

# Wisconsin

## APPLICATION KIT

**Immediate Solution**  
**Easy Solution**  
**10 Pay Solution**





# EXPRESS ISSUE COVER SHEET

(Please submit completed sheet with every application)

<b>Agent Information</b>		
Agent ID	Agent Name (Print)	Agent Phone (    )
Agent Email		Agent Fax (    )
<b>Proposed Insured Information</b>		
Insured's name (Print)		Last 4 digits of Insured's social security #
<p>Required Disclosures with Application:</p> <input type="checkbox"/> HIPPA Authorization Form <input type="checkbox"/> Bank Draft Form		
<p>Other Disclosures (if applicable):</p> <input type="checkbox"/> Accelerated Death Benefit Disclosure Form <input type="checkbox"/> HIV Consent Form <input type="checkbox"/> Replacement Form(s)		
<p>How are you paying the Initial Premium?</p> <input type="checkbox"/> By Check: Available with all methods, but must be used if subsequent payments are quarterly, semi-annual or annual <ul style="list-style-type: none"> <li>• Is the check for initial premium payment on the same account as monthly EFT payments? <span style="float:right"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></li> </ul> <input type="checkbox"/> Draft initial premium upon receipt		
<input type="checkbox"/> Draft initial premium at future date, please indicate the month and day (mm/dd): _____ / _____ <div style="text-align: center;"><b>Month      Day (1st thru 28th only)</b></div> <ul style="list-style-type: none"> <li>• 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.</li> </ul> <p><b>If you select an Initial Premium Draft date in the future, you will not have potential coverage until that date under the Conditional Receipt.</b></p> <p><b>(See 'Draft Date Procedures &amp; Scenarios' on Web site)</b></p>		
<p>Submitting Application to Monumental: <b><i>(Faxing is the preferred method)</i></b></p> <p>If faxing, fax to 1-866-834-0437 and enter date faxed _____. <b>Do Not</b> mail originals if faxing.</p> <p>If mailing the application and/or check for initial premium please send with cover sheet to:</p> <p><b>Monumental Life, 4333 Edgewood Road NE, Cedar Rapids, IA 52499</b></p>		



Agent ID #	State Application Taken	Policy # (H.O. Use Only)
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**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?						<input type="checkbox"/> Yes <input type="checkbox"/> 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?						<input type="checkbox"/> Yes <input type="checkbox"/> No
e) If 'yes,' adjust face amount to premium?						<input type="checkbox"/> Yes <input type="checkbox"/> No
3) Does the applicant have any existing life insurance or annuity contracts with the company or any other company?						<input type="checkbox"/> Yes <input type="checkbox"/> 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)						<input type="checkbox"/> Yes <input type="checkbox"/> 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.? If not, what country? <input type="checkbox"/> Yes <input type="checkbox"/> No	

**Part A3 - Beneficiary**

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

**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?		<input type="checkbox"/> Yes <input type="checkbox"/> No
2) To the best of your knowledge and belief has the proposed Insured ever:		
a) 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?		<input type="checkbox"/> Yes <input type="checkbox"/> No
b) Been diagnosed or treated by a licensed member of the medical profession for AIDS or ARC (AIDS Related Complex)? (Information concerning diagnostic testing and blood studies and the reporting of HIV test results is limited to the results of FDA-licensed tests. Wisconsin applicants need not report the results of tests conducted at an anonymous testing/counseling site or the results of a home kit).		<input type="checkbox"/> Yes <input type="checkbox"/> No
c) 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?		<input type="checkbox"/> Yes <input type="checkbox"/> No
3) Within the past <b>2 years</b> 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)?		<input type="checkbox"/> Yes <input type="checkbox"/> No
b) Undergone testing by a medical professional for which the results have not been received?		<input type="checkbox"/> Yes <input type="checkbox"/> No

**Part B2**

4) Has the proposed Insured been diagnosed with, been treated for or advised by a member of the medical profession to receive treatment for diabetes (other than gestational diabetes) before the age of 18?		<input type="checkbox"/> Yes <input type="checkbox"/> No
5) Within the past <b>4 years</b> 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)?		<input type="checkbox"/> Yes <input type="checkbox"/> No
6) Within the past <b>1 year</b> 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?		<input type="checkbox"/> Yes <input type="checkbox"/> 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?		<input type="checkbox"/> Yes <input type="checkbox"/> 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?		<input type="checkbox"/> Yes <input type="checkbox"/> 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?		<input type="checkbox"/> Yes <input type="checkbox"/> 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.



**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 to the best of my knowledge and belief 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 understand that I may revoke this authorization at any time by sending a written request to the registered representative or the Company.

I have received the MIB Disclosure Notification, Notice to Persons Applying For Insurance, Accelerated Death Benefit Disclosure and Conditional Receipt. I hereby authorize any licensed physician, medical practitioner, or the Medical Information Bureau or other institution that has any records or knowledge of the proposed Insured to give any such information, including medical information, to the life insurance company. A photocopy or facsimile of this authorization shall be made as valid as the original. This authorization will expire 30 months from the date signed.

**FRAUD WARNING:** Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

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](http://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**



**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, communicable or infectious conditions, such as HIV or AIDS, and use of alcohol, drugs and tobacco. **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, for the continuation or replacement of the policy, for reinstatement of the policy or to contest a claim under 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 (12 months in Kansas) 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.**

**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
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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, communicable or infectious conditions, such as HIV or AIDS, and use of alcohol, drugs and tobacco. **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, for the continuation or replacement of the policy, for reinstatement of the policy or to contest a claim under the policy.

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- 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 (12 months in Kansas) 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.**

**Monumental Life Insurance Company**

**Transamerica Life Insurance Company**

**Stonebridge Life Insurance Company**

**Western Reserve Life Assurance Co. of Ohio**

Administrative Office located at: 4333 Edgewood Road N.E., Cedar Rapids, Iowa 52499. Telephone: (319) 355-8511

**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 number or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

INSURER NAME	CONTRACT OR POLICY #	INSURED	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.)

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 expenses 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?

**30 DAY RIGHT TO CANCEL**

In the event of a replacement transaction, you may cancel this policy by delivering or mailing a written request to the Company. You must return the policy to the Company before midnight of the thirtieth day after the day you receive it. You will receive an unconditional full refund of all premiums or considerations paid on it, less any withdrawals and indebtedness, including any policy fees or charges or, in the case of a variable or market value adjustment policy, payment of the cash surrender value provided under the policy plus the fees and other charges deducted from the gross premiums or considerations or imposed under the policy. Your written request given by mail and return of the policy by mail are effective on being postmarked, properly addressed and postage prepaid.

**REPLACEMENT ADVERTISING  
AGENT STATEMENT**

I, \_\_\_\_\_, have complied with the following in connection with the replacement sales transaction:

- a. I have used only company approved sales advertising.
- b. I have given a copy of all sales advertising used during the presentation to the applicant, including printed copies of any electronically presented sales materials.

\_\_\_\_\_  
**DATE**

\_\_\_\_\_  
**AGENT SIGNATURE**

## **LIFE INSURANCE BUYER'S GUIDE**

This guide can help you when you shop for life insurance. It discusses how to:

1. Find a policy that meets your needs and fits your budget
2. Decide how much insurance you need
3. Make informed decisions when you buy a policy

Prepared by the National Association of  
Insurance Commissioners

The National Association of Insurance Commissioners is an association of state insurance regulatory officials. This association helps the various Insurance Departments to coordinate insurance laws for the benefit of all consumers.

### **THIS GUIDE DOES NOT ENDORSE ANY COMPANY OR POLICY.**

#### **IMPORTANT THINGS TO CONSIDER**

1. Review your own insurance needs and circumstances. Choose the kind of policy that has benefits that most closely fit your needs. Ask an agent or company to help you.
2. Be sure that you can handle premium payments. Can you afford the initial premium? If the premium increases later and you still need insurance, can you still afford it?
3. Don't sign an insurance application until you review it carefully to be sure all the answers are complete and accurate.
4. Don't buy life insurance unless you intend to stick with your plan. It may be very costly if you quit during the early years of the policy.
5. Don't drop one policy and buy another without a thorough study of the new policy and the one you have now. Replacing your insurance may be costly.
6. Read your policy carefully. Ask your agent or company about anything that is not clear to you.
7. Review your life insurance program with your agent or company every few years to keep up with changes in your income and your needs.

#### **BUYING LIFE INSURANCE**

When you buy life insurance, you want coverage that fits your needs.

First, decide how much you need— and for how long— and what you can afford to pay. Keep in mind the major reason you buy life insurance is to cover the financial effects of unexpected or timely death. Life

insurance can also be one of many ways you plan for the future.

Next, learn what kinds of policies will meet your needs and pick the one that best suits you.

Then, choose the combination of policy premium and benefits that emphasizes protection in case of early death, or benefits in case of long life, or a combination of both.

It makes good sense to ask a life insurance agent or company to help you. An agent can help you review your insurance needs and give you information about the available policies. If one kind of policy doesn't seem to fit your needs, ask about others.

This guide provides only basic information. You can get more facts from a life insurance agent or company or from your public library.

#### **WHAT ABOUT THE POLICY YOU HAVE NOW?**

If you are thinking about dropping a life insurance policy, here are some things you should consider:

1. If you decide to replace your policy, don't cancel your old policy until you have received the new one. You then have a minimum period to review your new policy and decide if it is what you wanted.
2. It may be costly to replace a policy. Much of what you paid in the early years of the policy you have now, paid for the company's cost of selling and issuing the policy. You may pay this type of cost again if you buy a new policy.
3. Ask your tax advisor if dropping your policy could affect your income taxes.
4. If you are older or your health has changed, premiums for the new policy will often be higher. You will not be able to buy a new policy if you are not insurable.
5. You may have valuable rights and benefits in the policy you now have that are not in the new one.
6. If the policy you have now no longer meets your needs, you may not have to replace it. You might be able to change your policy or add to it to get the coverage or benefits you now want.
7. At least in the beginning, a policy may pay no benefits for some causes of death covered in the policy you have now.

In all cases, if you are thinking of buying a new policy, check with the agent or company that issued you the one you have now. When you bought your old policy, you may have seen an illustration of the benefits of your policy. Before replacing your policy, ask your agent or

company for an updated illustration. Check to see how the policy has performed and what you might expect in the future, based on the amounts the company is paying now.

### **HOW MUCH DO YOU NEED?**

Here are some questions to ask yourself:

1. How much of the family income do I provide? If I were to die early, how would my survivors, especially my children, get by? Does anyone else depend on me financially, such as a parent, grandparent, brother or sister?
2. Do I have children for whom I'd like to set aside money to finish their education in the event of my death?
3. How will my family pay final expenses and repay debts after my death?
4. Do I have family members or organizations to whom I would like to leave money?
5. Will there be estate taxes to pay after my death?
6. How will inflation affect future needs?

As you figure out what you have to meet these needs, count the life insurance you have now, including any group insurance where you work or veteran's insurance. Don't forget Social Security and pension plan survivor's benefits. Add other assets you have: savings investments, real estate and personal property. Which assets would your family sell or cash in to pay expenses after your death?

### **WHAT IS THE RIGHT KIND OF LIFE INSURANCE?**

All policies are not the same. Some give coverage for your lifetime and others cover you for a specific number of years. Some build up cash values and others do not. Some policies combine different kinds of insurance, and others let you change from one kind of insurance to another. Some policies may offer other benefits while you are still living. Your choice should be based on your needs and what you can afford.

There are two basic types of life insurance: term insurance and cash value insurance. Term insurance generally has lower premiums in the early years, but does not build up cash values that you can use in the future. You may combine cash value life insurance with term insurance for the period of your greatest need for life insurance to replace income.

**Term Insurance** covers you for a term of one or more years. It pays a death benefit only if you die in that term. Term insurance generally offers the largest insurance protection for your premium dollar. It generally does not build up cash value.

You can renew most term insurance policies for one or more terms even if your health has changed. Each time you renew the policy for a new term, premiums may be higher. Ask what the premiums will be if you continue to renew the policy. Also ask if you will lose the right to renew the policy at some age. For a higher premium, some companies will give you the right to keep the policy in force for a guaranteed period at the same price each year. At the end of that time you may need to pass a physical examination to continue coverage, and premiums may increase.

You may be able to trade many term insurance policies for a cash value policy during a conversion period — even if you are not in good health. Premiums for the new policy will be higher than you have been paying for the term insurance.

**Cash Value Life Insurance** is a type of insurance where the premiums charged are higher at the beginning than they would be for the same amount of term insurance. The part of the premium that is not used for the cost of insurance is invested by the company and builds up a cash value that may be used in a variety of ways. You may borrow against a policy's cash value by taking a policy loan. If you don't pay back the loan and the interest on it, the amount you owe will be subtracted from the benefits when you die, or from the cash value if you stop paying premiums and take out the remaining cash value. You can also use your cash value to keep insurance protection for a limited time or to buy a reduced amount without having to pay more premiums. You also can use the cash value to increase your income in retirement or to help pay for needs such as a child's tuition without canceling the policy. However, to build up this cash value, you must pay higher premiums in the earlier years of the policy. Cash value life insurance may be one of several types; whole life, universal life and variable life are all types of cash value insurance.

**Whole Life Insurance** covers you for as long as you live if your premiums are paid. You generally pay the same amount in premiums for as long as you live. When you first take out the policy, premiums can be several times higher than you would pay initially for the same amount of term insurance. But they are smaller than the premiums you would eventually pay if you were to keep renewing a term policy until your later years.

Some whole life policies let you pay premiums for a shorter period such as 20 years or until age 65. Premiums for these policies are higher since the premium payments are made during a shorter period.

**Universal Life Insurance** is a kind of flexible policy that lets you vary your premium payments. You can also adjust the face amount of your coverage. Increases may require proof that you qualify for the new death benefit. The premiums you pay (less expense charges) go into a policy account that earns interest. Charges are deducted from the account. If your yearly premium payment plus the interest your account earns is less than the charges, your account value will become lower. If it keeps dropping, eventually your coverage will end. To prevent that, you may need to start making premium payments, or increase your premium payments, or lower your death benefits. Even if there is enough in your account to pay the premiums, continuing to pay premiums yourself means that you build up more cash value.

**Variable Life Insurance** is a kind of insurance where the death benefits and cash values depend on the investment performance of one or more separate accounts, which may be invested in mutual funds or other investments allowed under the policy. Be sure to get the prospectus from the company when buying this kind of policy and STUDY IT CAREFULLY.

You will have higher death benefits and cash value if the underlying investments do well. Your benefits and cash value will be lower or may disappear if the investments you chose didn't do as well as you expected. You may pay an extra premium for a guaranteed death benefit.

## LIFE INSURANCE ILLUSTRATIONS

You may be thinking of buying a policy where cash values, death benefits, dividends or premiums may vary based on events or situations the company does not guarantee (such as interest rates). If so, you may get an illustration from the agency or company that helps explain how the policy works. The illustration will show how the benefits that are not guaranteed will change as interest rates and other factors change. The illustration will show you what the company guarantees. It will also show you what could happen in the future. Remember that nobody knows what will happen in the future. You should be ready to adjust your financial plans if the cash value doesn't increase as quickly as shown in the illustration. You will be asked to sign a statement that says you understand that some of the numbers in the illustrations are not guaranteed.

## FINDING A GOOD VALUE IN LIFE INSURANCE

After you have decided which kind of life insurance is best for you, compare similar policies from different companies to find which one is likely to give you the best value for your money. A simple comparison of the premiums is not enough. There are other things to consider. For example:

1. Do premiums or benefits vary from year to year?
2. How much do the benefits build up in the policy?

3. What part of the premiums or benefits is not guaranteed?

4. What is the effect of interest on money paid and received at different times on the policy?

Remember that no one company offers the lowest cost at all ages for all kinds and amounts of insurance. You should also consider other factors:

1. How quickly does the cash value grow? Some policies have low cash values in the early years that build up quickly later on. Other policies have a more level cash value build-up. A year-by-year display of values and benefits can be very helpful. (The agent or company will give you a policy summary or an illustration that will show benefits and premiums for selected years.)

2. Are there special policy features that particularly suit your needs?

3. How are nonguaranteed values calculated? For example, interest rates are important in determining policy returns. In some companies increases reflect the average interest earnings on all of that company's policies regardless of when issued. In others, the return for policies issued in a recent year, or a group of years, reflects the interest earnings on that group of policies; in this case, amounts paid are likely to change more rapidly when interest rates change.



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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)	