

LIFE INSURANCE APPLICATION — PART IA (LUC-118 7/02)

- Symetra Life Insurance Company (Redmond, WA)  
 American States Life Insurance Company (Indianapolis, IN)

P.O. Box 84068  
 Seattle, WA 98124-9918

APPLICANT INFORMATION

Life Insurance for:  Male  Female Soc. Sec. No. \_\_\_\_\_

Street/PO Box \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_ Best Time to call \_\_\_\_\_ Best Day to call \_\_\_\_\_

Occupation \_\_\_\_\_ Annual Income \_\_\_\_\_ State of Birth \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Driver's License # \_\_\_\_\_ Date of Birth \_\_\_\_\_

Owner if other than proposed Insured (provide address in remarks section) Soc. Sec./Tax ID: \_\_\_\_\_

Insurance Needed For  Debt/Family/Business Protection  Income Replacement  Retirement/Estate Planning  Other \_\_\_\_\_

**BENEFICIARY INFORMATION** (P-Primary, C-Contingent)

Name	Relationship	%	P	C

Any living children born of this marriage or legally adopted to share equally. \_\_\_\_\_

Quoted Premium \$ \_\_\_\_\_

Premium Payment Frequency:  Annual  Semi-Annual  Qtr.  Automatic Monthly EFT \*

\*Marking this box authorizes us to automatically deduct premium from your account

**Plan Choice**

Symetra Variable Universal Life \_\_\_\_\_

Death Benefit Option:  Level  Increasing

Universal Life Plan \_\_\_\_\_

Death Benefit Option:  Level  Increasing

Term Plan (please select term) \_\_\_\_\_

10Yr  15Yr  20Yr  30Yr  ART

Other \_\_\_\_\_

**Riders**

On Self? (UL Only) \_\_\_\_\_

On others? How many? (please complete part 1A for each rider) \_\_\_\_\_

Include my children? (please complete the ICB form) \_\_\_\_\_

Waiver of Premium \_\_\_\_\_

Waiver of Monthly Ded. (UL Only) \_\_\_\_\_

Other \_\_\_\_\_

**Rate Class Applied For**

Standard Preferred Preferred Plus Preferred Best

Nonsmoker  Non-Nicotine User  Non-Nicotine User  Non-Nicotine User

Cigarette Smoker  Smoker  Non-Nicotine User

TEMPORARY INSURANCE

**Temporary Life Insurance Agreement (TIA) questions:**

	Yes	No
1. Within the past 90 days, has the proposed Insured been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>
2. In the past two years has the proposed Insured been treated for: heart attack, stroke, coronary artery disease, cancer, alcohol, drugs, or Acquired Immunodeficiency Syndrome (AIDS)/Aids Related Complex (ARC) by a medical professional?	<input type="checkbox"/>	<input type="checkbox"/>

**Payment Information:**  
 If either Temporary Life Insurance Agreement question is answered "yes" or left blank, or if the requested amount exceeds \$1,000,000, no premium may be collected and no coverage is in effect under the Temporary Life Insurance Agreement.

Payment with Application \$ \_\_\_\_\_ (payable to company):

I (we) agree that all statements and answers recorded on this application are true and complete to the best of my/our knowledge, and shall form a part of any policy issued. I have also read the Temporary Life Insurance Agreement. (Max. Coverage is \$250,000.)

REMARKS

Remarks: Please explain any yes answer to questions 1 and 2 under Temporary Insurance. Please list the address of the Owner if other than proposed insured.

REPLACEMENT		Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Do you have any other existing insurance policies or annuity contracts with this or any other company? (in force or applied for)	Company	Face Amount	Policy Type	Annual Premium
To the best of the applicant's knowledge, will the policy applied for replace any existing life insurance policy or annuity, or is any part of the premium to be paid by policy loan, or cash value on insurance presently in force? (if yes, attach state replacement disclosure)		Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Existing Policy Cash Value \$ _____	Amount of Surrender Charge \$ _____			
Will new policy have surrender charges?	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
Does the applicant have any existing life insurance policies or annuity contracts with this or any other company?	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
To the best of your knowledge, will this insurance replace or change any existing life insurance or annuity?	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
If replacing, how does this policy better serve the applicant's needs?				

**AGENT**

**AUTHORIZATION TO RELEASE PERSONAL INFORMATION**

I hereby authorize and request any medical care provider, pharmacy, pharmacy benefits manager, individual employer, insurance company, reinsuring company, medical examiner, consumer reporting agency, or other person or organization, and MIB, Inc., to disclose any and all medical information, non-medical information, employment information, and insurance information they hold concerning me, to the employees, agents, or attorneys of Symetra Life Insurance Companies\*. This disclosure authorization will permit employees, agents or reinsurers of Symetra Life Insurance Companies to view, copy, be furnished copies, share, or be given details of all such information described above including, but not limited to, mental and physical condition, evaluation, diagnoses, treatment, prognoses, prescription records, and/or toxicology results; specifically to include drug, alcohol use, mental illness, psychiatric treatment or diagnosis, testing and/or treatment of HIV (AIDS virus) and/or other sexually-transmitted diseases. Symetra Life Insurance Companies obtain medical information only in connection with specific products or claims. Symetra Life Insurance Companies will not use or share personally identifiable medical information for any purpose other than the underwriting or administration of your policy, claim or account. I understand that the information obtained pursuant to this Authorization will be used for the purpose of verifying, evaluating, negotiating, and other pertinent legal uses, with respect to my application for insurance, or claim under a policy of insurance. This authorization will expire at the end of the contestability period of any insurance policy issued in reliance on the records obtained through this authorization or twenty-four (24) months after the date of signing this authorization. The individual signing this authorization has the right to revoke an authorization in writing, except to the extent that action has been taken in reliance on the authorization, or during a contestability period. A written statement revoking this authorization delivered to Symetra Life Insurance Companies at their usual business addresses will revoke this authorization. Any copy of this authorization shall have the same authority as the original. I also understand that I have a right to receive a copy of this authorization upon request. I, the Owner, certify under the penalties of perjury that (1) the number shown in Applicant Info section is my correct taxpayer identification number, and (2) I am not subject to backup withholding.

Any person who, with intent to defraud or knowing he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud, excluding residents of Connecticut, Nebraska, and N. Carolina.

Signed this \_\_\_\_\_, at \_\_\_\_\_, State of \_\_\_\_\_

Printed Name of Proposed Insured \_\_\_\_\_

Signature of Proposed Insured (Age 15 or older, 16 in CA) \_\_\_\_\_

Signature of Applicant/Owner \*\* if other than Proposed Insured \_\_\_\_\_

Print Name of Writing or Authorized Agent \_\_\_\_\_

Signature of Writing or Authorized Agent \_\_\_\_\_

Agent Phone \_\_\_\_\_ Agent Email \_\_\_\_\_

Agent Stat Number \_\_\_\_\_

\* Symetra Life Insurance Companies include: Symetra Life Insurance Company, Symetra National Life Insurance Company, American States Life Insurance Company.  
 \*\* If applicant is corporation/partnership, a corporate officer/partner other than proposed insured must sign.

## NOTICE OF INSURANCE INFORMATION PRACTICES

**MIB, Inc. (Medical Information Bureau, MIB)** – MIB, Inc. is a nonprofit corporation which operates an information exchange on behalf of its member life insurance companies. We are a member. The purpose of the MIB is to protect its member companies and their policyowners from those who would conceal significant facts relevant to their eligibility for insurance. The information we obtain from MIB may alert us to the possible need for further investigation. We rarely use it to make a final underwriting decision, but if we do, we will notify you in writing. As a member company, we will ask the MIB if it has a record about you. If you previously applied to a member company, MIB may have information about you in its file. We will treat information about you as confidential. Symetra or American States Life or their reinsurers may, however, make a brief report to the MIB. This report is transmitted in a coded form, in order to maintain confidentiality, and only authorized underwriters may, however, make a brief report to the MIB. If you later apply to another MIB member company for life or health insurance, or you submit a claim to a member company, MIB, upon request, will supply the member company with the information it may have about you in its file. At your request the MIB will arrange disclosure of any information it may have about you in its file. If you question the accuracy of information on file, you may contact the MIB and seek a correction, following the procedures set forth in the Federal Fair Credit Reporting Act. The address of the information office of MIB, Inc. is P.O. Box 105, Essex Station, Boston Massachusetts 02112, telephone number (617) 426-3660.

**Investigative Consumer Report** – As a part of our underwriting procedure, we may request an investigative consumer report from a consumer reporting agency. A consumer report confirms and supplements the information on your application about your employment, residence, finances, smoking habits, marital status, occupation, hazardous avocations and general health. This report may also include information concerning your general reputation, personal characteristics and mode of living except as may be related directly or indirectly to your sexual orientation, including drug and alcohol use, motor vehicle driving record and any criminal activity. This information may be obtained through personal interviews with you, your family, friends, neighbors and business associates. If a report is required, you may request to be personally interviewed. If you wish to be personally interviewed, request this in the remarks section on the reverse side of this application and we will notify the consumer reporting agency.

The information contained in the report may be retained by the consumer reporting agency and later disclosed to other companies to the extent permitted by the Fair Credit Reporting Act. We hold investigative consumer reports in strict confidence, and we use them only to evaluate your application on a fair and equitable basis. You have a right to inspect and obtain a copy of this report from the consumer reporting agency. Such a report rarely has an adverse effect on an individual's eligibility for insurance. If it should, however, we will notify you in writing, and identify the reporting agency. You, or your authorized representative, are entitled to a copy of this Notice.

**Disclosure to Others** – Personal information we obtain about you during the underwriting process is confidential, and we will not disclose it to other persons or organizations without your written authorization, except to the extent necessary for the conduct of our business. Examples of situations where we may share information about you follow:

1. The agent may retain a copy of your application. If reinsurance is required, the reinsurance company will have access to our application file. We give the consumer reporting agency enough identify information about you so that it may initiate a consumer report investigation.
2. We may release information to another life insurance company to whom you have applied for life or health insurance, or to whom you have submitted a claim for benefits, if you have authorized that company to obtain such information, and it submits your authorization to us with its request for information.
3. As stated earlier, we may report information to the Medical Information Bureau.
4. We may release information to persons or organizations conducting bona fide actuarial or scientific research studies, audits or evaluations, or to our affiliates who may wish to market products or services.
5. We will disclose information to government regulatory officials, law enforcement authorities, and others where required by law.

**Access and Correction** – In general, you have a right to learn the nature and substance of any personal information about you in our file, upon your written request. Whenever we make an adverse underwriting decision, we will notify you of the reasons for the decision and the source of the information on which we based our decision. We will give medical record information, however, only to a licensed physician of your choice or yourself. Please refer to the section on MIB, Inc., for that organization's disclosure procedure. There are procedures by which you can obtain access to personal information about you appearing in our policy files, including information contained in Investigative consumer reports. We have also established procedures by which you may request correction, amendment or deletion of any information in our files which you believe to be inaccurate or irrelevant. A description of these procedures will also be sent to you upon request. If you feel that any information we have is inaccurate or incomplete, please write to the Individual Underwriting & Issue Department of Symetra and American States Life, P.O. Box 84068, Seattle, WA 98124-9918. Your comments will be carefully considered and corrections made where justified.

### TEMPORARY LIFE INSURANCE AGREEMENT

**AMOUNT OF COVERAGE:** If the Temporary Life Insurance questions have been answered "no" and if money has been accepted as advance payment for life insurance and the proposed insured dies while this temporary insurance is in effect, we will pay the beneficiary an amount equal to the lesser of:

- (a) the amount of all death benefits applied for with this application, including any accidental death benefits, if applicable; or
- (b) a maximum amount under all Temporary Life Insurance Agreements with Symetra or American States Life of \$250,000.

**COVERAGE BEGINS:** Life insurance under this Agreement will begin on the date of this application, if the Temporary Life Insurance questions have been completed and answered "no" and money equal to the first full premium has been accepted as advance payment for life insurance.

**COVERAGE ENDS:** Life insurance under this Agreement will terminate on the earliest of:

- (a) 90 days from the date of this Agreement; or
- (b) the date that insurance takes effect under the policy applied for; or
- (c) the date a policy, other than as applied for, is offered to the applicant; or
- (d) the date the Company mails notice of termination of coverage and a return of the payment to the applicant.

### LIMITATIONS:

- (a) This Agreement does not provide benefits for disability.
- (b) Fraud or material misrepresentation in the application or in the answers to the questions of this Agreement invalidate this Agreement and the Company's only liability is for refund of the payment made.
- (c) If the proposed insured is less than 15 days old or more than 80 years old, the Company's liability under this Agreement is limited to a refund of the payment made.
- (d) If the proposed insured commits suicide, the Company's liability under this Agreement is limited to a refund of the payment made. (For citizens of Missouri, suicide is no defense unless we can show that the insured intended suicide when the application was completed.)
- (e) If the check or draft submitted as payment is not honored by the bank, there is no coverage under this Agreement.
- (f) No one is authorized to waive or modify the terms of this Agreement.