TERM INSURANCE OR UNDER ANOTHER FORM OF NONFORFEITURE BENEFIT; OR OTHERWISE REDUCED IN VALUE BY THE USE OF NONFORFEITURE BENEFITS, DIVIDEND ACCUMULATIONS, DIVIDEND CASH VALUES OR OTHER CASH VALUES? YES☐ NO☐
3. CHANGED OR MODIFIED SO AS TO EFFECT A REDUCTION EITHER IN THE AMOUNT OF THE EXISTING LIFE INSURANCE OR ANNUITY BENEFIT OR IN THE PERIOD OF TIME THE EXISTING LIFE INSURANCE OR ANNUITY BENEFIT WILL CONTINUE IN FORCE? YES☐ NO☐
4. REISSUED WITH A REDUCTION IN AMOUNT SUCH THAT ANY CASH VALUES ARE RELEASED, INCLUDING ALL TRANSACTIONS WHEREIN AN AMOUNT OF DIVIDEND ACCUMULATIONS OR PAID-UP ADDITIONS IS TO BE RELEASED ON ONE OR MORE OF THE EXISTING POLICIES? YES☐ NO☐
5. ASSIGNED AS COLLATERAL FOR A LOAN OR MADE SUBJECT TO BORROWING OR WITHDRAWAL OF ANY PORTION OF THE LOAN VALUE, INCLUDING ALL TRANSACTIONS WHEREIN ANY AMOUNT OF DIVIDEND ACCUMULATIONS OR PAID-UP ADDITIONS IS TO BE BORROWED OR WITHDRAWN ON ONE OR MORE EXISTING POLICIES? YES☐ NO☐
6. CONTINUED WITH A STOPPAGE OF PREMIUM PAYMENTS OR REDUCTION IN THE AMOUNT OF PREMIUM PAID? YES☐ NO☐

IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, A REPLACEMENT AS DEFINED BY NEW YORK INSURANCE REGULATION 60 HAS OCCURRED OR IS LIKELY TO OCCUR AND YOUR AGENT OR BROKER IS REQUIRED TO PROVIDE YOU WITH THE **IMPORTANT** NOTICE REGARDING REPLACEMENT OR CHANGE OF LIFE INSURANCE POLICIES OR ANNUITY CONTRACTS. YOU WILL ALSO RECEIVE A COMPLETED DISCLOSURE STATEMENT NO LATER THAN THE TIME YOUR NEW POLICY OR NEW CONTRACT IS DELIVERED.

DATE: _____ **SIGNATURE OF APPLICANT/OWNER**: _____

DATE: _____ **SIGNATURE OF APPLICANT/OWNER**: _____

TO THE BEST OF MY KNOWLEDGE, A REPLACEMENT IS INVOLVED IN THIS TRANSACTION: YES☐ NO☐

DATE: _____ **SIGNATURE OF AGENT OR BROKER**: _____

WILLIAM PENN LIFE INSURANCE COMPANY OF NEW YORK
A Legal & General America Company
3275 Bennett Creek Avenue
Frederick, Maryland 21704
(800) 346-4773

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

THIS AUTHORIZATION COMPLIES WITH THE HIPAA PRIVACY RULE

Print Name of Proposed Insured/Patient

Date of Birth

Print Name of Person or Organization Providing Information

AUTHORIZATION

I authorize any physician, health plan, medical practitioner, medical care provider, psychologist, chiropractor, physical therapist, hospital, nursing home, mental health facility, rehabilitation or ambulatory care center, medical clinic, laboratory, pharmacy, Pharmacy Benefit Manager, treatment facility, insurer, insurance support organization, service provider, Kaiser Permanente, financial institution, consumer credit reporting agency, certified public accountants and tax preparers, educational institution, Federal, State, or Local Governmental Agency, including the Social Security Administration, Veterans Administration, or Workers Compensation Board, an authorized medical officer of a United States Government facility, law enforcement agencies, state and local tax agencies, or other medical or medically related facility, specifically including those persons/organizations listed above, to give or disclose my entire medical record and any other protected health information, or other personal, private, or privileged information concerning me for the past 10 years to **William Penn Life Insurance Company of New York**, its agents, employees, vendors or representatives. Any and all records and information regarding diagnosis, testing, treatment, and prognosis of my physical or mental condition are to be released. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness except psychotherapy notes, and the use of alcohol, drugs, and tobacco; and any genetic information or genetic testing results. This information does not apply to records protected under 42 USC 290dd-2.

I authorize MIB, LLC, and any MIB member insurer, to provide any medical or personal information that it has about me to **William Penn Life Insurance Company of New York**, its reinsurer(s), or any MIB-authorized third-party administrator performing underwriting services on **William Penn Life Insurance Company of New York's** behalf. I also authorize **William Penn Life Insurance Company of New York**, its reinsurer(s) or authorized third-party administrator, to make a brief report of My Information to MIB, LLC.

My Information is to be disclosed under this authorization so that **William Penn Life Insurance Company of New York** may: 1) underwrite my application for coverage, make eligibility, risk rating, and policy issuance determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with **William Penn Life Insurance Company of New York**.

I understand and acknowledge that any agreements I have made to restrict My Information, including protected health information, do not apply to this Authorization and I instruct any physician, health care professional, hospital, clinic, medical facility or other health care provider, or other entity to release and disclose My Information, including my entire medical record without restriction.

This authorization shall be valid for two (2) years after the date on which it is signed by me, and a copy of this authorization is as valid as the original.

I understand that I have the right to refuse to sign or to revoke this authorization in writing, at any time, by sending a written request for revocation to the Company at 3275 Bennett Creek Avenue, Frederick, Maryland 21704, Attention: Privacy Official. I understand that this authorization may be revoked except to the extent that any of my Providers have acted in reliance upon the authorization prior to notice of revocation. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by certain federal rules governing privacy and confidentiality of health information.

I understand that if I refuse to sign, alter, or revoke this Authorization the Company may not be able to process my application and it may be a basis for denying my request for coverage, or if coverage has been issued may not be able to make any benefit payments. I understand and acknowledge that I will receive or have received a copy of this authorization.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization.

Signature of Proposed Insured/Patient

Date (required)

Social Security Number of Proposed Insured

Agent or Witness Signature

WILLIAM PENN LIFE INSURANCE COMPANY OF NEW YORK
A Legal & General America Company
3275 Bennett Creek Avenue
Frederick, Maryland 21704
(800) 346-4773

NOTICE AND CONSENT FOR HIV/ AIDS-RELATED BLOOD TESTING

Acquired Immunodeficiency Syndrome (AIDS) is a life-threatening disorder of the immune system, caused by a virus, HIV. The virus is transmitted by sexual contact with an infected person, from an infected mother to her newborn infant, or by exposure to infected blood (as in needles shared during intravenous drug use). Persons at high risk of contracting AIDS include males who have had sexual contact with another man, intravenous drug users, hemophiliacs and sexual contacts with any of these persons. Symptoms of HIV infection may include but not be limited to fever, sweats, lethargy, headache, aching of the muscles and joints, diarrhea, sore throat, lymph node enlargement, unintentional weight loss, and a skin rash.

To evaluate your insurability, the Insurer named above has requested that you provide a sample of your blood for testing and analysis to determine the presence of Human Immunodeficiency Virus (HIV) antibodies and other tests which may include tests for cholesterol and related blood lipids, diabetes, liver or kidney disorders, or immune disorders. By signing and dating this form you agree that these tests may be done and that underwriting decisions will be based on the test results. Regarding the HIV test, a series of three tests will be performed by a licensed laboratory through a medically accepted procedure. An initial ELISA blood test will be done. If that is positive it will be repeated. If the second is positive a Western Blot test will be done.

The test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus. A positive test result does not mean that you have AIDS but that you are at a significantly increased risk of developing AIDS and that you can transmit the virus to someone else. The test for HIV antibodies is very sensitive. Errors are rare, but they do occur. Your private physician, a public health clinic, or an AIDS information organization in your city might provide you with further information on the medical implications of a positive test. You may wish to consider further independent testing.

Positive HIV antibody test results will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

All tests results will be treated confidentially. They will be reported by the laboratory to the Insurer. When necessary for business reasons in connection with insurance you have or have applied for with the Insurer, the Insurer may disclose test results to others involved solely in the underwriting process such as its affiliates, reinsurers, employees, or contractors. If the Insurer is a member of the Medical Information Bureau (MIB, Inc.), and if the test results for HIV antibodies/antigens are other than normal, the Insurer will report to the MIB, Inc. a generic code which signifies only a non-specific blood test abnormality. If your HIV test is normal, no report will be made about it to the MIB, Inc. Other test results may be reported to the MIB, Inc. in a more specific manner. The organizations described in this paragraph may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or as authorized by you.

If your test results are negative, no routine notification will be sent to you. If your test results are reported by the laboratory to the Insurer as being positive, you are entitled to that information if you so desire. Because a trained person should deliver that information so that you can understand clearly what the test result means, you are asked to list your private physician so that the Insurer can have him or her tell you the test result and explain its meaning.

Name of physician for reporting a positive test result: _____

Address _____

If you wish the results to be mailed to some person other than yourself who is not a physician, print that person's name and address here: _____

_____

_____

If you want the results sent directly to you, sign here: _____

Positive results will be sent by registered mail for restricted delivery to the addressee.

For further information about AIDS, the meaning of HIV related test results and the availability and location of HIV counseling services call the New York State Department of Health toll-free Hotline number **1-800-541-AIDS**

Consent

I have read and I understand this Notice and Consent for AIDS-Related Blood Testing. I voluntarily consent to the withdrawal of blood from me by needle from a vein or from a finger, the testing of that blood, and the disclosure of that test result as described above. I have read the information on this form about what a test result means and understand that I may contact a local AIDS service group or my private physician for further information and counseling if that test result is positive.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original. In the event the applicant is a minor, this authorization must be approved by a parent/guardian of the applicant in the space provided.

Proposed Insured	Date of Birth

Signature of Proposed Insured or Parent/Guardian	Date	State of Residence

WILLIAM PENN LIFE INSURANCE
COMPANY OF NEW YORK
A Legal & General America Company
3275 Bennett Creek Avenue
Frederick, Maryland 21704
(800) 346-4773

Accelerated Death Benefit Disclosure

Name of Proposed Insured _____ Policy Number _____

Accelerated Death Benefit Rider Description

This policy is issued with an Accelerated Death Benefit Rider. Eligibility for an accelerated death benefit payment, hereafter referred to as an ADB, requires that the insured is living, but is terminally ill with a life expectancy of no more than 12 months. As a result of payment of an ADB, a lien on the policy is imposed. **There is no premium charge or monthly cost of insurance charge for this rider**. A maximum $250 administrative charge may be imposed by the company upon making an accelerated death benefit payment. The ADB is payable as a lump sum; the Owner may make only one request for an accelerated death benefit payment. We must receive written approval from any irrevocable beneficiary, as well as a release of any collateral assignment of the policy before making a payment. An ADB will reduce the policy's death benefit proceeds otherwise payable and limit the availability of any policy cash surrender value. Following an ADB, access to a policy's cash value (where available), for policy permitted loans or policy permitted partial withdrawals, will be restricted to any excess of the policy's cash value, reflecting outstanding loans, less the outstanding ADB lien. Receipt of an ADB: 1) will not affect any accumulation values, 2) will not affect the future required premium payments, 3) will not affect future cost of insurance rates and values, and 4) will not affect future loan interest charges.

The maximum permitted ADB is equal to lesser of: i) 75% of death benefit or ii) $500,000, reduced by any outstanding loan. **Review your policy and the Accelerated Death Benefit Rider for complete limitations, terms, and conditions.**

Sample illustration

John Doe purchases a policy with a death benefit of $500,000 at age 45. Assume that ten years later, at age 55, John's policy has required monthly premium payments in addition to a policy loan and cash surrender values as shown below. At age 55 John becomes terminally ill with a life expectancy of no more than 12 months and thus becomes eligible for an accelerated death benefit. The maximum accelerated death benefit payment is the lesser of: i) 75% of the death benefit or ii) $500,000, reduced by any outstanding loan. In this example the maximum accelerated death benefit is equal to $375,000 less the $5,000 policy loan = $370,000.

Assume John requests 50% of the maximum accelerated death benefit which equals 50% x $370,000 = $185,000. An administrative fee of $250 is added to the lien resulting in a lien of 185,250.

	Before Acceleration	**Immediately after Accelerated Death Benefit payment of $185,000**	**12 months after Acceleration**
Death Benefit (Gross)	$500,000	$500,000	$500,000
Premium	$200 per month	$200 per month	$200 per month
Lien Amount	$0	$185,250	$200,070
Policy Loan	$5,000	$5,000	$5,000
Cash Surrender Value	$30,000	$30,000	
Available Cash Surrender	$25,000	$0	$0
Net Death Benefit	$495,000	$309,750	$294,930

Net Death Benefit = Death Benefit less Lien amount less any Policy loan (if applicable)
The Available Cash Surrender Value is the maximum available for full surrenders, partial surrenders, or loans. It is limited to the excess of the policy cash surrender value (reflecting any loan balance) less any lien amount.

** This example is illustrative only and is not intended to show actual values.*

*** The example reflects hypothetical lien interest of 8% and assumes policyholder pays due required premiums and loan interest (any unpaid required premium and loan interest payments are added to the lien and accrue lien interest)*

****Note: your policy may not provide for Cash Surrender Values and/or Loans. In such case, the maximum accelerated death benefit is the lesser of: i) 75% of the policy death benefit or ii) $500,000.*

Owner Signature _____ Date _____ Agent Signature _____ Date _____

WILLIAM PENN LIFE INSURANCE COMPANY OF NEW YORK

A Legal & General America Company
3275 Bennett Creek Avenue
Frederick, MD 21704-7608
(800) 346-4773

Best Interest and Suitability Disclosure Form

Insured A Name: _____ / _____ / _____ / _____
(First) (Middle) (Last) (Suffix)

Insured B Name: _____ / _____ / _____ / _____
(First) (Middle) (Last) (Suffix)

Insured A Date of Birth *(mm/dd/yyyy)*: ____ / ____ / _____ Insured B Date of Birth *(mm/dd/yyyy)*: ____ / ____ / _____

General Information (Based on the Owner/Applicant)

1. a. Owner (Select One)

☐ Individual: _____ _____ _____ / _____
(First) (M.I.) (Last) (Suffix)

☐ Trust/Entity: _____

Trustee/Officer: _____ _____ _____ / _____
(First) (M.I.) (Last) (Suffix)

b. Date of Birth/Trust Date *(mm/dd/yyyy)*: ____ / ____ / _____ c. SSN/TIN: _____

d. **Answer Only if Owner is a Trust**: Is this a revocable grantor trust? (*If "Yes", complete the Life Suitability Form based on the Insured's(s')/Grantor's overall income, assets and health.*)..... ☐ Yes ☐ No

2. a. Joint Owner Name (if any): _____

b. Date of Birth/Trust Date *(mm/dd/yyyy)*: ____ / ____ / _____ c. SSN/TIN: _____

3. Proposed Insured Rate Class Applied:

☐ Preferred Plus Non-Tobacco
☐ Preferred Non-Tobacco
☐ Standard Non-Tobacco
☐ Rated Non-Tobacco Table (*insert* A, B, C or D) _____
☐ Preferred Tobacco
☐ Standard Tobacco
☐ Rated Tobacco Table (*insert* A, B, C or D) _____

4. Type of Policy Applied For: _____

5. Amount of Proposed Coverage: _____

6. Anticipated Premiums: _____

7. Tax Status:

If Individual, select one of the following:	☐ Single ☐ Married Filing Jointly ☐ Married Filing Separately ☐ Head of Household ☐ Qualifying Widower with Dependent Child
If Business, select one of the following:	☐ C Corporation ☐ S Corporation ☐ Limited Partnership ☐ Limited Liability Corporation (LLC) ☐ Sole Proprietorship

Financial Information (Responses below should be for combined household excluding dependents.)

A. $1 - $24,999 B. $25,000 - $49,999 C. $50,000 - $99,999 D. $100,000 - $249,999
E. $250,000 - $499,999 F. $500,000 - $749,999 G. $750,000 - $999,999 H. $1,000,000 & Over I. None/Zero

8. **Choose the corresponding letter from the box above to answer the following financial questions.**

a. Annual Income:
(Total should include Annual plus any other recurring sources of income you receive) _____

b. Existing Assets:
(Total of all your Assets, including value of all annuities and cash value of permanent life insurance) _____

c. Total Net Worth: (Assets minus Liabilities) _____

d. Liquid Net Worth:
(Net worth that can readily be turned into cash - Not applicable to Term Life Insurance) _____

9. **For each type of liability or financial obligation that you currently have, check the corresponding box and complete the requested information.** Check here if you have no liabilities or financial obligations: ☐

☐ **Mortgage(s):** *(Provide combined amounts of all mortgages)*

Mortgage Balance(s): $ _____ Total Monthly Payment: $ _____

Remaining term of liability (Years left to pay off longest mortgage): _____ years

☐ **Credit Card(s):** *(Provide combined amounts of all credit card debt)*

Credit Card Debt Balance(s): $ _____ Total Monthly Payment: $ _____

Estimated time you plan to pay off all credit card debt: _____ years

☐ **Auto/Student/Personal Loans:** *(Provide combined amounts of all loans)*

Loan Balance(s): $ _____ Total Monthly Payment: $ _____

Remaining term of liability (Years left to pay off the longest loan): _____ years

☐ **Life Insurance and/or Annuity Premium Payments:** *(Provide combined amounts of all current inforce policies)*

Total Annual Premiums: $ _____

Estimated time you plan to stop premium payments on all policies: _____ years

☐ **Other liabilities not listed above:**

Type	Balance	Monthly Payment	Term
	$	$	_____ years
	$	$	_____ years
	$	$	_____ years
	$	$	_____ years
	$	$	_____ years

Financial Experience

10. Provide length of experience by selecting the appropriate number of years for the following investment vehicles you have owned.

Check "1-4 years", "5+ years", or "Never Owned" for each of the below.	1 to 4 years	5+ years	Never Owned
Annuities	☐	☐	☐
Life Insurance	☐	☐	☐
Investments	☐	☐	☐
CDs	☐	☐	☐
Checking/Savings Account	☐	☐	☐
Employer Retirement Account	☐	☐	☐

Source of Funds

11. What is the source of funds for purchasing this life insurance policy? (*Check all boxes that apply*)

☐ Single Premium Immediate Annuity
☐ Financial Distributions
☐ Savings/Checking
☐ Home Equity Loan
☐ Money Market
☐ Investment Products (Stocks, Bonds, etc.)
☐ **Money from a Canceled Life Insurance Policy or Annuity Contract
☐ Current Income
☐ Gift/Inheritance
☐ Premium Finance Loan
☐ Brokerage Account/Cash
☐ CDs
☐ Business Activity
☐ Loans (Other than Home Equity or Premium Finance)
☐ Employer Retirement Account

12. a. Have you surrendered or replaced any annuity or life insurance policy within the past 36 months? (*This question applies to partial or full surrenders/replacements.*)..... ☐ Yes ☐ No

b. If "Yes", will funds from the surrendered contract be used (directly** or indirectly**) toward the premium of this proposed contract? ***(If "Yes", complete Question 14 below and any applicable Replacement forms.)***..... ☐ Yes ☐ No

13. Will the proposed life insurance policy replace an existing annuity contract or life insurance policy? ***(If "Yes", complete Questions 14 below and any applicable Replacement forms.)***..... ☐ Yes ☐ No

Required if Question 12b. and/or Question 13. is "Yes."

14. What significant material benefit(s) will you realize by replacing your current contract or policy? *(Check all boxes that apply - None or N/A are not acceptable)*

- ☐ Long-Term Care Protection
- ☐ Level/Guaranteed Death Benefit Protection
- ☐ Increased Potential for Cash Value Growth
- ☐ Guaranteed Level Premiums for New Level Term Period
- ☐ Reduction in Premium Cost
- ☐ Increased Death Benefit Protection with Better Product Pricing
- ☐ Other _____

Product Considerations (To be completed by the Agent.)

15. a. In recommending the purchase or exchange of an annuity or life insurance product, has your client been reasonably informed of the following various features and considerations (but not limited to) of this life insurance policy?..... ☐ Yes ☐ No

- Basic policy fee
- Product restrictions or exclusions
- Potential charges for features or riders
- Contractual Conversion Provisions
- The manner in which the producer is compensated
- Others

b. How do the following factors or features impact the recommendation?

Unless indicated, check "Supports", "Neutral" or "Does Not Support" for each of the below.	**Supports**	**Neutral**	**Does Not Support**
Age	☐	☐	☐
Annual income	☐	☐	☐
Financial situation and needs, including the financial resources used for funding the policy	☐	☐	☐
Financial experience	☐	☐	☐
Intended use of the policy	☐	☐	☐
Financial time horizon, including duration of existing liabilities and obligations	☐	☐	☐
Existing assets, including investment and insurance holdings	☐	☐	☐
Other (*describe*) _____	☐	☐	☐

c. If any options were chosen in the "Does Not "Support" column above, please explain/describe.

_____

_____

Agent/Representative's Statement (Respond to each of the below statements by checking the appropriate answer.) I believe the purchase or modification of this life insurance policy is suitable and is in the best interest of the client based on information provided by the Owner/Applicant(s) regarding his/her insurance needs and financial objective(s). I have discussed the advantages and disadvantages of the life insurance policy with my client, including any replacement concerns or issues mentioned above. I have a reasonable basis to believe that the customer has the financial ability to meet the financial commitments of the life insurance.

16. a. My recommendation to the owner/applicant to purchase the proposed life insurance policy is based on the following significant material benefit(s) to the client: (None or N/A are not acceptable)

- ☐ Death Benefit Protection
- ☐ Business Insurance Needs
- ☐ Guaranteed Level Premiums for New Level Term Period
- ☐ Reduction in Premium Cost
- ☐ Increased Death Benefit Protection with Better Product Pricing
- ☐ Other _____

b. Did you provide the owner/applicant with a copy of the current version of the product illustration, projection of values or applicable product disclosure, if applicable?..... ☐ Yes ☐ No

c. Did you disclose to the owner/applicant the manner in which you receive compensation for the sale and servicing of this policy?..... ☐ Yes ☐ No

**Denotes Replacement

d. In your professional opinion based on the information the owner/applicant provided, **is the recommended life insurance policy suitable and in the client's best interest for the client's needs and objectives**, as compared to other life insurance products that you are appropriately authorized to offer, and is based on your evaluation of relevant suitability information and reflects the care, skill, prudence, and diligence that a prudent person acting in a like capacity and familiar with such matters would use under similar circumstances?..... ☐ Yes ☐ No

e. In making this recommendation, have you considered only the interests of the consumer and has **receipt of compensation or other incentives not influenced the recommendation?**..... ☐ Yes ☐ No

f. Did you provide the customer with the reasonable summary format disclosure?..... ☐ Yes ☐ No

I hereby attest to the following:

That if the transaction related to this application was not recommended by me to the customer, it was due to:

- ☐ I made reasonable efforts to collect the required suitability information from the customer but he/she refused to provide it and I have not made any recommendation;
- ☐ I did not make a recommendation in connection with the transaction related to this application; or
- ☐ The customer wishes to enter into the transaction related to this application even though I did not recommend it.

_____ _____/_____/_____

Signature of Licensed Agent Date (MM/DD/YYYY)

_____

Printed Name of Licensed Agent

OWNER/APPLICANT'S STATEMENT

17. I confirm the information given is accurate. My Agent/Representative has discussed surrender charges and other costs with me and I believe that the life insurance policy is appropriate for my insurance needs and financial objective(s). I acknowledge that I did not receive any advice from William Penn Life Insurance Company of New York regarding the purchase or investment of the life insurance policy.

_____ _____/_____/_____

Owner/Applicant's Signature Date (MM/DD/YYYY)
Provide Title if Owner is a Trust or Corporation

_____ _____/_____/_____

Owner/Applicant's Signature Date (MM/DD/YYYY)
Provide Title if Owner is a Trust or Corporation

WILLIAM PENN LIFE INSURANCE COMPANY OF NEW YORK
A Legal & General America Company
3275 Bennett Creek Avenue
Frederick, Maryland 21704
(800) 346-4773

ELECTRONIC FUNDS TRANSFER PAYMENT OPTIONS

Policy Owner Name _____ Policy Number _____
(leave blank if policy number not yet assigned)

Proposed Insured's Name _____ Date of Birth _____

Authorization

William Penn Life Insurance Company of New York will draft the checking account designated on this form for subsequent premiums only (unless initial premium payment is authorized by checking the box below) once the policy has been approved for issue, subject to the terms below.

☐ **Check here to authorize William Penn Life Insurance Company of New York to draft my checking account for the initial premium payment and subsequent premium payments subject to the terms of the life insurance contract.**

I understand and agree that this authorization is subject to the following conditions:

- This authorization shall remain in effect until revoked in writing by me or the Company.
- Signing this authorization does NOT mean that coverage is effective; coverage is effective only as stated in the application or Temporary Insurance Agreement, if issued.
- Completion of this form will satisfy the requirement for payment of an amount applied for as required by the Temporary Insurance Application and Agreement.
- Use of the selected payment method does not alter any provisions of any policy issued by William Penn Life Insurance Company of New York.
- William Penn Life Insurance Company of New York will process the selected payment only when one of the following events occur: 1) William Penn Life Insurance Company of New York has approved the policy for issue and there are no documents requiring the owner's and/or insured's signature; or 2) the policy has been accepted and William Penn Life Insurance of New York has received all of the necessary documents requiring the signature of the owner/insured.
- If necessary, refunds of initial premium will be refunded by Company check.
- If the payment method selected is not honored upon presentation, no coverage will be in effect and William Penn Life Insurance Company of New York will terminate any further attempt to use this payment method.

Temporary Insurance is limited to the lesser of: (1) the amount of insurance applied for in the Application or (2) $1,000,000 minus the amount of insurance on the Proposed Insured's life with the Insurer under any other applications for insurance now pending or other temporary insurance agreements.

Bank Account Information for Draft from Checking Accounts (Checking Accounts Only)

PLEASE ATTACH A VOID CHECK

Name of Financial Institution _____

ABA Routing Number _ _ _ _ _ _ _ _ _
(routing number typically located on bottom left of check)

Account Number _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _
(must include dashes and spaces as they appear in your account number)

Please indicate your payment frequency for your premium withdrawals.
(If no selection is made, withdrawals will be made monthly)

☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually

X _____ _____
Bank Account Owner Signature (Must be Payor, Owner or Proposed Insured as identified on application) Date

X _____ _____
Policy Owner Signature (If other than Bank Account Owner) Date

WILLIAM PENN LIFE INSURANCE COMPANY OF NEW YORK
A Legal & General America Company
3275 Bennett Creek Avenue
Frederick, Maryland 21704
(800) 346-4773

Supplement to Application

Application for insurance dated _____

First Insured_____ Second Insured _____
(Last) (First) (Middle) (Last) (First) (Middle)

"Remarks" continued:
(Show question and number, include dates, and show complete names and addresses where applicable.)

Question #	Please Print - Use Black Ink Only	Question #	Please Print - Use Black Ink Only

I have read the preceding questions and answers; I certify that they are complete and true to the best of my knowledge and belief. I agree that this is a part of the application and shall become a part of any insurance policy issued.

SIGNED AT _____ On _____ 20 _____
Town or City, State and Country

Witness _____ _____
Signature of Proposed Insured

_____ _____
Signature of Applicant - Owner

WILLIAM PENN LIFE INSURANCE COMPANY OF NEW YORK
A Legal & General America Company
3275 Bennett Creek Avenue
Frederick, Maryland 21704
(800) 346-4773

ACKNOWLEDGMENT OF LIFE INSURANCE POLICY SALES ILLUSTRATION

Applicant Statement

I acknowledge that no life insurance sales illustration has been given to me for the policy for which I have currently applied. Furthermore, I understand that I will receive an illustration, which conforms to any policy that may be issued, at the time of such policy delivery.

_____ _____
Signature of the Applicant/Owner Date

_____ _____
Print Name of Applicant/Owner Print Name of Proposed Insured, if different than Applicant/Owner

Agent Statement

I certify that:

☐ A life insurance sales illustration, which conforms to the life insurance policy applied for, has **not** been used in the presentation and explanation of this policy.

☐ A sales illustration was displayed on a **computer screen** in the presentation and explanation of this policy based on the criteria below. A printed copy of this illustration will be delivered to the applicant no later than the time the application is submitted for underwriting.

Plan: _____ Riders:_____ Initial Death Benefit $_____

Number of Years Illustrated:_____ Premium Amount:$_____ (Ann/SA/Qtr/PAC)

(For Universal Life):
Guaranteed Interest Rate:_____% Non-Guaranteed Interest Rate:_____%

Assumed Number of Years of Premium Payments:_____

_____ _____
Signature of the Agent Date

_____ _____
Print Name of Agent Print Name of General Agent

 Please make copies for relevant parties as appropriate.

WILLIAM PENN LIFE INSURANCE
COMPANY OF NEW YORK
A Legal & General America Company
3275 Bennett Creek Avenue
Frederick, Maryland 21704
(800) 346-4773

TRUST CERTIFICATION

Section 1 Purpose of this Form

This form is used for situations where a Trust is the owner or the beneficiary of the life insurance policy issued by our Company. The Trustee(s) should complete and execute this form.

Section 2 General Information

Proposed Insured name _____

Name of Trust _____

State where created _____ Date Trust created _____ Tax ID # _____

- If a living Trust, then the Tax ID may be the same as the grantor's SSN.

Section 3 Type of Trust (check all boxes that apply)

Trust is:

☐ Revocable Trust
☐ Irrevocable Trust
☐ Testamentary Trust under the last will and testament of _____
Date of death _____ Date will was executed _____

AND

Trust is:

☐ Family Trust
☐ Insurance Trust
☐ Trusteed Buy/Sell
☐ Employer Sponsored Trust
☐ Charity Trust
☐ Other type of Trust _____

Section 4 Grantor(s)

Identification information of the Grantor/Settlor(s) who established the Trust:

Name _____

Address _____ City, State, Zip _____

Name _____

Address _____ City, State, Zip _____

Section 5 Beneficiary(ies)

Names and relationships of the beneficiaries of the Trust:

Name _____ Relationship to Proposed Insured/Insured _____

Name _____ Relationship to Proposed Insured/Insured _____

Name _____ Relationship to Proposed Insured/Insured _____

Section 6 Trustee(s)

For multiple Trustees ONLY, please print the names of all Trustees and check one of the following boxes (if no box is checked, the Company will require all signatures on all policy requests).

☐ A majority may act for all
☐ Anyone may act alone
☐ All must act unanimously
☐ Certain trustees must act jointly (print names below)

Trustee #1 _____ Trustee #2 _____ Trustee #3 _____

Note: If the Insurance Producer is a Trustee, please provide the reason and relationship of that individual to the insured.

☐ Immediate family member or
☐ Other _____

Reason _____

I the undersigned Trustee(s) do hereby certify and affirm the following:

1. All information provided on this Certification is accurate and complete.
2. The named trust is currently in effect and has not been revoked, modified or amended in any manner that would cause the representations in this Certification to be incorrect.
3. I/We acknowledge and agree that the Company is relying exclusively on the representations in this Certification and not upon a review of the trust document, even if the trust document has been or is later provided. The Company is permitted to rely upon the representations in this Certification, unless or until notice of any change, amendment, or revocation is provided in writing and delivered to the Company.
4. I/We are duly authorized to act as trustee(s) under the terms of the trust provision and /or applicable law. I/We have the power to exercise all rights associated with ownership of a life insurance policy, including, but not limited to, purchase, surrender, selection of and transfers between variable funding options, withdrawal of funds, taking a loan or other encumberment and assigning the policy.
5. Beneficial interests under the Trust can and will only be established for persons who: (i) are related to the Proposed Insured(s) by blood or by law; (ii) have a substantial interest in the life of the Proposed Insured(s) engendered by love and affection; or (iii) hold a lawful and substantial economic interest in the continued life of the Proposed Insured(s).
6. If licensed to sell life insurance for the Company, the undersigned trustee has reviewed and has abided by the Company's guidelines on producers acting as trustees.
7. Each of the undersigned, jointly and severally, individually, and as trustee, indemnifies the Company and agrees to hold the Company harmless against all obligations, demands, losses or liabilities (including attorney's fees) that the Company incurred, suffered, or paid or may incur, suffer or pay in the future because of the Company's reliance on this Certification and/or transactions or actions by the undersigned. By indemnifying the Company, each of the undersigned, jointly and severally, individually, and as trustee, indemnifies the Company's agents, officers, employees. This indemnification shall survive termination of this document or the life insurance policy.
8. I/We understand that neither the Company nor its agents are responsible for the estate planning and tax implications of this sale, that they may not give legal or tax advice and that the Company's acceptance of this Certification is not an endorsement of the named trust. I/we have the opportunity to consult with an independent attorney and /or tax advisor, to the extent necessary, before executing this Certification.
9. I/We agree to inform the Company in writing of any trust amendments, changes of trustee(s), or other facts and events that would affect or alter this Certification.
10. For life insurance policy/policies being applied for, the Proposed insured has been informed or is otherwise aware that a policy is being purchased on his/her life.
11. The Trustee(s) may be named as policy owner(s) and have the power to exercise all rights of ownership of a life insurance policy, including, but not limited to, the right to surrender the policy(ies), take a loan or withdrawal, or make changes in the allocation of any invested premium amounts.
12. The Trustee(s) may purchase life insurance in the state in which it is applied for and delivered in, apply for the policy, and invest trust funds in the policy(ies).

Signatures

Print name of Trustee #1 _____

Address _____

Signature _____ Date _____

Print name of Trustee #2 _____

Address _____

Signature _____ Date _____

Print name of Trustee #3 _____

Address _____

Signature _____ Date _____

Note: If more than three Trustees, please provide the Trustee names, addresses, signatures, and dates on an additional sheet of paper and attach that paper to this form.