INSTRUCTIONS

- Please print clearly with black ink. No felt tip pens.
- Corrections should be initialed and dated by proposed insured/owner. Do not use white out.
- The insured's full name should be shown in Question 1 and signed identically on page 5.
- If the owner is a trust or business please include full title and name of trust or business.
  Ex: Paula Smith, Trustee — Paula Smith, President
  Paula Smith Irrev Trust date 1-2-98 — Paula's Shoe Store, Inc.
  Make sure that you have the complete name and date of trust and if it is revocable or irrevocable.
- List all owners' tax IDs on page 1. If all owners' tax IDs are not included, we will require completed W-9 before issue.
- Proposed insureds age 15 and over are required to sign the application.
- When insuring the life of children under the age of 15 a parent's signature is required even if they are not the owner of the policy.
- Submit all pages of the application even if information is not required.
- For Independent Choices, only the 5 YR Index and 5 YR Fixed-Term interest crediting strategies are available.
- Explain the terms of the Company's Conditional Life Insurance Agreement prior to accepting any settlement with the application.
- Leave the completed Conditional Life Insurance Agreement with the applicant if money is taken.
- Explain the Disclosure Notice and leave it with the Proposed Insured.
- Two applications need to be completed for joint life products—one for each insured.
- If required, send in complete illustration signed by owner and agent. Make sure the application and the illustration match.
- When submitting an application you must include a) a fully completed illustration including both the applicant's and your signatures; or b), a completed certification stating that no illustration was presented at application; or c) an electronic illustration certification stating that an illustration was shown on a computer but that no hard copy was printed or presented to the applicant. Do not mark, highlight or write on the illustration.
  If this application is completed for an indexed product in the states listed, you must provide a signed illustration with the application. A certification of non-illustration or electronic illustration only is not allowed: Arkansas, Connecticut, North Dakota, Oklahoma, South Dakota, Wyoming.
  If the application is completed for an indexed product for the following states, the Applicant must initial or sign the Indexed Acknowledgments as indicated: Connecticut, Massachusetts, South Carolina, and Texas.
- Complete the Pre-Authorized Check Information if requesting billing mode of PAC.
- Review the application prior to mailing to the Company to make certain it is complete and accurate. Include a cover memo with special instructions if needed.
- For faster service, fax the application to the number listed below. Please retain original, do not mail.

SPECIAL INSTRUCTIONS TO THE NEW BUSINESS STAFF:

Application for Life Insurance

AVIVA

Aviva Life and Annuity Company
Home Office: Des Moines, IA
Mailing Address:
P.O. Box 1555
Des Moines, IA 50306-1555
Fax: 1-800/531-0038

Aviva Life and Annuity Company
Home Office: Des Moines, IA
Mailing Address:
P.O. Box 1555
Des Moines, IA 50306-1555
Fax: 1-800/531-0038

AVIVA

Application for Insurance

AGENT CODE # _____

(In this application, "Company" refers to the insurance company named above.)

APPLICANT INFORMATION

1. PROPOSED INSURED

Name (First, Middle, Last) _____ Is Insured also the Owner? ☐ Yes ☐ No

Address _____ E-Mail: _____

City _____ Home Ph. (_____) _____ Bus. Ph. (_____) _____

State _____ Zip _____ Gender ☐ M ☐ F Maiden Name _____

Birth Date _____ Birth State _____ Social Security Number _____

Marital Status ☐ Married ☐ Single ☐ Divorced or Separated ☐ Widow or Widower U.S. Citizen? ☐ Yes ☐ No Permanent Resident? ☐ Yes ☐ No

Driver's License # _____ State _____ Issue Date _____ Expiry Date _____

Or, if you do not have a driver's license, other government issued photo ID: Document Type _____

Document # _____ Where Issued _____ Issue Date _____ Expiry Date _____

Employer _____ How Long? _____ Occupation/Duties _____

Annual earned income $_____ Annual unearned income $_____ Net worth $_____

If multiple life product, (2nd app required for multiple life)

Joint Insured Names: (1st): _____ (2nd): _____

2. OWNER (If different from Proposed Insured) ☐ Individual ☐ Business ☐ Trust (date of trust) _____

Name (Owner, Business or Trustee) _____ Birth Date _____

If trust, name of trust _____

Address _____ City _____ State _____ Zip _____

Relationship to Proposed Insured _____ Social Security # or Taxpayer ID # _____

Owner's or Trustee's personal driver's license # or other government issued photo ID document, or corporate license:

Document Type _____ Document # _____ Where Issued _____ Issue Date _____ Expiry Date _____

Contingent Owner (If none specified, policy provisions will apply.) _____

Driver's License # or other government issued photo ID document:

Document Type _____ Document # _____ Where Issued _____ Issue Date _____ Expiry Date _____

Mail notices to ☐ Insured ☐ Owner ☐ Other (specify) _____

Other Notice Address _____ City _____ State _____ Zip _____

Tax Qualification Type ☐ Qualified Plan: ☐ Non-Qualified Plan: ☐ Neither

Qualified Plan Type: ☐ Profit Sharing Plan ☐ 401(k) ☐ 412(i) ☐ Other Defined Benefit

Non-Qualified Plan Type: ☐ Welfare Benefit Plan: ☐ single employer ☐ multiple employer ☐ VEBA ☐ Deferred Comp ☐ Split Dollar ☐ Executive Bonus ☐ Other _____

3. PRIMARY BENEFICIARY(IES) - Applies to primary insured only. (If trust, complete name and date of trust.)

(If necessary, use an additional page for additional details, **signature of owner & date.)**

Print Full Name	Birth Date	Relationship	Percentage	Social Security # or Taxpayer ID #

4. CONTINGENT BENEFICIARY(IES)

Print Full Name	Birth Date	Relationship	Percentage	Social Security # or Taxpayer ID #

POLICY INFORMATION

5. PRIMARY INSURED ☐ Nonsmoker/Nontobacco ☐ Smoker/Tobacco

Base Plan _____ Amt. of Ins. $ _____

Additional Coverage _____ Amt. of Ins. $ _____ Premium $ _____

Additional Coverage _____ Amt. of Ins. $ _____ Premium $ _____

Riders (Complete Supplemental Application if applicable)

☐ Waiver Type _____ ☐ Other Riders (Type/Amount): _____

☐ Spouse Rider $_____ ☐ Child Rider $_____ _____

6. UL Death Benefit Option: ☐ Level ☐ Increasing ☐ Death Benefit Return of Premium Rider

Premium Direction/Interest Crediting Strategy: 1 Year Point-to-Point_____% 2 Year Point-to-Point_____% 1 Year Monthly Average_____%

1 Year Monthly Cap_____% 1 Year Average Multiple Index_____% 5 Year Fixed Term_____% 1 Year Fixed Term_____% _____%

Levelized Strategy Transfer ☐ Yes ☐ No

7. WHOLE LIFE APL (If applicable) ☐ Yes ☐ No Direct Recognition (if available) ☐ Yes ☐ No

PREMIUM INFORMATION

8. PREMIUM Planned Premium $_____ Additional Premium (Lump Sum) $ _____

Billing Frequency ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ PAC (Complete Authorization) ☐ Other _____

☐ Govt. Allotment (if available) ☐ Group Bill Group Bill #_____

Has the premium for the policy applied for been given to the agent? ☐ Yes ☐ No Amount $ _____

How Paid? ☐ Check ☐ Other (specify)_____

Additional Policy Specifications

Policy Date (optional)_____ Other _____

9. Are you financing or refinancing a mortgage and/or a home equity loan or contemplating the use of any kind of mortgage financing strategy in connection with the purchase of or the payment of premiums on the life insurance policy? . . . . . ☐ Yes ☐ No
(If yes, please review and acknowledge by signing the Mortgage Financing Disclosure Statement.)

10. Will you borrow money to pay the premiums for this policy or have someone else pay these premiums for you, in return for you assigning part of or all of the policy values to someone else? ☐ Yes ☐ No (If yes, please review and acknowledge by signing the Premium Financing Applicant Acknowledgement and Disclosure Statement.)

NON-MEDICAL INFORMATION

11. INSURANCE IN FORCE ON PROPOSED INSURED

a. Are any life insurance or annuity contracts in force? . . . . . ☐ Yes ☐ No
If yes, complete section below. (Attach separate sheet if necessary)

Company	Amount	WP ?	Personal/Business	Year Issued	Replacing ?	Amount ADB

b. Will any annuity or life insurance presently or recently inforce be replaced or changed by this policy applied for? . . . . . ☐ Yes ☐ No

c. Have you ever been declined, rated, or had coverage modified or withdrawn, or reinstatement declined by any insurance company? ☐ Yes ☐ No

d. Within the last year, has any other life, health or long term care insurance been issued or applied for, or is any to be applied for? . . . ☐ Yes ☐ No

12. OTHER NON-MEDICAL INFORMATION

a. Do you use any form of tobacco or nicotine based products? . . . . . ☐ Yes ☐ No
If no, have you used any form of tobacco or nicotine based products in the last 5 years? . . . . . ☐ Yes ☐ No
If yes, when did you last use tobacco or nicotine based products? _____ Type_____ Quantity_____

b. Have you engaged in the last 3 years, or do you intend within the next 12 months to engage:
1. In any aviation activity other than as a passenger? . . . . . ☐ Yes ☐ No
2. In ballooning, gliding, boat or vehicle racing, mountain or rock climbing, parachuting, sky diving, underwater diving or any other hazardous sport or activity? . . . . . ☐ Yes ☐ No

c. Within the last 5 years, have you filed for bankruptcy (personal or business)? . . . . . ☐ Yes ☐ No

d. Within the last 5 years, have you been charged with reckless driving, driving under the influence of alcohol or drugs, or 2 or more moving violations, or had your driver's license revoked or suspended, or received a warning letter? . . . . . ☐ Yes ☐ No

e. Have you been arrested for an illegal activity, acquired a criminal record, or are you currently on probation, parole, or under investigation? . ☐ Yes ☐ No

f. Are you a member of or do you contemplate joining one of the Armed Forces or an active or reserve military unit? . . . . . ☐ Yes ☐ No

g. Have you in the past 2 years traveled or do you intend to travel or live outside the United States or Canada? . . . . . ☐ Yes ☐ No

h. Is any proposed insured, owner or beneficiary a resident or citizen of or an entity organized under the laws of a country other than the U.S.? ☐ Yes ☐ No

i. Do you intend to sell or transfer all or any portion of this policy to another person, any group of investors or other entity? . . . . . ☐ Yes ☐ No

Give complete details of any **YES** answers to questions 11 and 12. (If necessary, use an additional page for additional details, **signed by the applicant and dated.)** _____

_____

13. PHYSICIAN INFORMATION

a. Name, address and phone # of your doctor(s) or health care provider(s): _____

_____

b. When did you last consult a doctor and why? _____

_____

c. What medication(s) (prescribed or over the counter) are you now taking? (If none, so state) _____

_____

MEDICAL INFORMATION If medical exam is required, questions 14-17 do not need to be completed.

14. PROPOSED INSURED

a. Height in shoes _____ feet _____ inches Weight in clothes _____ pounds

b. Have you gained or lost more than 10 pounds in the last year? ☐ Yes ☐ No

c. Are you now under observation or treatment? ☐ Yes ☐ No

d. Have you ever been diagnosed by a medical professional as having or been treated for AIDS or ARC (AIDS-related complex)? ☐ Yes ☐ No

e. Have you ever tested positive for antibodies to the AIDS Human T-Cell Lymphotropic (HIV) virus? ☐ Yes ☐ No

f. Have you ever requested or received a benefit, military deferment, discharge or rejection, payment or pension because of a disability, injury, or sickness? ☐ Yes ☐ No

15. HAVE YOU EVER HAD OR HAVE SYMPTOMS OF OR BEEN TREATED FOR:

a. Disease of the heart or circulatory system, including high blood pressure, heart attack, coronary artery disease, or chest pain? ☐ Yes ☐ No

b. Heart murmur, rhythm abnormality, heart catheterization, echocardiogram or an exercise treadmill test? ☐ Yes ☐ No

c. Cancer, tumors, lymphoma, leukemia, or any growths, lesions, polyps? ☐ Yes ☐ No

d. Diabetes, thyroid, glandular or endocrinal disorder? ☐ Yes ☐ No

e. Respiratory disorders including asthma, chronic bronchitis, emphysema, pneumonia, shortness of breath, or abnormal chest x-ray? ☐ Yes ☐ No

f. Disorder of the stomach, liver, pancreas or intestinal tract, including ulcerative colitis, Crohn's disease, or cirrhosis? ☐ Yes ☐ No

g. Disorder of the kidneys, prostate, bladder, reproductive organs, sexually transmitted diseases, sugar, albumin or blood in urine? ☐ Yes ☐ No

h. Stroke, transient ischemic attack (TIA), Parkinson's, multiple sclerosis, seizures, epilepsy, chronic headaches, memory changes or fainting? ☐ Yes ☐ No

i. Anxiety, depression, attempted suicide, attention deficit disorder or psychosis, mental or nervous system disorder? ☐ Yes ☐ No

j. Anemia, hepatitis, or any blood disorder? ☐ Yes ☐ No

k. Chronic back pain, arthritis, loss of limb, paralysis, muscle weakness or disease? ☐ Yes ☐ No

16. WITHIN THE LAST FIVE YEARS, OTHER THAN AS NOTED ABOVE, HAVE YOU:

a. Seen a doctor, health care provider, counselor, therapist, or had any illness, injury, surgery, diagnostic test or treatment, or been advised to have any diagnostic test, surgery or treatment not yet completed? ☐ Yes ☐ No

b. Been a patient of a clinic or hospital emergency room, or had any diagnostic test that was not normal? ☐ Yes ☐ No

c. Used any drug, narcotic or controlled substance not prescribed by a physician, or been arrested, counseled, treated, or participated in a support group because of alcohol, controlled substance or drug use? ☐ Yes ☐ No

d. Do you currently use alcoholic beverages? ☐ Yes ☐ No
If yes, what is the average number of drinks per day? ☐ 2 or less ☐ 3-5 ☐ 6 or more.

17. FAMILY HISTORY

a. Is there a family history of diabetes, cancer, heart disease, mental illness, or any hereditary disorders? ☐ Yes ☐ No

b. Family information (natural parents, brothers, sisters):

Family Member	Age if Living	Age at Death	Cause of Death
Father			
Brother(s)			

Family Member	Age if Living	Age at Death	Cause of Death
Mother			
Sister(s)			

Give complete details of any **YES** answers to questions 14 through 17. (If necessary, use an additional page for additional details, **signed by the applicant & dated.)**

Question Number	Date	Details, Include Diagnosis, Treatment, Duration, Result	Name, Address and Phone Number of Doctor / Medical Facility

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance may be guilty of a crime and subject to fines and confinement in prison, depending on state law.

TAXPAYER IDENTIFICATION

Instructions (Section references are to the Internal Revenue Code.)

Use this form to report the taxpayer identification number (TIN) of the **policy owner.**

Payors must generally withhold a specified percentage of taxable interest, dividend, and certain other payments if you fail to furnish payors with the correct taxpayer identification number (this is referred to as backup withholding). For most individual taxpayers, the taxpayer identification number is the social security number.

To prevent backup withholding on these payments, be sure to notify payors of the correct taxpayer identification number and properly certify that you are not subject to backup withholding under Section 3406(a)(1)(C).

Use this area to certify that the taxpayer identification number you are giving the payor is correct and that you are not subject to backup withholding.

Backup Withholding - You are subject to backup withholding if:

(1) You fail to furnish your taxpayer identification number to the payor; OR
(2) The Internal Revenue Service (IRS) notifies the payor that you furnished an incorrect taxpayer identification number; OR
(3) You are notified that you are subject to backup withholding [under Section 3406(a)(1)(C)]; OR
(4) For an interest or dividend account opened after December 31, 1983, you fail to certify to the payor that you are not subject to backup withholding under (3) above, or fail to certify your taxpayer identification number.

Payees Exempt From Backup Withholding - Certain payees, such as corporations, government agencies, etc. may be exempt from backup withholding.

What Number to Give the Payor - Give the social security number or employer identification number of the record owner of the account. If the account belongs to you as an individual, give your social security number. If the account is owned by a corporation, give the employer identification number of the corporation.

Obtaining a Number - If you don't have a taxpayer identification number or you don't know your number, obtain **Form SS-5**, Application for a Social Security Number Card, or **Form SS-4**, Application for Employer Identification Number, at the local office of the Social Security Administration or the Internal Revenue Service and apply for a number. Write “applied for” in place of your number. When you get a number, submit a new Form W-9 to the payor.

AGREEMENTS AND REPRESENTATIONS

It is hereby represented that the answers and statements on the application(s) and any Supplements required are complete, true and correctly recorded. Information not recorded on the application(s) and any Supplements will not be treated as known to the Company. A copy of the application(s) and any Supplements shall be a part of the policy, and it is agreed that the policy and copy of the application(s) and any Supplements constitute the entire contract. No changes will be made unless the owner agrees and the change is authorized in writing by an officer of the Company.

If a Conditional Life Insurance Agreement was delivered in consideration of the payment of the first premium and is in effect, its terms will apply. Otherwise the policy will take effect and coverage will begin on the issue date specified in the policy if the full first premium is paid, the Proposed Insured(s) is (are) living, and the answers and statements in the application(s) and any Supplements continue to be complete and true at the time of delivery of the policy.

Under penalties of perjury, I certify that (1) the social security or federal tax identification number shown on page 1 of this application for me as the owner of this policy is my correct taxpayer identification number, AND (2) I am a U.S. person (including a U.S. resident alien), AND (3) I am not subject to backup withholding because (a) I am exempt from backup withholding, or (b) I have not been notified by the IRS that I am subject to backup withholding as a result of failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding. NOTE: You must cross out item 3 in the above certification if you have been notified by the IRS that you are currently subject to backup withholding. The IRS does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

IMPORTANT INFORMATION ABOUT THE USA PATRIOT ACT

To help fight the funding of terrorism and money-laundering activities, the U.S. government has passed the USA PATRIOT Act, which requires financial institutions to obtain, verify and record information that identifies persons who engage in certain transactions with or through a financial institution, including insurance companies. This means that the Company will need to verify the **name, residential or street address (no P.O. Boxes), date of birth and social security number, drivers license and/or other identification information of all policy owners as may be required by law.**

AUTHORIZATION AND ACKNOWLEDGMENT

This authorization complies with the HIPAA Privacy Rule. I understand that if I refuse to sign this authorization, the Company may not be able to process my application for life insurance. I acknowledge that I have the right to request and receive a copy of this authorization.

Personal Health Information

I authorize any physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, health care provider, health plan, insurer, and/or any other entity subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that has provided treatment, service, payment, or coverage to me within the past 10 years to disclose my entire medical record and any other protected health information concerning me to the Company, its agents, employees, representatives, insurance support organizations, and reinsurers ("the Company"). Protected health information includes but is not limited to: hospital records, treatment records/office notes, consultation reports, workers' compensation information, diagnosis, prescriptions, and test results. It also includes information concerning the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases, and information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, health care provider, health plan, insurer, and/or other entity subject to HIPAA to release and disclose such information without restriction.

I understand that, unless prohibited by state and/or federal law, the protected health information is to be disclosed under this authorization so that the Company may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment 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, have applied for, or may in the future apply for with the Company. I understand any information disclosed under this authorization may no longer be covered by federal rules governing privacy and confidentiality of health information and may be subject to re-disclosure.

Personal Private Information

I understand that an investigative consumer report may be prepared in connection with this application. I authorize any consumer reporting organization or employer having non-medical information about me to release such information to the Company, its reinsurers, or its authorized representatives. I authorize the Company to prepare an investigative consumer report. I understand that I may request to be personally interviewed if an investigative consumer report is prepared in connection with this application and not to have personal information disclosed for marketing purposes. Any information obtained will not be released by the Company, its reinsurers, or representatives to any person or organization except to reinsuring companies, the Medical Information Bureau, or other persons or organizations performing business or legal services in connection with my application, claim, as may be permitted or required by law, or as I may further authorize.

Limitations, Revocation and Rights

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization at any time. The request for revocation must be in writing and sent to the attention of the Underwriting Department of the Company. I understand that a revocation is not effective to the extent that the Company has already relied on this authorization or to the extent that the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. Such revocation shall not apply to any use or disclosure of my protected health information specifically allowed without authorization by HIPAA and no action relating to this authorization shall be construed as creating any restriction on the uses that HIPAA allows without my authorization.

SIGNATURES

I have reviewed and understand the information contained above in the "Taxpayer Identification", "Agreements and Representations", including reviewing the answers and statements on the application(s) and any Supplements for accuracy, "Important Information About the USA Patriot Act", and "Authorization and Acknowledgment" sections, and further acknowledge receipt of the Disclosure Notice to Proposed Insured.

I understand, acknowledge and agree that the Agent has no authority to make any promise, representation or waiver regarding coverage or the terms of the policy. I also understand, acknowledge and agree that the Agent has no authority to provide any legal or tax advice on behalf of the Company. If any such legal or tax advice has been given, I understand, acknowledge and agree it has been done without Company authority and has not been given on behalf of the Company. I understand, acknowledge and agree that I am responsible for obtaining independent legal or tax advice with respect to any such matters. I understand, acknowledge and agree that all premium payments after the first are to be provided directly to the Company and that the Agent has no authority to receive, transmit, sign, endorse, deposit or process any subsequent payments made on the policy.

Signed / Dated at _____
City, State

On _____
Date

X _____
Signature of Licensed Agent

_____
Parent/Guardian or Witness (if required)

X _____
Signature of Owner/Proposed Insured
(or signature of Insured's Personal Representative*)

X _____
Signature of Owner if other than Proposed Insured

_____
If Owner is a corporation, business firm or trust, give full name and an Authorized person must sign and provide title

*If you are the Proposed Insured's Personal Representative, describe the scope and/or basis of your authority to act on the Proposed Insured's behalf:

_____

_____

INDEXED ACKNOWLEDGMENTS

I understand that I am applying for an indexed product. While the values of the policy may be affected by an external index, the policy does not directly participate in any stock or equity investments. I understand that any values shown, other than guaranteed minimum values, are not guarantees, promises or warranties.

_____

Applicant's Signature

Aviva Life and Annuity Company
P.O. Box 1555
Des Moines, IA 50306-1555

AVIVA

Conditional Life Insurance Agreement

(In this receipt, "Company" refers to the insurance company named above.)

ADDITIONS, DELETIONS, OR OTHER ALTERATIONS TO THIS AGREEMENT ARE STRICTLY PROHIBITED.

Insurance applied for on the application is provided by this form from the START DATE to the STOP DATE, as defined below. However, NO INSURANCE is provided unless ALL the CONDITIONS AND LIMITATIONS of this Agreement are met. If not met, the Company's liability under this Agreement is limited to a refund of the total premium received.

DO NOT COLLECT CASH IF DEATH BENEFIT AMOUNT APPLIED FOR EXCEEDS $3,000,000.

CONDITIONS AND LIMITATIONS

1. It is a condition precedent that the proposed insured be insurable on the START DATE. This means "insurable" under our rules and limits.
2. There is no insurance before the START DATE.
3. There is no insurance after the STOP DATE.
4. There is no insurance if any material misrepresentation exists on the application or supplements.
5. This form is void if any check or draft is not valid.
6. There is no insurance if less than a full month premium is paid.
7. Life Insurance limits are the lesser of:
   a. $500,000 or the amount on page 2 of the application, if the proposed insured is insurable at the rate applied for or better; or
   b. $100,000 or the amount on page 2 of the application, if the proposed insured is insurable, but at a higher rate than applied for.
8. If the proposed insured dies by suicide, the Company's liability under this Agreement is limited to a refund of the payment received.

START DATE

START DATE means the later of:

1. completion of all parts of the application and supplements thereto; OR
2. the date any medical exam or other required medical studies or tests are completed.

STOP DATE

STOP DATE means the earliest of:

1. the date a non-acceptance notice is mailed by the Company; OR
2. the day before the policy date; OR
3. 60 days after the START DATE.

RECEIVED from _____ Payment in the Amount of $ _____

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE COMPANY. DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE PAYEE BLANK. ALL PREMIUMS AFTER THE FIRST ARE TO BE PROVIDED DIRECTLY TO THE COMPANY.

The Proposed Insured is _____ Signature of Owner _____

Signed at _____ _____ _____ _____
City State Date Signature of Agent

PLEASE RETURN ONE COPY TO HOME OFFICE WITH CHECK

Aviva Life and Annuity Company
P.O. Box 1555
Des Moines, IA 50306-1555

AVIVA

Conditional Life Insurance Agreement

(In this receipt, "Company" refers to the insurance company named above.)

ADDITIONS, DELETIONS, OR OTHER ALTERATIONS TO THIS AGREEMENT ARE STRICTLY PROHIBITED.

Insurance applied for on the application is provided by this form from the START DATE to the STOP DATE, as defined below. However, NO INSURANCE is provided unless ALL the CONDITIONS AND LIMITATIONS of this Agreement are met. If not met, the Company's liability under this Agreement is limited to a refund of the total premium received.

DO NOT COLLECT CASH IF DEATH BENEFIT AMOUNT APPLIED FOR EXCEEDS $3,000,000.

CONDITIONS AND LIMITATIONS

1. It is a condition precedent that the proposed insured be insurable on the START DATE. This means "insurable" under our rules and limits.
2. There is no insurance before the START DATE.
3. There is no insurance after the STOP DATE.
4. There is no insurance if any material misrepresentation exists on the application or supplements.
5. This form is void if any check or draft is not valid.
6. There is no insurance if less than a full month premium is paid.
7. Life Insurance limits are the lesser of:
   a. $500,000 or the amount on page 2 of the application, if the proposed insured is insurable at the rate applied for or better; or
   b. $100,000 or the amount on page 2 of the application, if the proposed insured is insurable, but at a higher rate than applied for.
8. If the proposed insured dies by suicide, the Company's liability under this Agreement is limited to a refund of the payment received.

START DATE

START DATE means the later of:

1. completion of all parts of the application and supplements thereto; OR
2. the date any medical exam or other required medical studies or tests are completed.

STOP DATE

STOP DATE means the earliest of:

1. the date a non-acceptance notice is mailed by the Company; OR
2. the day before the policy date; OR
3. 60 days after the START DATE.

RECEIVED from _____ Payment in the Amount of $ _____

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE COMPANY. DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE PAYEE BLANK. ALL PREMIUMS AFTER THE FIRST ARE TO BE PROVIDED DIRECTLY TO THE COMPANY.

The Proposed Insured is _____ Signature of Owner _____

Signed at _____ _____ _____ _____
City State Date Signature of Agent

PLEASE RETURN ONE COPY TO HOME OFFICE WITH CHECK

Aviva Life and Annuity Company
Home Office: Des Moines, IA
Mailing Address:
P.O. Box 4905
Des Moines, IA 50306-4905
Fax: 1-800/531-0038

AVIVA

Disclosure Notice to Proposed Insured

In this Disclosure, "Company" refers to the insurance company named above.
In this Disclosure, "You" and "Your" mean the Proposed Insured.

MEDICAL INFORMATION BUREAU (MIB)

Information regarding Your insurability will be treated as confidential. The Company or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau (MIB), a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. If You apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from You, MIB will arrange disclosure of any information it may have in Your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642) if you are interested in such a disclosure. If you question the accuracy of information in MIB's file, you may contact the MIB information office in writing at Post Office Box 105, Essex Station, Boston, Massachusetts 02112 and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act.

The Company or its reinsurers may also release information in its file to insurance support organizations, or to other insurance companies to whom You may apply for life or health insurance or to whom a claim for benefits may be submitted. Insurance support organizations include any person or entity that assembles or collects information about individuals primarily for the purpose of providing such information to an insurance company.

INVESTIGATIVE CONSUMER REPORT

In addition to requesting a report from MIB, as a part of the Company's underwriting process the Company may request an investigative consumer information report to confirm and supplement the information on Your application about Your general health, employment and occupation, finances, smoking habits, and hazardous activities. Such a report may also cover Your mode of living, except as may be related directly or indirectly to Your sexual orientation, but including alcohol and drug use, general reputation, and driving record. Some of this information may be obtained through personal interviews with You or Your family, friends, associates, or others with whom You are acquainted. If a consumer information report is requested, You may request to be personally interviewed if You can be contacted during normal business hours. An interview is normally conducted, but You are entitled to make a specific request. You may submit a written request asking to be notified if an investigative consumer report has been prepared. You may also request information on what organization prepared such a report and how to contact that organization.

The Company keeps such information reports confidential and uses them only to evaluate and underwrite Your application. You have a right under the Fair Credit Reporting Act to make a written request to inspect and obtain a copy of a consumer information report. If the Company requests a report and the report has an adverse effect on Your insurability, the Company will notify You in writing and give You the name and address of the reporting company.

USA PATRIOT ACT

To help fight the funding of terrorism and money-laundering activities, the U.S. government has passed the USA PATRIOT Act, which requires financial institutions to obtain, verify and record information that identifies persons who engage in certain transactions with or through such financial institutions, including insurance companies.

This means that the Company will need to verify the **name, residential or street address (no P.O. Boxes), date of birth and social security number or other tax identification number, and other information as deemed necessary, of all policy owners.**

INFORMATION PRACTICES

Personal information the Company obtains during the underwriting process is private and confidential, and the Company will not disclose it to other persons or organizations without Your written authorization except to the extent necessary to conduct the Company's business, or as permitted or required by law. The Company reserves the right to disclose medical information to a medical professional of Your choice and the right to arrange for an insurance support organization to disclose information on the Company's behalf.

Personal information that may be collected includes mental and physical health conditions, medical history, medical treatment, and information about Your general character, habits, hobbies or avocations, finances, employment, occupation, reputation, or marital

status. The information may be collected for the Company by the Company's employees, the Agent, and insurance support organizations that assemble information or prepare investigative consumer reports about You. Information may be collected from personal interviews or by telephone calls with You or Your family, neighbors, friends, business associates, and employers, also from public records, court documents, insurance support organizations and other insurance companies or insurance institutions. If there is a need to contact You by phone, a specially trained representative will call to verify or to ask for additional information relating to the underwriting of Your application.

DISCLOSURE OF INFORMATION AND RIGHT OF ACCESS TO INFORMATION

The Company may disclose personal information about You without prior authorization under certain circumstances. For instance, disclosure may be made to persons or organizations to allow such persons or organizations to perform a business, professional, or insurance function for the Company, or an insurance support organization, or to provide information to determine eligibility for insurance benefits or detect fraud, misrepresentation, or material non-disclosure. The Company may give information to accounting firms performing audits, governmental agencies reviewing Company practices, or attorneys hired to protect the Company's legal interest.

Information may be disclosed to reinsurance companies or another insurance company to which You have applied for coverage or benefits. Information may be furnished to agents to aid them in providing adequate service to a policyowner. Other disclosures may be made as permitted or required by law. The Company may also disclose information to medical professionals where required by law for the purpose of informing You of a medical problem of which You may not be aware or to persons or organizations for the purpose of conducting research including actuarial, marketing, and underwriting studies. This may include various insurance industry groups which conduct studies about risk experience or medical backgrounds of insured lives. No medical record information or personal information relating to Your character, personal habits, mode of living, or general reputation will be released to anyone who receives personal information for purposes of marketing a product or service.

Upon Your written request, the Company will inform You of all persons or entities to whom the Company, the Agent, or any insurance support organization has released Your personal information during the 2 years prior to Your request.

You have a right of access to Your personal information that the Company has collected, and a right to know from what sources it was collected. You may submit a written request to the Company that includes Your full name, address, and policy number and reasonably describes the information desired. The Company will mail the information to You or You may review such personal information in person at one of the Company's offices. The Company will inform You of the nature and substance of the information within 30 days from receipt of the request. The Company will identify sources of information such as hospitals, clinics, doctors, or insurance support organizations. The Company will not identify sources of information where such information was obtained from individuals such as friends or neighbors. The Company will not provide access to information obtained in connection with or in anticipation of a claim for policy benefits, or as part of a civil or criminal proceeding.

You may request that the Company correct, amend, or delete personal information in whole or in part by making written request to the Company. Within 30 days from receipt of the request, the Company will inform You that the Company has either changed such information or the Company will communicate the reasons for not changing such information. If the Company does not make the requested change(s), You may then submit a written statement to the Company setting forth Your opinion regarding the information and/or the reasons why You disagree with the Company's position. All written communications will become part of the policy file.

In any case, the Company will provide either the corrected personal information, or Your request and statement, to all insurance support organizations with whom the Company has shared such information during the previous 7 years. The Company will also notify any specific persons or entities that You direct the Company to inform, who may have received such information during the previous 2 years.

Aviva Life and Annuity Company
800/800-9882
P.O. Box 1555
Des Moines, Iowa 50306-1555

Pre-Authorized Check (PAC) Authorization Form

MUST BE COMPLETED IN FULL - (Please print or type all information **except** signatures. Please use black ink.)

Insured: _____

Owner: _____ Telephone No. of Owner: (_____)_____-_____

Owner's Address: _____ Address Change Requested: ☐

CHECK APPROPRIATE BOX

TYPE OF REQUEST:

☐ FIRST REQUEST FOR PAC PLAN (A check with receipt of funds is needed for initial premium payments. First or initial premiums cannot be drawn automatically.)

☐ ADD TO EXISTING PAC UNDER POLICY #_____

☐ CHANGE OF BANKS, ACCOUNT NUMBER, OR PREMIUM PAYOR - allow 15 days for change processing.

FOR USE ON NEW BUSINESS CASES ONLY:

☐ REQUESTED BILLED AMOUNT (Universal Life Only) $_____

☐ PLEASE INDICATE DAY 1st - 28th _____

PAC WILL BE THE SAME AS POLICY DATE UNLESS OTHERWISE INDICATED.

Completion of this Authorization DOES NOT provide coverage under a Conditional Life Insurance Agreement.

POLICIES TO BE INCLUDED IN THIS (PAC) PLAN

Policy Number	Insured's Name	Premium/Loan Repay Amount
_____	_____	_____
_____	_____	_____
_____	_____	_____

AUTHORIZATION TO HONOR BANK WITHDRAWALS BY (Must be completed)**:**

PREMIUM PAYOR (Print Name as Shown on Financial Institution Records) _____

Financial Institution Name _____ hereinafter referred to as "You"

Address _____

Telephone Number _____

Bank Routing No. ☐☐☐☐☐☐☐☐☐ Bank Account No. _____

9 numbers required

☐ Checking account ☐ Savings account

The Company may assess a $25 fee if any withdrawal authorized herein is dishonored for any reason.

I hereby request and authorize you to pay and charge to my account debit entries, including checks, drafts and other orders whether by electronic or paper means initiated on my account by the Company, to its own order. This authorization will remain in effect until revoked by me in writing in such time and in such manner as to afford you the Company a reasonable opportunity to act on it, and until you receive such notice, I agree that you shall be fully protected in honoring any such debit entry. In the event you comply with the above request and authorization, I agree that you may at any time cease your participation in and compliance with this request and authorization by giving thirty (30) days written notice to me and the Company.

I further agree that if such debit entry is dishonored, whether with or without cause, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance. I understand this form is a bank authorization only and there will be no charge to my account until and unless a policy of insurance is issued by the Company.

X_____ X_____

(Signature of Premium Payor) (Additional signature if joint account)

X_____ Date_____

(Signature of Policyholder if other than Premium Payor)

15036 1006

Aviva Life and Annuity Company
P.O. Box 1555
Des Moines, IA 50306-1555

Agents Report for Life Application

1. a. Does the proposed insured have any life insurance or annuity contract(s) currently active with our company or any other company? ☐ Yes ☐ No
(If Yes, and if required by state regulation, any Replacement Comparison, Notice or Statement must accompany this application.)
b. Will any annuity or life insurance presently or recently in force be replaced or changed by this policy applied for? . . . . . ☐ Yes ☐ No
if 1b is answered "yes", please complete the following questions:
i. What is the primary reason for the replacement? _____
ii. Are you the writing producer on the current policy? . . . . . ☐ Yes ☐ No
iii. When was the current policy issued? _____
iv. With what underwriting classification was the current policy issued? _____
v. What are the current/proposed annualized premiums? _____
vi. What are the current/proposed death benefit amounts? _____
vii. What are the remaining surrender charges on the current policy? _____
viii. Have you discussed/described the surrender charges and surrender charge period regarding the proposed policy? . . . . . ☐ Yes ☐ No
ix. If values from an existing annuity contract are being used to pay premiums on the proposed policy, how has the original objective of the annuity contract changed? _____
x. If values from an existing annuity contract are being used to pay premiums on the proposed policy, have any tax implications been explained to the customer? . . . . . ☐ Yes ☐ No
xi. 1035 Exchange (attach required forms) ☐ External ☐ Internal _____
2. a. How long have you known the proposed insured? _____
b. Is the proposed insured a relative of or does proposed insured have a business relationship with the producer? . . . . . ☐ Yes ☐ No
If Yes, explain _____
c. Did the producer personally see all the persons to be covered and were answers recorded exactly as given? . . . . . ☐ Yes ☐ No
If No, explain and arrange for additional evidence of insurability _____
d. I personally viewed all driver's licenses or other government issued photo identification documents . . . . . ☐ Yes ☐ No
3. Is proposed insured(s) a U.S. citizen? ☐ Yes ☐ No If no, how long in U.S.? _____ Type of Visa? _____
4. Was any other person present to answer questions? ☐ Yes ☐ No If yes, who and why _____
5. Does proposed insured and owner speak and understand English? ☐ Yes ☐ No
6. **a. If proposed insured is a minor dependent, complete for all brothers and sisters:**

Age	Sex	Amount of Life Insurance in Force

Age	Sex	Amount of Life Insurance in Force

b. Amount of life insurance in force on each supporting parent or legal guardian $ _____
7. **Medical requirements arranged ☐ Paramedical Exam ☐ EKG ☐ Blood Analysis ☐ Physician's Exam Date Scheduled** _____
☐ Check here if the exam has already been done. Name & Phone # of vendor _____
8. If Married:
a. Spouse's name _____ b. Spouse's occupation _____
c. Amount of life insurance in force on spouse $ _____ d. Spouse's annual earned income $ _____
9. a. Purpose of insurance ☐ Business ☐ Personal ☐ Estate
(If multi-purpose, give percentage of face or split the amount by purpose in remarks section below.)
b. If business: ☐ Deferred Comp ☐ Buy/Sell ☐ Split Dollar ☐ Key Person ☐ Premium Financing ☐ Mortgage Financing
☐ _____
Business net annual income $ _____ Business net worth $ _____
Proposed insured's business life insurance in force $ _____ % of ownership _____
Business life insurance issued or applied for on other owners, officers, partners or key person(s):

Name and Title	% of Business Owned	Insurance Company	Amount in Force

10. ☐ Additional ☐ Alternate policy: Amount $ _____ Plan _____

11. Remarks _____

_____

_____

_____

PRODUCER'S CERTIFICATION

I certify that:

- I saw and know the proposed insured(s) to be the person(s) described in this application;
- I reviewed the appropriate documents, and have truly and accurately recorded the information supplied by the applicant;
- I know of no condition affecting the eligibility or insurability of the applicant not fully set forth in the application;
- I have made no declaration, representation, or waiver regarding coverage or the provisions or terms of the application or policy;
- Other than policy-related information, I have given the proposed insured or owner(s) nothing of value in connection with this application or policy;
- I am licensed in the state in which this application was completed;
- I have delivered all required notices and disclosures and fully complied with all privacy and replacement regulations;
- Only company approved sales materials were used and copies of such materials were left with the client and retained in my files;
- I assume full responsibility for the delivery of the policy and the submission of the first premium.

Agency No. _____ Agency Name _____

List of all producers (please print)	Producer code#	Commission share

Signed at _____ Signed (writing producer) **X** _____ Date _____

Phone #_____ E-Mail _____ Fax # _____

Preferred mode of communication? ☐ Phone ☐ E-Mail ☐ Fax

Aviva Life and Annuity Company
P.O. Box 1555
Des Moines, IA 50306-1555

Notice and Consent For HIV-Related Testing

To evaluate your insurability, the insurer named above (the Insurer) has requested that you provide a sample of your blood, oral fluid extracted from cheek and gum tissue, or urine for testing and analysis to determine the presence of human immunodeficiency virus (HIV) antibodies. By signing and dating this form you agree that this test may be done and that underwriting decisions will be based on the test result. A series of three tests will be performed by a licensed laboratory through a medically accepted procedure.

Pre-Testing Considerations
Many public health organizations have recommended that before taking an HIV-related blood test a person seek counseling to become informed concerning the complications of such a test. You may wish to consider counseling, at your expense, prior to being tested.

Meaning of Positive Test Result
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 you are at significantly increased risk of developing problems with your immune system. 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 information on the medical implications of a positive test.

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.

Confidentiality to Test Results
All test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed as required by law or may be disclosed to employees of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer or to outside legal counsel who needs such information to effectively represent the Insurer in regard to your application. The results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover results of test for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular person.

Notification of Test Result
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 will receive written notification of such results from a physician you have designated or, in the absence of such designation, from the Texas Department of Health. Because a trained person should deliver that information so you can understand clearly what the test result means, please list your private physician so that the Insurer can have him or her tell you the test result and explain its meaning.

Name of physician for reporting a possible positive test result: _____

Address: _____

In event the test is positive and you are denied coverage because of that fact and you request the reason for denial, the Insurer may require you to name a physician at that time in order to receive the information.

If the test indicates a positive result, but you do not designate a private physician, the test result will be provided to you by a representative of the Texas Department of Health.

Consent
I have read and I understand this Notice and Consent for HIV-Related Testing. I voluntarily consent to the collection of a sample of blood, oral fluid extracted from cheek and gum tissue, or urine from me, the the testing of that sample, and the disclosure of the test results as described above. I have read the information on this form about what a test result means.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

_____ _____
Name of Proposed Insured Signature of Proposed Insured or Parent/Guardian

_____ _____
Address Date Signed

Aviva Life and
Annuity Company
800/800-9882
P.O. Box 1555
Des Moines, IA 50306-1555

Authorization for Release of Personal Health Information

Any alteration of this form will not be accepted.

This authorization complies with the HIPAA Privacy Rule

Name of Proposed Insured _____ Birth Date _____/_____/_____
month day year

I authorize any physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, health care provider, health plan, insurer, and/or any other entity subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that has provided treatment, service, payment, or coverage to me within the past 10 years to disclose my entire medical record and any other protected health information concerning me to the Company, its agents, employees, representatives, insurance support organizations, and reinsurers ("the Company"). Protected health information includes but is not limited to: hospital records, treatment records/office notes, consultation reports, workers' compensation information, diagnosis, prescriptions, and test results. It also includes information concerning the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases, and information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, health care provider, health plan, insurer, and/or other entity subject to HIPAA to release and disclose such information without restriction.

I understand that, unless prohibited by state and/or federal law, the protected health information is to be disclosed under this authorization so that the Company may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment 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, have applied for, or may in the future apply for with the Company. I understand any information disclosed under this authorization may no longer be covered by federal rules governing privacy and confidentiality of health information and may be subject to redisclosure.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization at any time. The request for revocation must be in writing and sent to the attention of the Underwriting Department of the Company at the address listed above. I understand that a revocation is not effective to the extent that the Company has already relied on this authorization or to the extent that the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. Such revocation shall not apply to any use or disclosure of my protected health information specifically allowed without authorization by HIPAA and no action relating to this authorization shall be construed as creating any restriction on the uses that HIPAA allows without my authorization.

I understand that if I refuse to sign this authorization, the Company may not be able to process my application for life insurance. I acknowledge that I have received a copy of this authorization.

_____ _____
Signature of Proposed Insured or Personal Representative Date

If you are the Personal Representative of the Proposed Insured, describe the scope and/or basis of your authority to act on the Insured's behalf: _____

_____

AMERUS
Life Insurance Group

☐ **AmerUs Life Insurance Company**
800/800-9882
P.O. Box 1555 • Des Moines, Iowa 50306-1555

☐ **Indianapolis Life Insurance Company**
800/428-7031
P.O. Box 14590 • Des Moines, IA 50306-3590

Please check appropriate company. ONE BOX MUST BE CHECKED.

Supplemental Information Questionnaire - Life Insurance Application

Policy Number: _____

As part of your application for life insurance, please complete the following:

1. Are you financing or refinancing any type of mortgage and/or home equity loan, or contemplating the use of any kind of mortgage financing strategy in connection with the purchase of or to pay or facilitate the payment of premiums on the life insurance policy being applied for? This includes, among other things, any type of "reverse" mortgage strategy. ☐ Yes ☐ No
2. Will you borrow money from any source to pay the premiums for this policy? ☐ Yes ☐ No
3. Will you have someone other than yourself pay the policy premiums for you or on your behalf? ☐ Yes ☐ No
   If yes, will you be assigning part of or all of the policy cash values and/or death benefit to someone else? ☐ Yes ☐ No
4. Do you intend to sell and/or transfer all or any portion of this policy to another person, or any group of investors, or any other entity? ☐ Yes ☐ No
5. Has anyone offered you "free insurance" in connection with this policy application? ☐ Yes ☐ No

If any of the answers to the above are "yes" answers, please attach a sheet to this form giving complete details to those "yes" answers. Such sheet must be signed and dated by all owners and insureds.

I certify that my answers to the questions on this supplemental information form are true and accurate.

IMPORTANT INFORMATION ABOUT THE USA PATRIOT ACT

To help fight the funding of terrorism and money-laundering activities, the U.S. government has passed the USA PATRIOT ACT, which requires financial institutions to obtain, verify and record information that identifies persons who engage in certain transactions with or through a financial institution, including insurance companies. This means that the Company will need to verify the **name, residential or street address (no P.O. Boxes), date of birth and social security number, drivers license and/or other identification information of all policy owners as may be required by law.**

_____ _____
Insured Owner (if other than insured)

Date: _____ Date: _____

Agent's Signature: _____ Signed / Dated at: _____
City, State

16137020 7

AVIVA

☐ **Aviva Life and Annuity Company**
P.O. Box 4905
Des Moines, IA 50306-4905

☐ **Indianapolis Life Insurance Company**
P.O. Box 14590
Des Moines, IA 50306-3590

Part 1

IMPORTANT NOTICE:

REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

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

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

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

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

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

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

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

2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ❑ YES ❑ NO

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

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

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

The existing policy or contract is being replaced because _____.

I certify that the responses herein are, to the best of my knowledge, accurate:

_____ _____
Applicant's Signature and Printed Name Date

_____ _____
Producer's Signature and Printed Name Date

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

PROVIDE IN TRIPLICATE: 1 - H.O. 2 - APPLICANT 3 - AGENT

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

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

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

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

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:
How are premiums for both policies being paid?
How will the premiums on your existing policy be affected?
Will a loan be deducted from death benefits?
What values from the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:
Will you pay surrender charges on your old contract?
What are the interest rate guarantees for the new contract?
Have you compared the contract charges or other policy expenses?

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

RIGHT TO CANCEL: AMENDED
The language found on the cover of your policy will state that you have the right to cancel your policy and receive an unconditional full refund of all premiums paid. This document amends your right to cancel this policy by extending the cancellation time period to 30 days after the date of receipt of the policy.

PRODUCER:
I certify that I have used only Company approved sales materials, or I have attached copies of any unapproved sales materials. Copies of all sales materials were left with the applicant.

_____ _____
Producer's Signature Date

PRODUCER OPTIONAL:
List all company approved sales material by form number or brief description.

_____ _____ _____
_____ _____ _____
_____ _____ _____

PROVIDE IN TRIPLICATE: 1 - H.O. 2 - APPLICANT 3 - AGENT