[Marketing Message]

[Application for MyLife Select Individual Term Life Insurance]

Insurance provided by Minnesota Life Insurance Company
[400 Robert Street North, St. Paul MN 55101]

[ABC Client Logo
123 Sample St. Sample, MN 12345]

[MINNESOTA LIFE]

[1.] [Please complete all fields]

[Sam A Sample]
[1234 Any Road Apt #3]
[Anytown, MN 55101]

[XXXXXXXXXXXX]

[Gender] ☐ Male ☐ Female
[Date of birth (mm/dd/yyyy) ☐☐ – ☐☐ – ☐☐☐☐]
[Height ____ft.____ in. Weight _____lbs.]
[Social Security Number: ☐☐☐ – ☐☐ – ☐☐☐☐]

[Home Phone: ( ) _____] [Email Address: _____]

[Driver's License or State I.D. Number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐] [Issue State: ☐☐] [☐ Driver's License ☐ State I.D.]

[Annual Household Income: _____] [Are you a United States resident? ☐ Yes ☐ No]

[[1.] Are you actively performing all the duties of your regular occupation (including homemaker or student)? ☐ Yes ☐ No]
[[2.] Have you smoked cigarettes or used tobacco products in any form in the past year? ☐ Yes ☐ No]
[3.] Have you ever been convicted of a felony, DUI, had your driver's license suspended or revoked, or are you currently on probation or parole? ☐ Yes ☐ No
[4.] Do you have any existing life insurance policies or annuity contracts in force with any insurer? ☐ Yes ☐ No
[5.] Do you intend for this policy to replace any annuity or life insurance policy you currently have with any company? ☐ Yes ☐ No

[2.] [Please complete the following questions about your health history:]

[1.] Have you ever received medication for, been diagnosed by a medical professional, or tested positive for: Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS)? ☐ Yes ☐ No

[2.] Have you ever received medication, or been diagnosed by a medical professional for any of the following: diabetes, alcoholism or substance abuse, stroke, congestive heart failure, heart attack, coronary stent placement or bypass, coronary artery disease, cardiomyopathy (other than post-partum fully resolved), cancer (excluding basal cell skin cancer), kidney disorder (excluding kidney stones and infections), liver disorder (excluding hepatitis Type A), Parkinson's disease, multiple sclerosis, cerebral palsy, muscular dystrophy, lupus, epilepsy, paralysis or lung disorder (excluding asthma, pneumonia and bronchitis)? ☐ Yes ☐ No

[3.] In the past five years, have you been treated by a member of the medical profession for schizophrenia, suicide attempt, or bipolar disorder? ☐ Yes ☐ No

[4.] In the past 90 days, have you been advised by a medical professional to have a consultation, medication, treatment, surgery, hospitalization, lab test or diagnostic testing (excluding routine check-ups and tests related to the Human Immunodeficiency Virus (AIDS virus)) that has not been started or completed, or the results of which are not yet known? ☐ Yes ☐ No

[5.] In the past 90 days, have you been hospitalized for more than two days (excluding maternity)? ☐ Yes ☐ No

[3.] [Select your coverage amount and designate your beneficiary:]

[Check the desired amount of coverage:]

[Amount of insurance] [☐ $10,000 ☐ $25,000 ☐ $50,000 ☐ $75,000 ☐ $100,000 ☐ $125,000 ☐ $150,000 ☐ $175,000 ☐ $200,000 ☐ $225,000 ☐ $250,000]

[Note coverage limitation]

[Payment Frequency:] [Monthly] [☐ Term (years):] [☐ 5 ☐ 10 ☐ 15 ☐ 20]

[Payment Method:] [☐ EFT] [☐ Payment Card] [☐ Direct Bill] [☐ Escrow]

[Account Number] [Routing Number]

October 2B, 2015

[Financial Institution] [☐ Checking or ☐ Savings]

[Credit Card Number] [Expiration Date]

[CVC] [Card Type]

Beneficiary Name: _____ Relationship to the applicant: _____

[Address (Street, City, State, Zip) _____]

[Home Phone: ( ) _____] [Email Address: _____]

[Date of birth (mm/dd/yyyy) ☐☐ – ☐☐ – ☐☐☐☐]

[Social Security Number: ☐☐☐ – ☐☐ – ☐☐☐☐]

[IMPORTANT: PLEASE COMPLETE THE REVERSE SIDE OF THIS APPLICATION.]

[Please see enclosed materials for product details, rates and fees.]

[Unique ID: [XXXXXXXXXXXXXXXX] Solicit code: [XXXXXXXXXX] Case: [XXXXXXX-XXX]]

ICC15-50894

BarCode

Date: December 16, 2015 Product: MyLife Select Component: Application All Bill Methods
Version Compact Base Only
Special Instr: Legal Template

[Authorization]

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, pharmacy benefit manager, or other health care provider that has provided payment, treatment or services to me or on my behalf to disclose my entire medical record and any other protected health information concerning me to Minnesota Life Insurance Company, (the Company), and its employees, reinsurers and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs and tobacco. I also authorize any person(s), medical practitioner, institution, insurance company or MIB, Inc. to give any medical or nonmedical information about me including alcohol or drug abuse, or any medical or nonmedical information about any minor child for whom application is being made, to the Company and its reinsurers. I authorize all said sources, except MIB, Inc., to give such information to any agency employed by the Company to collect and transmit such information. I authorize the Company, or its reinsurers, to make a brief report of my personal, or if applicable, my protected health information to MIB, Inc. This health information is to be disclosed under this Authorization so the Company may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Company. This Authorization shall remain in force for 24 months following the date of my signature below. The 24 month time limit complies with the time limit, if any, permitted by applicable law in the state where the policy is delivered or issued for delivery. A copy of this Authorization is as valid as the original. I understand I[, or my legal representative, am/is] entitled to receive a copy of this Authorization. I understand that I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to the Company. I understand that a revocation does not apply to any action that was taken in reliance on this Authorization or to the Company's legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that there is a possibility of re-disclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality. I understand that if I refuse to sign this Authorization to release my complete medical record, the Company may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. [I understand that no sales representative has the company's authorization to accept risk, pass on insurability or make, or void, waive or change any conditions or provisions of the application or policy as applicable.]

[Consumer Privacy Notice

To underwrite your insurance request, the Company may ask for additional personal information, such as an insurance medical exam; lab tests; medical records from your insurance company, physician or hospital; a report from the MIB, Inc., a non-profit organization of life insurance companies that exchanges information among its members. Information about your insurability is confidential. Without your express authorization, the Company or its reinsurers may send your information to government agencies that regulate insurance; or, without identifying you, to insurance organizations for statistical studies. If you apply to a MIB, Inc. member company for life or health insurance, or submit a benefits claim for benefits to a member company, the MIB, Inc., upon request, will supply the member company with the information in its file. You [or your authorized representative] have the right to: receive by mail or to copy your personal information in the Company or MIB, Inc. files, including the source and who received copies within the past two years; to correct or amend personal information in these files; to know specific reasons why coverage was not issued as applied for; and to revoke your authorization at any time. At your written request, within 30 days the Company will explain in writing how to learn what is in your file, its source, how to correct or amend it or how to learn why coverage was not issued as applied for. You can send the Company a written statement as to why you disagree. If we correct or amend the information, we will notify you and anyone who may have received the information. If we do not agree with your statement, we will notify you and keep your statement in your file:

For further information about your application or your rights, contact:

Customer Service
Minnesota Life Insurance Company
400 Robert Street North
St. Paul, Minnesota 55101-2098
Telephone: [1-XXX-XXX-XXXX]

For information about the MIB, Inc., you may contact:

MIB, Inc.
50 Braintree Hill, Suite 400
Braintree, MA 02184-8734
MIB, Inc. Telephone: (866) 692-6901
MIB, Inc. TTY: (866) 346-3642
Website: www.mib.com]

[Agreements and Authorizations]

I have read this Authorization and Consumer Privacy Notice [provided in the enclosed brochure] and I understand I can have copies. The answers provided on this application are representations of the person [signing below]. The answers given are true and complete to the best of my knowledge and belief. I will notify the company of any changes in the statements or answers given in the application between the time of application and delivery of policy. It is understood that Minnesota Life Insurance Company shall incur no liability because of this application unless and until it is approved by the Company and the first premium is paid while my health and other conditions affecting my insurability are as described in this application. I understand that false or incorrect answers to the above questions may lead to rescission of coverage. If coverage is rescinded, an otherwise valid claim will be denied. 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. I have received, read and understand the Consumer Protection Disclosures [provided in the enclosed letter.]

[[I authorize [Minnesota Life Insurance Company] to debit the premium for the coverage I've selected from [the checking/savings/credit card account] [the account I have designated on this application] [monthly] [quarterly].] [I authorize [ABC Client] to bill and collect the premium for the coverage I've selected with my [monthly] mortgage payment.] [I authorize [ABC Client] to debit the premium for the coverage I've selected from the account I have designated on this application [monthly].] [I have agreed to use the payment authorized through [credit card vendor].] [I have authorized [ABC Client] to request payment of the [monthly] premium in the amount of [$X], based upon the information provided through [ABC Client].] [I understand and agree that in addition to the [monthly] premium charge, I will be charged an administrative fee of [$1.00] per [month].] [My payment authorization will remain in effect until [Minnesota Life] has received and has had reasonable time to act on my request to cancel in writing at [400 Robert Street North, Saint Paul, MN 55101] or by telephone at [1-XXX-XXX-XXXX from _____a.m. CST to _____p.m. CST.]] [I also authorize [ABC Financial Institution] to provide the billing information to Minnesota Life, a non-affiliate of [ABC Client] to activate my coverage.]]]

[4.] [Your Signature:]_____ [Your name:]_____ [Date:]_____ [Contact Info:]_____

[Is replacement of existing life insurance or annuity involved in this application? ☐ Yes ☐ No

I believe that the information provided by this applicant is true and accurate. I certify I have accurately recorded all information given by the proposed insured(s).

Licensed Representative's Signature:_____ [Agent Number:]_____ Date:_____ **]**

[Return your completed and signed application to Minnesota Life in the postage-paid envelope provided.]