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APPLICATION KIT

Immediate Solution
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10 Pay Solution

Monumental Life Insurance Company

L120 0210 ME 05

67864 0510

Monumental Life Insurance Company

EXPRESS ISSUE COVER SHEET

(Please submit completed sheet with every application)

Agent Information		
Agent ID	Agent Name (Print)	Agent Phone ( )
Agent Email		Agent Fax ( )
Proposed Insured Information		
Insured's name (Print)		Last 4 digits of Insured's social security #

Required Disclosures with Application:

❑ HIPPA Authorization Form ❑ Bank Draft Form

Other Disclosures (if applicable):

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

How are you paying the Initial Premium?

❑ By Check: Available with all methods, but must be used if subsequent payments are quarterly, semi-annual or annual

- Is the check for initial premium payment on the same account as monthly EFT payments? ❑ Yes ❑ No

❑ Draft initial premium upon receipt

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

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

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

If you select an Initial Premium Draft date in the future, you will not have potential coverage until that date under the Conditional Receipt.

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

Submitting Application to Monumental: ***(Faxing is the preferred method)***

If faxing, fax to 1-866-834-0437 and enter date faxed _____ . **Do Not** mail originals if faxing.

If mailing the application and/or check for initial premium please send with cover sheet to:

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

Monumental Life INSURANCE COMPANY

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

LIFE APPLICATION

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

Part A1 - Proposed Insured

Name (First, M.I., Last)	Address, City, State, Zip Code (cannot be a P.O. Box)

SSN	Gender	D.O.B. (MM/DD/YYYY)	Age	U.S. State or Country of Birth	Phone Number ( )

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

Part A2 - Owner (If Other Than Proposed Insured)

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

Address, City, State, Zip Code (If different from Insured) (cannot be a P.O. Box)	Are you a citizen of the U.S.? ❑ Yes ❑ No If not, what country?

Part A3 - Beneficiary

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

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

1) Is the proposed Insured hospitalized, bedridden, residing in a nursing home or long term care facility, receiving hospice or home health care, confined to a wheelchair, been advised by a member of the medical profession or planning to have inpatient surgery or currently waiting for an organ transplant? ❑ Yes ❑ No
2) To the best of your knowledge and belief has the proposed Insured:
   a) Ever been diagnosed with, been treated for or advised by a member of the medical profession to receive treatment for Alzheimer's disease, senile dementia, organic brain disease, mental incapacity, Lou Gehrig's disease (ALS), Downs Syndrome, Huntington's disease, sickle cell anemia, Spina Bifida not surgically corrected, cystic fibrosis, cerebral palsy or any terminal medical condition (excluding HIV)? ❑ Yes ❑ No
   b) Within the last 10 years, been told by a member of the medical profession that he or she had a diagnosis of AIDS (Acquired Immune Deficiency Syndrome) or ARC (AIDS Related Complex)? **Answer this question no if you have tested positive for HIV but have not developed symptoms of the disease AIDS/ARC.** ❑ Yes ❑ No
   c) Ever been in a diabetic coma or had or been advised by a member of the medical profession to have an amputation due to disease or disorder? ❑ Yes ❑ No
3) Within the past **2 years** has the proposed Insured:
   a) Been diagnosed with, been treated for or advised by a member of the medical profession to receive treatment for cancer (other than basal cell carcinoma)? ❑ Yes ❑ No
   b) Undergone testing by a medical professional for which the results have not been received (excluding HIV)? ❑ Yes ❑ No

Part B2

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

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

Last Name and Last 4 Digits of SSN: _____

Part B3

7) Within the past **2 years** has the proposed Insured:
   a) Had or been treated by a member of the medical profession for a heart attack, angina (chest pain), stroke (CVA), transient ischemic attack (TIA), aneurysm, circulatory or blood disorder (excluding HIV), heart surgery including bypass or irregular heart rhythm such as atrial fibrillation? ❑ Yes ❑ No
   b) Had more than 12 seizures, taken insulin shots or been diagnosed with, been treated for or advised by a member of the medical profession to receive treatment for congestive heart failure, cirrhosis, hepatitis B or C or other liver disease? **Answer this question no if you have tested positive for HIV but have not developed symptoms of the disease AIDS/ARC.** ❑ Yes ❑ No
   c) Used illegal drugs or been diagnosed with, been treated for or advised by a member of the medical profession to receive treatment for alcohol abuse or drug abuse? ❑ Yes ❑ No
8) Within the past **4 years** has the proposed Insured been diagnosed with, been treated for or advised by a member of the medical profession to receive treatment for kidney disease? ❑ Yes ❑ No
9) Has the proposed Insured **ever** been diagnosed with, been treated for or advised by a member of the medical profession to receive treatment for Parkinson's disease, multiple sclerosis, chronic obstructive pulmonary disease (COPD) including emphysema, chronic asthma, black lung or other chronic respiratory disease? ❑ Yes ❑ No
10) Is the proposed Insured currently under the age of 50 **and** if so, has the proposed Insured within the past **5 years** been diagnosed with, been treated for or advised to receive treatment for any mental disorder such as manic or clinical depression, schizophrenia, bipolar disease or post traumatic stress syndrome? ❑ Yes ❑ No

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

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

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

Part C1 - Face Amount & Payment Method

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

Full Modal Premium Included or Authorized With Application Is:

Part C2 - Payor Information

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

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

Address, City, State, Zip Code (cannot be a P.O. Box)	Are you a citizen of the U.S.? ❑ Yes ❑ No If not, what country?

Part C3 - Premium Payment Authorization For Electronic Funds Transfer (EFT): Payor's Authorization To Insurance Company

As a convenience to myself, I hereby authorize Monumental Life Insurance Company to draft premium payments from my financial institution account.

It is understood that credit for payment is conditioned upon the draft being honored when presented for payment. Furthermore, this authorization may be terminated (a) at the option of the Company if any draft is not honored when presented for payment; or (b) by the Company, financial institution or the undersigned upon 30 days written notice to the parties hereto.

If this authorization is terminated, the amount due on the policy involved will be billed on a quarterly basis.

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

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

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

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

Last Name and Last 4 Digits of SSN: _____

Agent's Report

I represent that:

1) I have personally seen the proposed Insured. ❑ Yes ❑ No

2) I have truly and accurately recorded on this application the information as supplied by the Owner and the proposed Insured. ❑ Yes ❑ No

Is the person proposed for insurance related to you? ❑ Yes ❑ No Relationship _____

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

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

Home or work phone number _____

Agent Signature _____

AGREEMENT / AUTHORIZATION

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

I authorize Medical Information Bureau, Inc., any consumer reporting agency, or any insurer or reinsurer to provide *medical information about me to Monumental Life Insurance Company, its representatives or its reinsurers. I understand that this information is to be used by the Company to determine eligibility for insurance and/or eligibility for benefits under an existing policy. Failure to sign this authorization may impair the Company's ability to evaluate or process my application or a future claim and may be a basis for denying my application or claim for benefits. I may revoke this policy by sending written notice to: Monumental Life Insurance Company Attention: Underwriting, 4333 Edgewood Road, Cedar Rapids IA 52499. However, I understand that revocation may be a basis for denying insurance benefits. A copy of this authorization shall be as valid as the original. Either my authorized representative or I may receive a copy of this authorization upon request. This authorization will expire 30 months from the date signed. ***This authorization excludes disclosure of the results of a test for HIV if the applicant has tested HIV positive but has not developed symptoms of the disease AIDS. Such test results shall not be discovered or published. Nothing in the caveat will prohibit this section from including the fact that the applicant has AIDS.**

FRAUD WARNING: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Signed at City _____ State _____ Proposed Insured Signature _____

Date _____ Owner Signature _____

(If Owner other than Insured)

Witness _____ _____

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

If The EFT Premium Payment Method Is Chosen, Please Tape A Voided Check In This Box.

NOTICE TO PERSONS APPLYING FOR INSURANCE

As part of the Company's procedure for processing your insurance application, an investigative consumer report may be prepared whereby information is obtained through physicians, hospitals, clinics, and other medically-related facilities, who may be contacted using your signed authorization, to obtain details of your past medical treatment.

You have the right to be interviewed as part of any investigative consumer report that may be prepared. If you desire to be interviewed, you must indicate this to the Company. You also have the right to request access to, and correction and amendment of, any personal information collected. Additionally, you are entitled to receive a description of procedures which allow access to and correction of personal information which may be obtained, the nature and scope of the investigation requested, and a description of the circumstances under which personal information may be disclosed without prior authorization. Your written request should be addressed to the Company.

MONUMENTAL LIFE INSURANCE COMPANY
Home Office: 4333 Edgewood Road NE, Cedar Rapids, IA 52499

MIB DISCLOSURE NOTIFICATION

Information regarding your insurability will be treated as confidential. Monumental Life Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 or (TTY 866-346-3642). If you question the accuracy of information in the MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is: 50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734.

Monumental Life Insurance Company, or its reinsurers may also release information from its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

7/08

CONDITIONAL RECEIPT

No coverage will be effective prior to delivery of the policy applied for unless and until all the following conditions are met:

Conditions of Coverage

1. On the Effective Date indicated below, the state of health and all factors affecting insurability of each person proposed for coverage must be stated in the application required by the Company;
2. An amount equal to the first full premium required is paid on the plan and any check, money order, or Authorization for Electronic Funds Transfer (EFT) given in payment is honored when first presented; and,
3. Each person proposed for coverage is on the Effective Date insurable and acceptable to the Company under its rules, limits and underwriting standards for the plan and for the amount applied for, without modification of plan, premium of rates or amount of coverage.

Effective Date

If all of the above conditions are met, insurance in the amount applied for or $25,000, whichever is lower, will become effective on the date the application is completed. If any of the above conditions are not met, or the application contains a material misrepresentation, or if the proposed Insured dies by suicide, this receipt provides no coverage, and the liability of the Company is the return of the amount remitted with this receipt. Coverage which takes effect through this receipt will terminate at the EARLIEST of the following: (a) the effective date of the policy; (b) thirty (30) days after the date of the application; (c) three (3) days after the date the Company sends written notice that the receipt is terminated.

Agent Instructions: Please leave this page with the Proposed Insured/Owner

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

Supplemental Information to the Application for Life Insurance

Proposed Primary Insured Name: _____ Social Security Number: _____

ADDITIONAL INFORMATION		
Question Number	Name of Proposed Insured	Details to General and Medical Questions (Diagnosis, Dates, Durations, and Medications, Dosages, Frequency) Medical Facilities & Physicians Names, Addresses, Phone Numbers

ADDITIONAL INFORMATION

FRAUD WARNING: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

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

_____
Signature of Proposed Insured

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

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

_____
Signature of Additional Insured

_____
Signature of Agent

SA-ADINFO 0805 ME

Monumental Life Insurance Company
Stonebridge Life Insurance Company
Transamerica Life Insurance Company
Western Reserve Life Assurance Co. of Ohio
4333 Edgewood Road NE, Cedar Rapids, IA 52499

HIPAA Authorization for Release of Health-Related Information

This authorization complies with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

Name of Primary Proposed Insured/Patient	Date of birth	Last four digits of SSN
Name of Secondary Proposed Insured/Patient	Date of birth	Last four digits of SSN
Name(s) of Unemancipated Minors	Date(s) of birth	Last four digits of SSN(s)

I hereby authorize the use or disclosure of health information, as described below, about me or my above-named unemancipated minor children and revoke any previous restrictions concerning access to such information:

1. **Person(s) or group(s) of persons authorized to use and/or disclose the information:** Any health plan, physician, health care professional, hospital, clinic, long-term care facility, medical or medically-related facility, laboratory, pharmacy, pharmacy benefit manager, insurance company [including the Companies noted above (the "Companies")], insurance support organization such as MIB Group, Inc., or other medical practitioner or health care provider that has provided payment, treatment or services to me or on my behalf or to or on behalf of my unemancipated minor children.
2. **Person(s) or group(s) of persons authorized to collect or otherwise receive and use the information:** The Companies, their affiliates and reinsurers, and their agents, employees, or other representatives. I further authorize the Companies and their affiliates and reinsurers to redisclose the information to MIB Group, Inc., which operates an information exchange on behalf of life and health insurance companies.
3. **Description of the information that may be used or disclosed:** This authorization specifically includes the release of all information related to my health or that of my unemancipated minor children and my or my unemancipated minor children's insurance policies and claims, including but not limited to, information on the diagnoses, prognoses, treatments, prescription drug information, and information regarding diagnosis, prognosis and treatment of mental illness, use of alcohol, drugs and tobacco, communicable or infectious conditions, excluding HIV. **This Authorization excludes psychotherapy notes that are separated from the rest of my medical records.**
4. **The information will be used or disclosed only for the following purpose(s):** For the purpose of underwriting my insurance application with the Companies, to support the operations of our business, and, if a policy is issued, for evaluating contestability and eligibility for benefits and for the continuation or replacement of the policy.

STATEMENTS OF UNDERSTANDING & ACKNOWLEDGMENT:

- I understand that health information about me provided to the Companies may be protected by state and federal privacy regulations including the HIPAA Privacy Rule and that the Companies will only use and disclose such information as permitted by applicable regulations and as described in their privacy notices. However, I also understand that any information disclosed under this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal regulations such as the HIPAA Privacy Rule governing privacy and confidentiality of health information.
- I understand that if I refuse to sign this authorization to release my health information or that of my unemancipated minor children, the Companies may not be able to process my application, or if coverage is issued may not be able to make any benefit payments.
- I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on it, or to the extent that other law provides the Companies with the right to contest a claim under the policy or the policy itself, by sending a written revocation to the Companies' Privacy Official at the address at the top of this form. I also understand that the revocation of this authorization will not affect uses and disclosures of my health information for purposes of treatment, payment and business operations, including agent commission statements.
- This authorization shall remain in force for 24 months from the date signed, regardless of my condition and whether living or deceased.
- I acknowledge I have received a copy of this authorization.

_____ _____
Signature of Primary Proposed Insured/Patient or Personal Representative — Date

_____ _____
Signature of Secondary Proposed Insured/Patient or Personal Representative — Date

If signed by an individual's personal representative or the parent or guardian of an unemancipated minor, describe authority to sign on behalf of the individual:

❑ Parent ❑ Legal guardian ❑ Power of Attorney ❑ Other (please describe): _____

(NOTE: If more than one individual is named above, please specify the individual(s) to which the personal representative applies.)

Policy or contract number (if known): _____

A copy of this authorization will be considered as valid as the original.
Please return this original copy to Company

Monumental Life Insurance Company
Stonebridge Life Insurance Company
Transamerica Life Insurance Company
Western Reserve Life Assurance Co. of Ohio
4333 Edgewood Road NE, Cedar Rapids, IA 52499

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Name of Primary Proposed Insured/Patient	Date of birth	Last four digits of SSN
Name of Secondary Proposed Insured/Patient	Date of birth	Last four digits of SSN
Name(s) of Unemancipated Minors	Date(s) of birth	Last four digits of SSN(s)

I hereby authorize the use or disclosure of health information, as described below, about me or my above-named unemancipated minor children and revoke any previous restrictions concerning access to such information:

1. **Person(s) or group(s) of persons authorized to use and/or disclose the information:** Any health plan, physician, health care professional, hospital, clinic, long-term care facility, medical or medically-related facility, laboratory, pharmacy, pharmacy benefit manager, insurance company [including the Companies noted above (the "Companies")], insurance support organization such as MIB Group, Inc., or other medical practitioner or health care provider that has provided payment, treatment or services to me or on my behalf or to or on behalf of my unemancipated minor children.
2. **Person(s) or group(s) of persons authorized to collect or otherwise receive and use the information:** The Companies, their affiliates and reinsurers, and their agents, employees, or other representatives. I further authorize the Companies and their affiliates and reinsurers to redisclose the information to MIB Group, Inc., which operates an information exchange on behalf of life and health insurance companies.
3. **Description of the information that may be used or disclosed:** This authorization specifically includes the release of all information related to my health or that of my unemancipated minor children and my or my unemancipated minor children's insurance policies and claims, including but not limited to, information on the diagnoses, prognoses, treatments, prescription drug information, and information regarding diagnosis, prognosis and treatment of mental illness, use of alcohol, drugs and tobacco, communicable or infectious conditions, excluding HIV. **This Authorization excludes psychotherapy notes that are separated from the rest of my medical records.**
4. **The information will be used or disclosed only for the following purpose(s):** For the purpose of underwriting my insurance application with the Companies, to support the operations of our business, and, if a policy is issued, for evaluating contestability and eligibility for benefits and for the continuation or replacement of the policy.

STATEMENTS OF UNDERSTANDING & ACKNOWLEDGMENT:

- I understand that health information about me provided to the Companies may be protected by state and federal privacy regulations including the HIPAA Privacy Rule and that the Companies will only use and disclose such information as permitted by applicable regulations and as described in their privacy notices. However, I also understand that any information disclosed under this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal regulations such as the HIPAA Privacy Rule governing privacy and confidentiality of health information.
- I understand that if I refuse to sign this authorization to release my health information or that of my unemancipated minor children, the Companies may not be able to process my application, or if coverage is issued may not be able to make any benefit payments.
- I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on it, or to the extent that other law provides the Companies with the right to contest a claim under the policy or the policy itself, by sending a written revocation to the Companies' Privacy Official at the address at the top of this form. I also understand that the revocation of this authorization will not affect uses and disclosures of my health information for purposes of treatment, payment and business operations, including agent commission statements.
- This authorization shall remain in force for 24 months from the date signed, regardless of my condition and whether living or deceased.
- I acknowledge I have received a copy of this authorization.

_____ _____
Signature of Primary Proposed Insured/Patient or Personal Representative — Date

_____ _____
Signature of Secondary Proposed Insured/Patient or Personal Representative — Date

If signed by an individual's personal representative or the parent or guardian of an unemancipated minor, describe authority to sign on behalf of the individual:

❑ Parent ❑ Legal guardian ❑ Power of Attorney ❑ Other (please describe): _____

(NOTE: If more than one individual is named above, please specify the individual(s) to which the personal representative applies.)

Policy or contract number (if known): _____

A copy of this authorization will be considered as valid as the original.

4333 Edgewood Rd. NE, Cedar Rapids, IA 52499

Initial and/or Recurrent Billing Authorization Form

I, the undersigned Cardmember, hereby authorize Monumental Life Insurance Company (MLIC) to charge my Visa or Mastercard account specified below, as updated from time to time by you or your card issuer, ("Card Account") any premium amounts due during the applicable billing cycles for insurance products purchased by me from MLIC unless and until MLIC has received notification in writing from me that I have withdrawn such consent and permission. I also authorize Visa or Mastercard to advise MLIC of any changes to the status of the Card Account, including updated account number and expiration date information, to ensure my uninterrupted service by MLIC.

INITIAL PREMIUM

☐ Draft initial premium upon receipt

☐ Draft initial premium at future date as indicated _____/_____
mo day

RECURRING PAYMENTS – Complete the Following Information for Future Recurring Payments

☐ New Authorization ☐ Credit/Debit Card Update

Billing Date (only select one box)

☐ Bill credit/debit card listed on day of the month matching the policy's effective day (this will be elected if option is chosen)

☐ Bill credit/debit card on a different day of the month; choose a day between 1 and 28 _____

CREDIT/DEBIT CARD ACCOUNT INFORMATION

_____

Visa or Mastercard Account No.

_____

Cardmember Signature Date

_____

Card Expiration Date Mo./Yr.

_____

Cardmember Name (Please Print)