PRIMERICA®

Primerica Life Insurance Company
[1 Primerica Parkway · Duluth, Georgia 30099-0001
1-800-257-4725]

APPLICATION / POLICY CHANGE APPLICATION / REINSTATEMENT APPLICATION FOR INDIVIDUAL TERMPRO LIFE INSURANCE

1. **Check one: This is a** ☐ New Business application ☐ Policy Change application for decreases or adding children ☐ Reinstatement application Policy Number

2. PROPOSED PRIMARY INSURED

Last Name | First Name | Middle Initial

SSN ___-___-___ | Male ☐ | Female ☐ | Married ☐ | Date of Birth ___-___-___ | Save Age Requested ☐

Driver's Lic # | State

Email

3. RESIDENCE ADDRESS

Street Address | City

State | ZIP Code | Home Phone ___-___-___ | Mobile Phone ___-___-___

Yrs./Mos. in U.S., Primary ___/___ | Occupation | Business Phone ___-___-___

Employer Name | If military, give pay grade | Yrs./Mos Employed ___/___

4. FINANCIAL INFORMATION

Annual Household Income $ ___,___,___.00 | Insured Monthly Income $ ___,___,___.00

Household Investable Assets (Supporting documentation must be submitted) $ ___,___,___.00 | Net Worth (Total Assets, including equity in property) $ ___,___,___.00

5. AMOUNT REQUESTED [($500,000 min.)]

Amount $ ___,___,___

Initial Level Premium Period ☐ 20 yr ☐ 10 yr

Primary Insured's issued class will be best available, based on underwriting results.

Class Requested
☐ Preferred
☐ Non-Tobacco/Non-Nicotine
☐ Tobacco/Nicotine

6. RIDER BENEFITS

☐ Waiver of Premium

7. OWNER (Do not fill out this section if Owner is the same as Primary Insured. Complete only if Primary Insured is Not the Owner.)

Last Name or Business Name | First Name | Middle Initial

SSN or TIN ___-___-___ | Date of Birth ___-___-___ | Relationship to Insured

Street Address | City

State | ZIP Code | Phone ___-___-___

8. ELECTRONIC DELIVERY

Do you consent to electronic delivery of your policy and all of the terms contained in the "Consent to Electronic Delivery of Policy and Related Disclosures" on page [17], which you have read and received? By checking yes, you will receive Electronic Policy Delivery. YES ☐ NO ☐

Owner Email

9. REPLACEMENT – Do you have any existing life insurance with this Company or another company that you intend to replace or change (i.e. lapse, convert to non-forfeiture option, reduce, surrender or otherwise terminate)? YES ☐ NO ☐ If yes, replacement must be indicated on page 2 in the Existing Insurance section.

Amount paid with application

CWA $ ___,___,___

BAR CODE

10. EXISTING INSURANCE INFORMATION - List below details of ALL Life Insurance or Annuities in force, including Group (GRP) and Individual (IND), on the Proposed Primary Insured and Children (IF PROPOSED FOR COVERAGE) and whether the Insurance or Annuities will be replaced or changed.

Existing Insurance Company Full Name & Address, City, State, ZIP	Name of Person(s) Covered	Policy or Certificate # of Existing Coverage	Face Amount	Month, Day, & Year Issued	Replaced?	GRP or IND?
					☐ Yes ☐ No	☐ GRP ☐ IND
					☐ Yes ☐ No	☐ GRP ☐ IND
					☐ Yes ☐ No	☐ GRP ☐ IND

11. CHILD RIDER COVERAGE: UNITS ☐☐ **Maximum 25 Units.** 1 Unit equals $1,000 in coverage. If amount entered, please complete Child Rider Information below.

12. CHILD RIDER INFORMATION – Not available after age 24 If additional children, please attach a separate sheet providing the information requested below.

Full Names of Children Proposed for Insurance Last First M.I.	Resides with Primary Yes/No	M/F	Relationship to Applicant (Son, Daughter, Stepchild, etc.)	Date of Birth Mo./Day/CCYY	Height ft. in.	Weight lbs.	Social Security Number
	☐ Yes ☐ No						
	☐ Yes ☐ No						
	☐ Yes ☐ No						

13. PRIMARY INSURED BENEFICIARIES Beneficiaries to share equally unless otherwise specified. If a group is named as beneficiary, you must name each individual of this group. IF A MINOR (below the age of 18) IS LISTED BELOW, PLEASE UNDERSTAND THAT FINANCIAL GUARDIANSHIP FOR THE MINOR'S ESTATE WILL BE REQUIRED BEFORE POLICY PROCEEDS CAN BE RELEASED. If additional beneficiaries, please attach a separate sheet providing the information requested below.

IF THESE ARE IRREVOCABLE BENEFICIARIES, CHECK HERE ☐

List PRIMARY INSURED'S Beneficiaries

1. Last Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ First Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Middle Initial ☐
   SSN ☐☐☐-☐☐-☐☐☐☐ Relationship to Applicant ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ (Total must equal 100) ☐☐☐ %
2. Last Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ First Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Middle Initial ☐
   SSN ☐☐☐-☐☐-☐☐☐☐ Relationship to Applicant ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ (Total must equal 100) ☐☐☐ %

List PRIMARY INSURED'S Contingent Beneficiaries

1. Last Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ First Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Middle Initial ☐
   SSN ☐☐☐-☐☐-☐☐☐☐ Relationship to Applicant ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ (Total must equal 100) ☐☐☐ %
2. Last Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ First Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Middle Initial ☐
   SSN ☐☐☐-☐☐-☐☐☐☐ Relationship to Applicant ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ (Total must equal 100) ☐☐☐ %

1 A. Primary Insured Weight Information

Height: ☐ ft. ☐☐ in. ☐☐☐ lbs.

B. Primary Insured Tobacco Information

Has tobacco/nicotine been used in the past 5 years? Yes ☐ No ☐

If yes, check when last used: ☐ within 1 year ☐ 1-2 years ☐ 2-3 years ☐ 3-5 years.

If telephone interview is necessary, what is your language preference? ☐ English ☐ Spanish

	Primary	Children
2. Within the past 10 years has any person named in this application been treated for or diagnosed by a member of the medical profession with:		
a. Hypertension (high blood pressure)? (If "YES," must answer questions 1. and 2. below)	Y☐ N☐	Y☐ N☐
1. Are you taking 3 or more medications for hypertension (high blood pressure)?	Y☐ N☐	Y☐ N☐
2. Have you been hospitalized within the past 3 years for hypertension (high blood pressure)?	Y☐ N☐	Y☐ N☐
b. Stroke; diabetes; cancer; tumor; paralysis; multiple sclerosis; lupus; scleroderma; rheumatoid arthritis; muscular dystrophy; leukemia; lymphoma (Hodgkin's and Non-Hodgkin's); seizure; mental or nervous disorder?	Y☐ N☐	Y☐ N☐
c. Any disease or disorder of the heart (excluding hypertension); liver (including hepatitis); pancreas; blood; brain; kidneys; circulatory; respiratory (including sleep apnea); gastrointestinal; neurological or nervous system?	Y☐ N☐	Y☐ N☐
d. Acquired Immune Deficiency Syndrome (AIDS); or tested positive for Human Immunodeficiency Virus (HIV)?	Y☐ N☐	Y☐ N☐
Within the past 10 years, has any person named in this application:		
e. Received professional counseling or medical treatment due to the use of alcohol or drugs (including prescription drugs)?	Y☐ N☐	Y☐ N☐
f. Used illegal or illegally obtained drugs (including prescription drugs) or been convicted of drug or alcohol related charges?	Y☐ N☐	Y☐ N☐
g. Plead guilty to or been convicted of a felony; or have any pending felony charges?	Y☐ N☐	Y☐ N☐
3. Within the past 5 years, has any person named in this application: Received disability benefits for a period of 6 months or longer or currently receiving disability benefits (except for partial military disability or maternity)?	Y☐ N☐	Y☐ N☐
4. Within the past 3 years, has any person named in this application:		
a. Plead guilty to or been convicted of 2 or more moving violations? (not including DUI or DWI)	Y☐ N☐	Y☐ N☐
b. Flown as a pilot, student pilot, or crew member on any aircraft (other than commercial); or intend to do so within the next 2 years?	Y☐ N☐	Y☐ N☐
c. Engaged in motor sports events or racing (auto, truck, cycle, boat, personal watercraft, snowmobile); caving; rock, canyon or mountain climbing; scuba diving (excluding snorkeling); aeronautics (hang-gliding, sky diving, parachuting, base jumping, ultralight, soaring, ballooning) or street luge or intend to do so within the next 2 years?	Y☐ N☐	Y☐ N☐
5. Within the past 12 months, has any person named in this application:		
a. Been hospitalized for any reason for more than 24 hours other than childbirth?	Y☐ N☐	Y☐ N☐
b. Except for tests related to Human Immunodeficiency Virus (AIDS Virus), received medical testing with results not yet reported?	Y☐ N☐	Y☐ N☐
c. Except for tests related to Human Immunodeficiency Virus (AIDS Virus), been advised to receive medical testing; or treatment that has not yet been completed?	Y☐ N☐	Y☐ N☐
6. Does any person named in this application: Have any plans within the next two years to reside outside of the United States or Canada for 30 days or longer?	Y☐ N☐	Y☐ N☐
7. Has any person named in this application:		
a. Had a parent or sibling prior to age 65 diagnosed with a cardiovascular illness or cancer?	Y☐ N☐	Y☐ N☐
b. Had a parent who died prior to age 65 as a result of cardiovascular illness or cancer?	Y☐ N☐	Y☐ N☐
c. Had a sibling who died prior to age 65 as a result of cardiovascular illness or cancer?	Y☐ N☐	Y☐ N☐
8. Within the past 5 years, has any person named in this application: Plead guilty to or been convicted of a DUI or DWI (driving under the influence or driving while intoxicated)?	Y☐ N☐	Y☐ N☐

For all "YES" answers for the Child Riders, list names, diagnoses, dates and details of treatment.

Question #	Child's Name	Diagnoses, dates and details of treatment
		FOR CHILDREN ONLY

Primerica Life Insurance Company
[1 Primerica Parkway
Duluth, Georgia 30099-0001
1-800-257-4725]

[THIS PAGE WILL CONTAIN AN INFORMED CONSENT FOR BLOOD AND BODY FLUID TESTING AND WILL NOT HAVE A FORM NUMBER ON IT.]

PAC

METHOD OF BILLING

You may save money by paying the premium on an annual basis. Semi-annual, quarterly, and monthly premiums include additional premium charges. Whether you will save money depends upon a number of factors, including the interest rate applicable to your savings or other account and/or the interest or other cost to you of borrowing money from a third party to make an annual premium payment rather than periodic payments. If you would like additional information, including information about the cost of our periodic payments, please contact your sales representative.

AUTHORIZATION FOR IMMEDIATE FUNDS TRANSFERS

If you have submitted a payment along with this application, you authorize Primerica Life to immediately deduct from your checking/savings account the CWA amount on page 1 of this application. Additionally, if you have chosen to pay the premiums for this policy monthly, you authorize Primerica Life to continue to deduct from your checking/savings account, on a monthly basis, for premium payments according to the specifications page(s) of your policy. These authorizations will remain in effect for 3-10 business days after Primerica Life actually receives written revocation by you. If any debt is dishonored for any reason, Primerica Life shall not have any liability whatsoever, even if the dishonor results in the forfeiture of insurance. **You understand that your account is subject to immediate draft upon application submission to Primerica Life's Home Office.**

CHOICE OF BILLING

☐ Annual Direct Bill ☐ Semi Annual Direct ☐ Quarterly Direct Bill ☐ Monthly Bank Draft - Requested Draft Day (Select a day 1-28) ☐☐

If MONTHLY BANK DRAFT is selected, this section MUST be completed, even if C.O.D. is requested.

Tape a Blank VOIDED CHECK for all drafts from CHECKING account.

Complete the following if draft is from a SAVINGS account, CHECK HERE ☐

Name on Account**

Bank/Credit Union Name

Bank Transit Routing #

The first two digits of the routing # must be 01 through 12 or 21 through 32. Do not use a deposit slip to verify the # because it may contain internal routing numbers that are not part of the actual routing number.

Bank Account Number

The account # can be up to 19 digits. Omit spaces, hyphens and special symbols. Be sure not to include the check #.

Relationship to Insured

**If you are NOT the Primary Insured or the Policy Owner, as indicated on Page 1, you MUST complete the name and signature for the Bank Account Owner on Page 9.

Primerica Life Insurance Company
[1 Primerica Parkway
Duluth, Georgia 30099-0001
1-800-257-4725]

NEW BUSINESS APPLICATION AGREEMENT, ACKNOWLEDGEMENTS AND AUTHORIZATIONS

By our signatures on page 9, we (Owner, Applicant and Primary Insured) understand and agree that:

1. In the sale or service of Primerica Life Insurance, Primerica agents represent Primerica Life Insurance Company and may provide services to us for Primerica Life Insurance Company. Agents do not have the authority to accept risk, pass on insurability, or make void, waive or change any conditions or provisions of this application, policy or receipt.
2. We have received pages [11-18] and have read, understand and accept the terms of the: [New Business Application Agreement, Acknowledgements and Authorizations; Conditional Coverage, HIPAA Authorization; Disclosure For Motor Vehicle Reports, Investigative Consumer Reports and MIB, Inc.; Terminal Illness Accelerated Benefit Disclosure; Authorizations for Electronic Funds Payments; Consent to Electronic Delivery of Policy and Related Disclosures; Method of Billing; and Informed Consent and Notice for Blood and Body Fluid Testing].
3. We authorize the Company to request consumer reports (which could include investigative consumer reports, credit reports, employment background checks and/or credit purchasing history) and motor vehicle reports on us; and the Company and its reinsurers to request our medical information from MIB, Inc. and its members.
4. By choosing to pay premiums through monthly bank draft, we authorize the Company to immediately deduct premiums directly from the account indicated in this application as described in the "Authorization for Electronic Funds Payments".
5. All of the information in this application and all additions to this application (such as examination reports and amendments) are true and complete to the best of our knowledge.
6. The statements and answers in this application and any other evidence of insurability are the basis for and become a part of the policy, and no information about us will be considered to have been given unless it is stated in this application.
7. Upon delivery, either by paper or electronically, we will review it to confirm that our responses are true and complete.
8. Prior to accepting any issued coverage, we will also review all policy and disclosure documents in the policy kit including the policy summary. These documents show any premium and benefit changes that occur over the period of coverage. We acknowledge that Primerica Life Insurance Company relies on this information to determine whether, and on what terms, to issue a policy.
9. Our acceptance of our policy will be considered our confirmation of the accuracy of our application information. If the application information is false, incorrect, or incomplete, we will immediately inform our agent or the Company.
10. We will accept return of any amount paid with this application if the Company does not approve this application. We understand Primerica Life will not contest a policy after it has been in force for two years during the Insured's life except for non-payment of premium and fraud in the procurement of the policy, when permitted by applicable law in the state where the policy is delivered or issued for delivery. The two years begin on the Date of Issue.

EFFECTIVE DATE OF POLICY COVERAGE

We understand and agree that, but for Conditional Coverage, no insurance will be in effect until the first premium due is paid in full while we are alive and a policy is issued on this application and delivered to and accepted while the information provided in this application and all additions continue to be true.

CONDITIONAL COVERAGE

There is no Conditional Coverage unless: (1) All of the information in the application and any additions to the application must be true and complete; (2) The proposed insured(s) must be a standard risk according to the Company's underwriting rules; (3) All items concerning insurability (including, but not limited to, the results of medical examinations or body fluid studies and attending physician statements) must be received; (4) At least one full month's premium (but not more than the amount required to purchase $500,000 of insurance for the Primary Insured exclusive of any riders) for the policy applied for must be received with the application; and (5) If the proposed insured(s) dies by suicide, while sane or insane, before the policy is issued, we are only liable for the premiums paid.

EFFECTIVE DATE OF CONDITIONAL COVERAGE

Any Conditional Coverage will become effective on the date the application is signed, or the date the Company receives the results of all required tests and exams or other requested information, whichever is later.

CONDITIONAL COVERAGE AMOUNT AND LIMIT

The amount of insurance provided under this Conditional Coverage is the amount applied for and for which current premium has been paid, but not exceeding $500,000 for the Proposed Primary Insured.

Primerica Life Insurance Company
[1 Primerica Parkway
Duluth, Georgia 30099-0001
1-800-257-4725]

POLICY CHANGE APPLICATION AGREEMENT, ACKNOWLEDGEMENTS AND AUTHORIZATIONS

By our signatures on page 9, we (Owner, Applicant and Primary Insured) understand and agree that:

1. In the sale or service of Primerica Life Insurance, Primerica agents represent Primerica Life Insurance Company and may provide services to us for Primerica Life Insurance Company. Agents do not have the authority to accept risk, pass on insurability, or make void, waive or change any conditions or provisions of this application or policy.

2. We have received pages [11-18] and have read, understand and accept the terms of the: [Policy Change Application Agreement, Acknowledgements and Authorizations; HIPAA Authorization; Disclosure For Motor Vehicle Reports, Investigative Consumer Reports and MIB, Inc.; Terminal Illness Accelerated Benefit Disclosure; Authorizations for Electronic Funds Payments; Consent to Electronic Delivery of Policy and Related Disclosures; Method of Billing; and Informed Consent and Notice for Blood and Body Fluid Testing].

3. We authorize the Company to request consumer reports (which could include investigative consumer reports, credit reports, employment background checks and/or credit purchasing history) and motor vehicle reports on us; and the Company and its reinsurers to request our medical information from MIB, Inc. and its members.

4. All of the information in this application and all additions to this application (such as examination reports and amendments) are true and complete to the best of our knowledge. The Company relies on this information to determine whether and on what terms, to issue any insurance.

5. The statements and answers in this application and any other evidence of insurability are the basis for and become a part of the policy, and no information about us will be considered to have been given unless it is stated in this application.

6. The Company will have no liability and no insurance applied for in this Policy Change Application is effective until:

(a) coverage is issued on this application and delivered to and accepted by the Owner; and

(b) the first premium due is paid in full while each insured is alive while the information provided in this application and all additions continue to be true.

7. If within two years of a policy or rider issue date, any information is determined to be false, incomplete or incorrect, the entire policy or rider may be rendered void.

8. There is no Conditional Coverage with a Policy Change Application.

9. We will accept the return of any premium paid if the Company does not approve this application.

10. We will review any policy and disclosure documents. These documents show any premium and benefit changes.

PRIMERICA®

Primerica Life Insurance Company
[1 Primerica Parkway
Duluth, Georgia 30099-0001
1-800-257-4725]

REINSTATEMENT APPLICATION AGREEMENT, ACKNOWLEDGEMENTS AND AUTHORIZATIONS

Amount Submitted With Reinstament
$ _____

REINSTATEMENT: ☐ Original Date (All Back Premiums Are Required)
☐ Redate (Current Mode Of Premium Or New Signed Voided Check Required)

You have two options to reinstate your policy. For the first option (original date), you must pay all unpaid, past due premiums with interest and the reinstated date of your policy will be the same date as your original policy date. By choosing this option, you will keep your original issue age.

If you do not want to pay all past due premiums with interest, you may choose the second option (redate). For this option, you will pay one month's premium and you will be given a new anniversary date. By choosing this option, your insurance age may change and your premiums may increase.

Regardless of the election made above, there will be a new two (2) year contestable period that begins with reinstatement.

By our signatures on page 9, we (Owner, Applicant and Primary Insured) understand and agree that:

1. In the sale or service of Primerica LIfe Insurance, Primerica agents represent Primerica Life Insurance Company and may provide services to us for Primerica Life Insurance Company. Agents do not have the authority to accept risk, pass on insurability, or make void, waive or change any conditions or provisions of this application, policy or receipt.
2. We have received pages [11-18] and have read, understand and accept the terms of the: [Reinstatement Application Agreement, Acknowledgements and Authorizations; HIPAA Authorization; Disclosure For Motor Vehicle Reports, Investigative Consumer Reports and MIB, Inc.; Terminal Illness Accelerated Benefit Disclosure; Authorizations for Electronic Funds Payments; Consent to Electronic Delivery of Policy and Related Disclosures; Method of Billing; and Informed Consent and Notice for Blood and Body Fluid Testing].
3. We authorize the Company to request consumer reports (which could include investigative consumer reports, credit reports, employment background checks and/or credit purchasing history) and motor vehicle reports on us; and the Company and its reinsurers to request our medical information from MIB, Inc. and its members.
4. By choosing to pay premiums through monthly bank draft, we authorize the Company to immediately deduct premiums directly from the account indicated in this application as described in the "Authorization for Electronic Funds Payments".
5. All of the information in this application and all additions to this application are true and complete to the best of our knowledge and belief.
6. The statements and answers in this application are the basis for and become a part of the policy, and no information about us will be considered to have been given unless it is stated in this application.
7. We will accept return of any amount paid herewith should the Company decline to approve this application.
8. There is no Conditional Coverage and the Company shall have no liability until:

   (a) a policy is issued on this application and delivered to and accepted by Us; and

   (b) the first premium is paid in full while each proposed insured is alive while the information in this application and all additions continue to be true.

RST

THIS IS A NEW BUSINESS APPLICATION, POLICY CHANGE APPLICATION OR REINSTATEMENT APPLICATION AS INDICATED ON PAGE 1, SECTION 1.

IF THIS IS A NEW BUSINESS APPLICATION, I HAVE READ PAGE 6 CAREFULLY AND UNDERSTAND WHAT IT MEANS.

IF THIS IS A POLICY CHANGE APPLICATION, I HAVE READ PAGE 7 CAREFULLY AND UNDERSTAND WHAT IT MEANS.

IF THIS IS A REINSTATEMENT APPLICATION, I HAVE READ PAGE 8 CAREFULLY AND UNDERSTAND WHAT IT MEANS.

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.

➞ _____
Signature of Proposed Primary Insured

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

➞ _____
Signature of Authorized Signer of Bank Checking/ Savings Account (if not already included)

Dated In ☐☐ on ☐☐-☐☐-☐☐☐☐
State Month Day Year

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) AUTHORIZATION

For Use and Disclosure of Protected Health Information

By my signature below:

(1) We (Owner, Applicant and Primary Insured) authorize Primerica Life Insurance Company, its affiliates, (collectively the "Company"), reinsurers, and authorized representatives, including Agents, insurance support organizations and service providers to receive our health information; **(2)** We acknowledge that health information may include information about prescription histories, the diagnosis, treatment and prognosis of any physical or mental condition and the use of drugs or alcohol, but not psychotherapy notes; **(3)** We authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, Veteran's Administration, government facility, pharmacy, pharmacy benefit manager, insurance company, clearinghouse, or other entity or person ("Providers") to disclose our health information; **(4)** We acknowledge that this Authorization may be relied upon to determine our eligibility for insurance, to obtain reinsurance, to administer any claim for insurance benefits or for any other business purpose not otherwise prohibited, including but not limited to any activities related to coverage or benefits or to support the business operations of the Company; **(5)** We acknowledge that this Authorization expires two (2) years from the date it is signed; **(6)** We acknowledge that we may revoke this Authorization at any time by sending written notice to the Company's address, however, any revocation will not apply retroactively or prevent the Company from contesting a claim for insurance benefits or the policy itself; **(7)** We acknowledge that if we refuse to sign this Authorization, a Provider may not refuse to provide treatment or payment for health care services, however the Company may not be able to process this application or, if coverage is issued, make any benefit payments; **(8)** We acknowledge that information disclosed pursuant to this Authorization may be redisclosed and no longer covered by certain federal rules governing privacy of health information; and **(9)** We acknowledge that a photographic copy of this Authorization, including a photographic or electronic copy of Our signature, is valid as the original and We may receive a copy of this Authorization after it is signed.

➞ _____
Signature Primary Insured

☐☐-☐☐-☐☐☐☐
Month Day Year

RVP Name (Please print) Solution No.

Contact Me At This Number

Street Address Suite #

City State ZIP

RVP Fax Number

1st AGENT CERTIFICATION:

I certify that: **(1)** I personally saw the Proposed Primary Insured and witnessed him/her signing this application; **(2)** I personally have asked and recorded completely and accurately the answers to all questions on this application; **(3)** To the best of my knowledge and belief all answers provided by the Proposed Primary Insured on all completed parts are true; **(4)** I know of nothing affecting the risk that has not been recorded herein; **(5)** I have given the applicant Pages [11-18] and "What Does Primerica Do With Your Personal Information?"; **(6)** I have explained to the applicant(s) the provisions of any Conditional Coverage; **(7)** I have not made any proposal to or agreement with anyone whereby the applicant or any other person has received directly or indirectly, in settlement of the premium on the proposed insurance, any concession or rebate from the regular premium; **(8)** I assume full responsibility for the delivery of any Policy issued and sent to me to deliver and for the delivery to the Company of any payment of the first premium I receive; **(9) I have accurately recorded Proposed Primary Insured representation about tobacco or nicotine use and understand false or misleading representations will result in a denial of coverage in a claims investigation. If I provide false information in an application for insurance, I understand that I may be found guilty of insurance fraud.**

Agent Replacement Statement

Life insurance or annuities will be replaced or changed (i.e. lapsed; converted to a non-forfeiture option; reduced; surrendered; or otherwise terminated) if indicated on page 1.

Special request(s) and additional comments by agent:

1st Licensed Agent

Last Name First Name MI

Solution No. Date Month - Day - Year

→ Signature of 1st Licensed Agent

2nd Representative

Last Name First Name MI

Solution No.