ONEAMERICA®

Asset-Care®

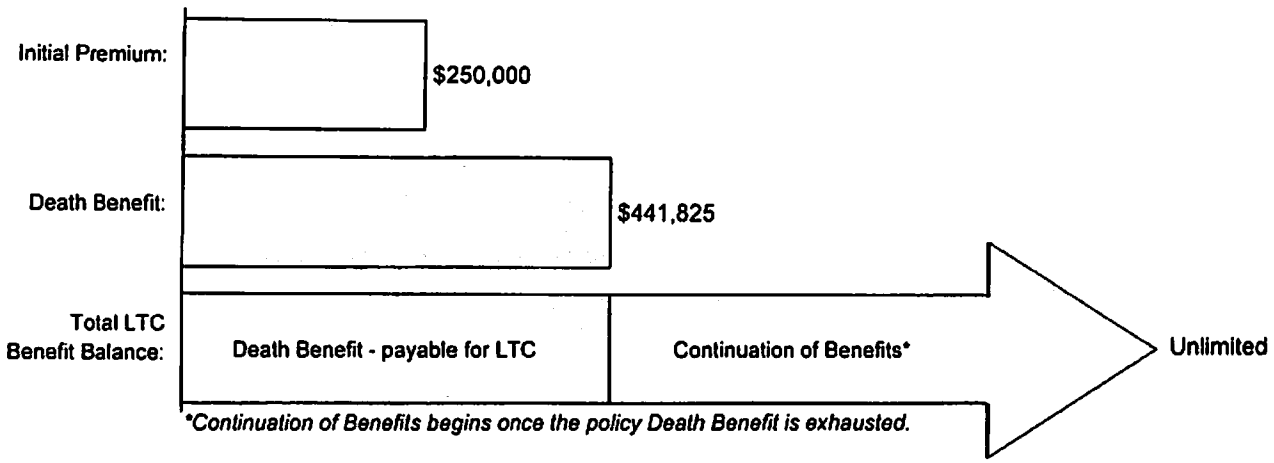
Product: Asset-Care I - Single Premium (cash)
State: HI

Presented by:
Tracey Lyum
LPL Ins. Associates

Prepared for:
Jurg Munch
Male, 60
Class: Non-Smoker

Linda Munch
Female, 54
Class: Non-Smoker

Total Initial Premium:	$250,000
Death Benefit:	$441,825
Total LTC Benefit Balance / Benefit Period:	Unlimited / Lifetime



Initial LTC Benefit Limit, Per Individual:	$13,255 Monthly $159,060 Annually
Initial LTC Benefit Limit, For One or Both Individuals:**	$26,510 Monthly ($13,255 per person) $318,120 Annually ($159,060 per person)

***If both insureds receive long-term care benefits at the same time, the long-term care benefit will last for a shorter period of time than if only one insured receives long-term care benefits.*

Product Features:
Single Premium - $193,688
Guaranteed Return of Premium***
3% Acceleration Rate / 33 Months
Guaranteed Cash Value Accumulation
****Excludes cost of enhanced LTC monthly payout*

Continuation of Benefits Data:
Single Pay - $56,312
Benefit Balance - Unlimited
Benefit Period - Lifetime
Inflation Option - None

Not all features and benefits of the policy are shown here. For additional details of all benefits and features, please see the policy.

THE STATE LIFE INSURANCE COMPANY®

The State Life Insurance Company®

Single Premium Whole Life Insurance with Long-Term Care Benefits - Basic Illustration

Prepared for:
Jurg Munch
Linda Munch

First Insured: Male Preferred (Non-Smoker) Age: 60 State: HI
Second Insured: Female Preferred (Non-Smoker) Age: 54
Joint Class: 1 Joint Equal Age: 56

Initial Death Benefit: $441,825

Contract Premium: $193,687.60

It is assumed the single premium will be paid no later than upon issuance of the policy.

Presented by: Tracey Lyum, CRPS, AIF

		Guaranteed			Non-Guaranteed Midpoint Assumptions			Non-Guaranteed Illustrated Basis		
End of Policy Year	Contract Premium	Accumulated Value	Cash Surrender Value	Death Benefit/ LTC Benefit Balance	Accumulated Value	Cash Surrender Value	Death Benefit/ LTC Benefit Balance	Accumulated Value	Cash Surrender Value	Death Benefit/ LTC Benefit Balance
5	$0	$161,173	$190,499	$441,825	$161,173	$190,499	$441,825	$161,173	$190,499	$441,825
10	$0	$194,178	$191,265	$441,825	$194,178	$191,265	$441,825	$194,178	$191,265	$441,825
20	$0	$270,525	$270,525	$441,825	$270,525	$270,525	$441,825	$270,525	$270,525	$441,825
30	$0	$342,454	$342,454	$441,825	$342,454	$342,454	$441,825	$342,454	$342,454	$441,825
Age 70	$0	$223,533	$223,533	$441,825	$223,533	$223,533	$441,825	$223,533	$223,533	$441,825

Guaranteed: "Guaranteed" benefits and values are based on your contract premium of $193,687.60, assuming a guaranteed minimum interest rate of 4.00% and guaranteed maximum cost of insurance charges. The benefits and values shown are guaranteed provided the premium is paid, no policy loans or partial withdrawals are taken, and no long-term care benefits are used.

Non-Guaranteed/ Midpoint Assumptions: All "non-guaranteed" benefits and values are not guaranteed. The interest rate and cost of insurance charges are subject to change by The State Life Insurance Company. As a result, the actual results may be more or less favorable than those illustrated. Policy benefits and values which are based on an interest rate and cost of insurance charges which are midway between the guaranteed and illustrated (non-guaranteed) interest rates and cost of insurance charges.

Non-Guaranteed/ Illustrated Basis: "Non-guaranteed/illustrated basis" benefits and values are based on your contract premium of $193,687.60, an illustrated interest rate of 4.00%, and illustrated cost of insurance charges.

I have received all pages of this illustration and understand that any non-guaranteed elements illustrated are subject to change and could be higher or lower. The agent has told me that they are not guaranteed.

Jurg X

Linda X

Proposed Owner

7/18/2019
Date

I certify that this illustration has been presented to the proposed owner and that I have explained that any non-guaranteed elements are subject to change. I have not made any representations that are inconsistent with the illustration.

Agent

Date

Tracey Lyum, CRPS, AIF
(808) 544-3634

Central Pacific Investment Services
220 South King Street, Suite 260
Honolulu, HI, 96813

THIS ILLUSTRATION IS NOT A POLICY CONTRACT

Statement of Understanding

By Signing Below, I (we) understand and agree:

(1) The statements and answers given in this application, and in any supplements or amendments to it, will form the basis of, and be made a part of, any policy which may be issued.

(2) The statements and answers on all pages of this application are true, complete, and correctly recorded to the best of my knowledge.

(3) The policy will become effective only upon: (a) approval the The State Life Insurance Company; (b) payment of the first full premium; (c) delivery of the policy to the applicant(s) while alive and in good health; and (d) acceptance of the policy.

(4) The agent is only authorized to submit the application and initial premium and may not change any application, policy, or receipt or waive any right or requirement.

I (we) have received the Notice of Information Practices.

Caution: If your answers are incorrect or untrue, The State Life Insurance Company has the right to deny benefits or rescind your policy.

Signed 7/17/2019 at LAHAINA HAWAII

Date *City* *State*

X _____ ← Jurg

Signature of Proposed Insured

X _____ ← Linda

Signature of Owner (if Other than Proposed Insureds)

Signature of Second Proposed Insured (If Joint or Last Survivor Policy)

Agent's Statement

	Yes	No
Was the Conditional Receipt given?	☐	☒
Is the insurance applied for intended to replace or change any existing insurance or annuity policy not mentioned in Section F?	☐	☒

I have reasonable grounds to recommend the purchase of the policy as suitable for the owner and the proposed applicant(s).

Client's Income: _____ Client's Net Worth: _____

I personally witnessed the reading, completion, and signing of this application, and I recommend the Proposed Insured(s) for the insurance applied for except: _____

X _____ X _____

Signature of Licensed Agent *Signature of Resident Agent (If Required)*

TRACEY LYUM

Print Full Name *Agent No.* *Print Full Name* *Agent No.*

E-mail Address *E-Mail Address*

Authorization For Disclosure, Receipt And Use Of Personal Health Information

Products and financial services provided by
The State Life Insurance Company
a ONEAMERICA® company
P.O. Box 406
Indianapolis, IN 46206

ONEAMERICA®

"I", "me", "my" means each Applicant signing this Authorization.

AUTHORIZATION FOR DISCLOSURE

I authorize any licensed physician or licensed health care practitioner, hospital, clinic, medical facility, health care provider, insurance company or health plan that has provided treatment, payment or health care services to me or any other insurance company to which I have applied for insurance coverage or the MIB, Inc. (formerly known as Medical Information Bureau) or any pharmacy benefit manager ("My Providers") to disclose my entire medical record and any knowledge of my past or present health or medical condition to The State Life Insurance Company, its reinsurers and any third party administrator designated by The State Life Insurance Company. This includes any information relating to HIV and AIDS (where permitted by law), any sexually transmitted diseases and mental illness, and the use of drugs, alcohol and tobacco, but excludes psychotherapy notes. Psychotherapy notes means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. Psychotherapy notes excludes the following information which is subject to disclosure under this Authorization: medication prescription and monitoring; counseling session start and stop times; the modalities and frequencies of treatment furnished; results of clinical tests; and any summary of the following items: diagnosis; functional status; the treatment plan; symptoms; prognosis; and progress to date.

By my signature below, I terminate any agreements I have made with My Providers to restrict information in my medical records or any knowledge of my past or present health or medical condition and I instruct My Providers to release and disclose my entire medical record and other records or knowledge of me or my health without restriction.

AUTHORIZATION FOR RECEIPT AND USE

I authorize the employees and business associates of The State Life Insurance Company, its reinsurers and any third party administrator designated by The State Life Insurance Company who are responsible for the processing of my application for insurance to receive and use any information I have provided on my application form or provided by me during the course of a personal interview with me and to receive and use any information provided by other parties under the above Authorization For Disclosure for the purpose of determining my eligibility to obtain coverage under the insurance policy for which I have applied, and to determine the rates and terms which apply to the policy.

I understand that the information which will be provided under this Authorization is necessary for the Company to determine my eligibility for coverage under the insurance policy I have applied for and that the Company will condition approval and issuance of the policy on my providing this Authorization. I also understand that my application may be denied if I refuse to provide this Authorization.

REDISCLOSURE OF INFORMATION

I authorize any company listed as a OneAmerica company and its reinsurers to make a brief report of my personal health information to MIB. I understand that if the person or entity that receives information provided pursuant to this Authorization is not subject to federal privacy regulations, the information may be redisclosed and will no longer be protected by the federal or state privacy regulations. In the case of this Authorization, however, the information described above will be received by an insurance company which is covered by the federal privacy regulations, and will not be used or redisclosed except as described above, and the information will continue to be protected under the federal privacy regulations.

REVOCATION OF AUTHORIZATION

I understand that I may revoke this Authorization in writing at any time by sending a written revocation to: *The State Life Insurance Company, ATTN: Privacy Manager, P.O. Box 6062, Indianapolis, IN 46206-6062.* I also understand that any such revocation will not be effective to the extent that action has been taken by the Company in reliance on this Authorization or the extent that the Company has a legal right to contest a claim under the policy which I have applied for or to contest the policy itself.

EXPIRATION OF AUTHORIZATION

This Authorization will be valid for 24 months from the date of my signature below. A copy of this Authorization is as valid as the original.

JURG MUNCH	10/21/1958
Applicant's Name (Please Print)	Date of Birth
X _____	_____
Applicant's Signature	Date
LINDA WANG-MUNCH	01/05/1964
Joint Applicant's/Eligible Person's Name (Please Print)	Date of Birth
X _____	7/18/2019
Joint Applicant's/Eligible Person's Signature	Date

RETURN TO HOME OFFICE