Part I of Application for Individual Life Insurance

ZURICH

Zurich American Life Insurance Company (the "Company")

Administrative Office
7045 College Boulevard
Overland Park, KS 66211-1523

Phone: 877.678.7534
Fax: 888.871.7537
www.zlifeusa.com

Section A: Product and Amount of Insurance

Product Name
Product Name data

Specified Amount of Insurance

Death Benefit Option (check one):

☐ Option A (Level)
☒ Option B (Increasing)
☒ Option C (Specified Amount plus return of net premiums paid)
☒ Option D (Specified Amount plus return of net premiums paid plus interest)

Section B: Proposed Insured

First Proposed Insured

1. Name (First, Middle Initial, Last)	2. Gender ☐M ☐F	3. Birth Date (MM/DD/YYYY)
4. Birth Place (Country/State)	5. Social Security Number	6. Home Phone Number
7. Work Phone Number	8. E-mail Address	
9. Address (Street, City, State, Zip Code, Country)		10. Driver's License State of Issue
11. Driver's License Number and Expiration Date		12. Occupation
13. Employer Name and Address		
14. Annual Income	15. Net Worth (approximate)	16. Permanent U.S. Resident? ☐ Yes ☐ No

Citizenship

17. Are you a citizen of the United States? ☐ Yes ☐ No
If "No", provide details below

18. Country of Citizenship	19a. ☐ Green Card ☐ Visa	19b. If "Visa", provide type
20. Expiration Date	21. Country of Permanent Residence	22. Years in the U.S.

Second Proposed Insured

1. Name (First, Middle Initial, Last)	2. Gender ☐M ☐F	3. Birth Date (MM/DD/YYYY)
4. Birth Place (Country/State)	5. Social Security Number	6. Home Phone Number
7. Work Phone Number	8. E-mail Address	
9. Address (Street, City, State, Zip Code, Country)		10. Driver's License State of Issue
11. Driver's License Number and Expiration Date		12. Occupation
13. Employer Name and Address		
14. Annual Income	15. Net Worth (approximate)	16. Permanent U.S. Resident? ☐ Yes ☐ No

Citizenship

17. Are you a citizen of the United States? ☐ Yes ☐ No If "No", provide details below		
18. Country of Citizenship	19a. ☐ Green Card ☐ Visa	19b. If "Visa", provide type
20. Expiration Date	21. Country of Permanent Residence	22. Years in the U.S.

Section C: Proposed Owner (If other than Proposed Insured(s))

1. Owner/Trust Name		2. Relationship to Insured(s)
3. Social Security/Tax ID Number	4. Permanent U.S. Resident? ☐ Yes ☐ No	5. U.S. Citizen? ☐ Yes ☐ No
6. E-mail Address	7. Phone Number	
8. Name(s) Authorized Trustee(s)	9. Trust Date (MM/DD/YYYY)	10. State Trust Established
11. Address (Street, City, State, Zip Code, Country) of Owner		

Section D: Beneficiary

Beneficiary Type	Name (First, Middle, Last)	Relationship to Proposed Insured(s)	Percentage of Proceeds (if not equal)
Primary			
Primary			
Contingent			
Contingent			

Note: Unless otherwise specified, surviving beneficiaries within a class (primary or contingent) will share equally.

Section E: Proposed Insured's Other Insurance

1. Do you have any other life insurance/annuity(ies), including ultimate death benefit amounts of any policy/rider in effect with Zurich American Life Insurance Company, its affiliated companies or any other life insurance company? (Include any policy that has been sold, assigned or settled to or with a settlement or viatical company or any other person or entity.) If "Yes", complete the chart below. ☐ Yes ☐ No

Proposed Insured	Name of Company	Face amount plus riders	Year Issued	Insurance	To be replaced, changed or affected?	Section 1035 Exchange?
☐ 1 ☐ 2				☐ Pers. ☐ Bus.	☐ Yes ☐ No	☐ Yes ☐ No
☐ 1 ☐ 2				☐ Pers. ☐ Bus.	☐ Yes ☐ No	☐ Yes ☐ No
☐ 1 ☐ 2				☐ Pers. ☐ Bus.	☐ Yes ☐ No	☐ Yes ☐ No
☐ 1 ☐ 2				☐ Pers. ☐ Bus.	☐ Yes ☐ No	☐ Yes ☐ No
☐ 1 ☐ 2				☐ Pers. ☐ Bus.	☐ Yes ☐ No	☐ Yes ☐ No

Section F: Proposed Insured(s) Personal History (Proposed Insured referred to as "you")

	First Proposed Insured Yes	First Proposed Insured No	Second Proposed Insured Yes	Second Proposed Insured No
1. Have you ever used tobacco or nicotine products in any form (e.g., cigars, cigarettes, cigarillos, pipes, chewing tobacco, nicotine patches, or nicotine gum)? If "Yes", please provide details.	☐	☐	☐	☐

Product(s)	Frequency/Amount	Date last used

	First Proposed Insured Yes	First Proposed Insured No	Second Proposed Insured Yes	Second Proposed Insured No
2. Within the next 12 months, do you plan to fly, or within the last two years have you flown, as a pilot, student pilot, or crew member? If "Yes", complete the Aviation Questionnaire.	☐	☐	☐	☐
3. Within the next 12 months, do you plan to participate in, or within the last 12 months have you participated in, parachute jumping, scuba diving, auto/motorboat/motorcycle racing, hang gliding, or mountain climbing? If "Yes", complete the Avocation Questionnaire.	☐	☐	☐	☐
4. Have you traveled or resided outside the U.S. or Canada within the past two years; or do you plan to travel or reside outside the U.S. or Canada within the next two years? If "Yes", please provide details.	☐	☐	☐	☐

Past	Future	Duration (weeks)	Cities and Countries	Purpose				
☐	☐				☐	☐	☐	☐
☐	☐				☐	☐	☐	☐
☐	☐				☐	☐	☐	☐

	First Proposed Insured Yes	First Proposed Insured No	Second Proposed Insured Yes	Second Proposed Insured No
5. Have you ever received medical treatment or counseling for, or been advised by a physician to reduce or discontinue the use of alcohol or prescribed or non-prescribed drugs? (Do not complete if your age is 0-17 on your nearest birthday.) If "Yes", complete the Alcohol and Drug Use Questionnaire	☐	☐	☐	☐
6. Have you ever had a driver's license suspended or revoked, been convicted of DUI or DWI, or in the last five years had any moving violations?	☐	☐	☐	☐
If "Yes", please provide date(s) and violation(s):				
7. Have you applied for any other life insurance within the last six months?	☐	☐	☐	☐
8. Have you ever had life insurance declined, rated, modified, cancelled, or not renewed?	☐	☐	☐	☐
9. Have you been convicted of a felony within the past five years?	☐	☐	☐	☐

Remarks:

Section G: Premium and Billing Information

1. A current Policy Date will be used unless you select one of the following.

☐ Date to save age ☐ Specific date _____ (indicate a date, excluding 29th, 30th and 31st)
MM/DD/YYYY

By signing in the signature section, I understand that insurance and expense charges begin on the Policy Date.

2. Amount paid with this Application

The Application, Temporary Insurance Agreement, and check should all have the same date.

A. Is an initial premium submitted with this Application?
☐ No ☐ Yes (Do not submit money unless the face amount is $500,000 or less and the Temporary Insurance Insurance completed).

B. If "Yes", show amount of initial premium. Amount $ _____
If "Yes", by signing in the signature section, I understand, accept, and agree to the terms of the Temporary Insurance Agreement, if eligible.

C. Planned Periodic Premium Amount $ _____
Frequency of premium: ☐ Weekly ☐ Monthly ☐ Quarterly ☐ Annually

D. Will a loan be carried over from another insurance carrier? ☐ Yes ☐ No
If "Yes" , what is the amount of the loan $ _____

3. Premium Payment Assistance

Is a third party (family member, friend or non-relative) helping you to pay all or any part of your first year premium?
☐ Yes ☐ No

If so, please advise details of the individual/entity and amount involved:

_____

_____

_____

4. Premium Financing

All questions must be answered.

Premium financing, or borrowing life insurance premiums from a lender or other third party, can be a legitimate method of funding life insurance premiums. However, not all premium financing arrangements may be appropriate and in compliance with applicable laws and regulations. In fact, the Company does not allow its products to be used in certain premium financing arrangements and will decline applications for life insurance made in connection with a premium financing arrangement that is not approved for use with the Company products.

1. Have you entered into, or have you made plans to enter into, an agreement to borrow current or future premiums, or both, in connection with this Application for Individual Life Insurance?
☐ Yes ☐ No

If "Yes", indicate name of the financing agreement: _____

If "Yes", indicate name of the lender: _____

2. Have you made plans to transfer the Policy to a third party as repayment of any premium financing debt?
☐ Yes (Give details in the Remarks section) ☐ No

5. Premium Billing Methods

A. Billing method: (Check one)
☐ Direct ☐ Monthly bank draft (Complete Section H: Pre-Authorized Checking) ☐ Single premium

B. Frequency of Payment: (Check one)
☐ Annually ☐ Semi-Annually ☐ Quarterly ☐ Monthly (Available with List Bill only)

C. Indicate the duration of the no-lapse guarantee that will be funded: _____

D. Desired premium payment period: _____

6. Payor of Premiums

Individual or entity paying premium.

A. Payor of premium is: (Check one)
☐ First Proposed Insured ☐ Second Proposed Insured ☐ Employer
☐ Primary Policyowner ☐ Other: _____

6. Payor of Premiums (continued)

B. Complete information below for above party(ies), if different from Owner.

1. Name

2. Relationship to Insured(s)

3. Care of (if applicable)

4. Street

5. City

6. State

7. Zip Code

7. Remarks

Section H: Pre-Authorized Checking

(Available only if the bank account holder is the Owner or Proposed Insured.)

The undersigned ("I") hereby authorize the Company with whom I am completing this Application to initiate debit entries through the Company to the deposit account designated below, at the Financial Institution named below, using the Automated Clearing House. I authorize:

1. Recurring debits; and
2. Debits made from time to time, as I authorize

This Authorization is to remain in full force and effect until the Company has received written notification from the Owner and/or Proposed Insured of its termination at such time and in such manner as to afford the Company and the Financial Institution a reasonable opportunity to act on it.

Beginning Debit Date: ____ / ____ / ____
MM DD YYYY

Amount: $ _____

Frequency: Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly

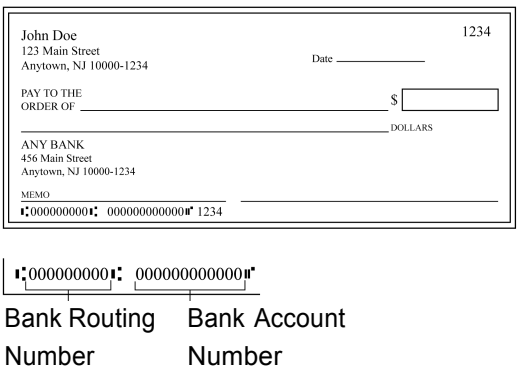
Bank Account Type: ☐ Checking ☐ Savings

Bank Routing Number Bank Account Number

_____ _____

Name of Financial Institution

_____



Note: Please attach a voided check or deposit slip.

The Company cannot establish banking services from starter checks, cash management, brokerage, or mutual fund checks. We cannot establish banking services from foreign banks unless the check is being paid in U.S. dollars through a U.S. correspondent bank (the U.S. correspondent bank name must appear on the check).

Section I: Signature: (All Proposed Insured(s) and Policy Owner must sign)

I (we) have read all the questions and answers in the Application, including all required parts. All responses are true and complete to the best of my (our) knowledge and belief. I (we) promise to tell Zurich American Life Insurance Company of any change in the health or habits of the Proposed Insured that occurs after completing this Application, but before the policy is delivered to me (us) and the first premium is paid. I (we) agree:

1. This Application, including all of its parts, statements and answers, will be the basis for and form part of the policy, if issued, and no information will be considered to have been given to Zurich American Life Insurance Company unless it is stated in the Application.
2. No Agent has authority to alter Zurich American Life Insurance Company's rules or requirements, the Application, any Temporary Insurance Agreement, or any policy.
3. The first premium will not be deemed paid unless any check, draft, or other instrument of payment (given as premium) is paid in accordance with its terms.
4. Except as provided in the Temporary Insurance Agreement, if given, the insurance applied for never takes effect unless, during the lifetime of the Proposed Insured:
   (a) the policy has been issued, delivered to, and accepted by me (us);
   (b) the required first premium has been paid while each Proposed Insured is alive; and
   (c) any amendments issued with the policy have been completed and signed, all while the health and habits of the Proposed Insured(s) remain as stated in this Application.
5. In those states where required by state regulations, Zurich American Life Insurance Company will notify the Proposed Insured(s) within (60) days of the Application as to whether or not the Application has been accepted or rejected or will give the reason for further delay.

Amendments to plan, amounts, classification or benefits will be made only with my (our) consent. I (we) have received the notification about the Federal Fair Credit Reporting Act and the MIB, Inc. Zurich American Life Insurance Company or its reinsurers may make a brief report regarding me to other companies to whom I have applied or may apply.

I (We) authorize Zurich American Life Insurance Company to obtain an investigative consumer report on me (us). (Upon written request, you may obtain a copy of the report. There may be a fee for the copy.) I (We) agree to be interviewed if an investigative consumer report is prepared in connection with this Application.

Zurich American Life Insurance Company, its reinsurers, insurance support organizations, the MIB, Inc. and their authorized representatives may obtain medical and other information in order to evaluate my (our) Application for life insurance. Any employer, consumer reporting agency, insurance company, licensed physician or medical practitioner, hospital, clinic, the Veterans Administration, the MIB, Inc., or other medical or medically related facility who possesses information of care, treatment or advice of me or my health or information of care, treatment or advice of my (our) children or their health may furnish such information to Zurich American Life Insurance Company, its reinsurers, insurance support organizations, the MIB, Inc. and their authorized representatives upon presenting this Authorization. I (We) understand that this Authorization includes information about drugs, alcoholism or mental illness, and that I (we) or my (our) representative may request and receive a copy of this Authorization. A copy of this Authorization is as valid as the original. I (we) authorize Zurich American Life Insurance Company, or its reinsurers, to make a brief report of my (our) personal health information to the MIB, Inc. This Authorization is valid for two and one-half years from the date this form is 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 and State — Signature of Proposed Insured/Signature of Parent or Guardian (if Proposed Insured is a minor)

on _____ _____
MM/DD/YYYY — Signature of Owner/Applicant, if other than Proposed Insured

_____ _____ _____
Signature of Broker/Witness — Print Broker Name — Broker License Number

_____ _____
Signature of Second Proposed Insured — Print Second Proposed Insured Name

Section J: Broker Identification and Certification

(Incomplete information may delay your Application)

1. What is the purpose of insurance? (Check all that apply)
   - ☐ Estate planning ☐ Charitable giving
   - ☐ Buy/sell If "Yes", percentage of Business Owned: _____ % Fair market value of Business $ _____
   - ☐ Key person ☐ Income protection ☐ Other _____
2. Is this insurance a replacement? ☐ Yes ☐ No
3. Have you completed and attached the required replacement forms? ☐ Yes ☐ No ☐ N/A
4. Have you attached the Internal Revenue Code Section 1035 form? ☐ Yes ☐ No ☐ N/A
5. Did you use only sales material approved for use by the appropriate Company? ☐ Yes ☐ No
6. Did you see all persons to be insured on the date the Application was taken? ☐ Yes ☐ No
   If "No", why not? _____
7. Are you related to the Proposed Insured(s)? ☐ Yes ☐ No
   If "Yes", indicate relationship: _____

Certification of Owner Identity:

☐ I certify that I personally met with the Owner(s)/legal representative(s) of the entity and reviewed the appropriate identification documents. To the best of my knowledge, the documents accurately reflect the identity of the Owner(s)/legal representatives of the entity.

☐ I did not meet in person with the Owner(s)/legal representative(s) of the entity or I was otherwise unable to personally review the Owner(s)/entity's identification documents. I certify that, to the best of my knowledge, the Owner(s)/entity's identification information provided by the legal representative(s) either by mail or phone is accurate.

I certify that I have truly and accurately recorded on all parts of this Application the information supplied by the Proposed Insured(s) or the applicant(s). As noted in Question Number 6 above, I have personally observed each Proposed Insured. Apart from any admissions recorded on the Application or any additional comments that I have supplied to underwriting, each appears to me to be healthy. The purpose of this sale has been discussed with the Owner(s) and I believe this Application to be an appropriate recommendation.

Producer Name (Please print full name)	Sales Office/ Agency Number/ID	Broker Number/ID	Commission Split % 1st Year	Renewal

Section K: Signatures

I have personally reviewed this Application for appropriateness of sale. I was appropriately licensed and appointed on the date the Application was signed.

Name of Broker _____ Broker Signature _____ Date (MM/DD/YYYY) _____

Section L: Temporary Insurance Agreement

Proposed Insured Name	Date of Birth (MM/DD/YYYY)	Application Number

Notice to Proposed Insured and Owner

Subject to a signed and dated Application for Individual Life Insurance (Application) bearing the same number as the Application Number printed above, the Terms of Eligibility below, and payment of the full first modal premium for the policy applied for in the Application, coverage provided by this Conditional Temporary Insurance Agreement (TIA) is limited to the amount applied for in the Application (exclusive of riders or supplemental benefits) or $500,000, whichever is less, and applies to the life of the Proposed Insured named in the Application Part 1. Coverage under this TIA begins on the Start Date and ends on the Stop Date described below. No Agent or Representative has the authority to change the terms and conditions of this TIA.

Terms of Eligibility

If the following five questions cannot be truthfully answered "No" or if any questions are left blank, no Agent of Zurich American Life Insurance Company is authorized to collect premiums associated with your Application and this TIA and no life insurance coverage is in force by virtue of your Application or this TIA until the policy requested in your Application takes effect.

		Yes	No
1.	Is the Proposed Insured less than 15 days old or more than 70 years old as of the date of the Application?	☐	☐
2.	Has the Proposed Insured ever been diagnosed or treated by a physician for any of the following: disorder of the heart or blood vessels, angina, heart attack, stroke, cancer, tumor, Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARCS) or any other immunological disorder, drug dependency, or alcohol dependency?	☐	☐
3.	Within the past two years, has the Proposed Insured been diagnosed or treated by a physician for a medical condition that resulted in hospitalization for more than five days?	☐	☐
4.	Has the Proposed Insured ever applied for insurance which has been declined, rated or modified in any way?	☐	☐
5.	Within the past 90 days, has the Proposed Insured been unable to perform the normal duties of his/her occupation for fifteen or more working days because of health reasons?	☐	☐

Agreement

This TIA provides for a death benefit limited to the amount applied for in the Application (exclusive of riders or supplemental benefits) or $500,000, whichever is less. Life insurance benefits will be paid, subject to the Limitations described below, upon presentation of due proof of death of the Proposed Insured occurring between the Start Date and Stop Date of this TIA. The death benefit will be paid to the person who would have received payment under the policy applied for had it been issued. In the event the Application is declined or withdrawn or this TIA is cancelled for any reason, Zurich American Life Insurance Company's only obligation will be to return the premium paid.

Start Date

Once the Terms of Eligibility have been met and the full first modal premium for the policy applied for in the Application has been paid, the coverage provided under this TIA begins on the date the Application for Individual Life Insurance bearing the same number as this TIA is signed.

Policy Effective Date

If the policy applied for is issued on the plan, for the amount and at the rate specified in the Application, and the full first modal premium has been paid, the policy will take effect on the Issue Date assigned by Zurich American Life Insurance Company. If the policy can not be issued as applied for or a request to backdate the policy has been made, the policy will take effect on its Issue Date once it has been issued, delivered and accepted by the Policy Owner and the full first modal premium has been paid. All of the funds used to purchase TIA coverage will be applied to the policy as it takes effect.

Stop Date

Coverage under this TIA ends when the policy takes effect or when the Company receives the Policy Owner's signed request to cancel or withdraw the Application or this TIA.

Coverage under the TIA also ends when the Policy Owner receives notice that either this TIA or the Application has been declined; and in no case later than 12:01 A.M. Pacific Standard Time of the fifth day after Zurich American Life Insurance Company has mailed a letter giving such notice.

Limitations

No benefits under this TIA will be paid if the full first modal premium check/draft submitted is not honored by the bank upon first presentation. If a material misrepresentation or omission of fact is made with respect to the Terms of Eligibility requirements above or the Proposed Insured dies by suicide, whether sane or insane, coverage under this TIA will be void and Zurich American Life Insurance Company's only obligation will be to return the premium paid.

I (We) represent that: (1) I (We) have read and received a copy of this TIA and agree to all of its terms and conditions; (2) I (We) understand and agree that no life insurance coverage, other than coverage provided by this TIA, is in force by virtue of my Application, until the policy takes effect; (3) I (We) understand that purchasing the coverage under this TIA does not guarantee that Zurich American Life Insurance Company will issue a policy on the Proposed Insured's life; and (4) I (We) understand that the Agent is not authorized to change or waive the terms of this TIA or collect premium if the Proposed Insured is not eligible for coverage.

Signature of Proposed Insured	Date of this TIA (MM/DD/YYYY)	Signature of Proposed Policy Owner (if other than Proposed Insured)

Licensed Broker's Statement

Amount Remitted: $_____ Person from whom received: _____

On the Date of this TIA, I received the Amount Remitted in exchange for this TIA. This TIA bears the same date and number as the Application - Part I. I agree that I am not authorized to change or waive the terms of this TIA and represent that I have not attempted to do so. I have read and explained the terms of this TIA to the Proposed Insured and Owner. I have left a copy with the Owner.

Signature of Broker	Broker's Number

Section M: Notice to Owner and Proposed Insured(s) Regarding Coverage

No insurance coverage is in force as a result of your insurance Application unless and until the policy applied for has been issued on the plan, for the amount and at the rate specified in the Application, and the full first modal premium has been paid, at which time the policy will take effect on the Issue Date assigned by the Company. If the policy cannot be issued as applied for or a request to backdate the policy has been made, no insurance coverage is in force as a result of this Application unless and until the Company issues a policy that has been delivered and accepted by Owner and the full first modal premium has been paid, at which time the policy will take effect on its Issue Date. If eligible, you have the right to purchase coverage under a Temporary Insurance Agreement that will provide a limited amount of coverage from the time this Application is signed until the policy takes effect. The terms and conditions for eligibility, coverage, duration and termination are described on the TIA attached to and bearing the same number as this Application. If you are eligible and choose to purchase coverage under the TIA, 100% of the premium paid for the TIA will be applied to the policy as of its Issue Date if the policy is issued as applied for. If the policy cannot be issued as applied for or a request to backdate the policy has been made, 100% of the premium paid for coverage under the TIA will be applied to the policy as of its Issue Date at the time the Policy is delivered and accepted, as issued, by Owner. If you are not eligible or choose not to purchase, no Agent of Zurich American Life Insurance Company is allowed to accept a premium payment in connection with this Application or an Application for coverage under a TIA and no coverage of any kind is in force by virtue of this Application until a policy takes effect.

Part II of Application for Individual Life Insurance

ZURICH®

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www.zlifeusa.com

Paramedical The following is to be completed by the Proposed Insured (referred to as "you").

1.a. Proposed Insured (Please Print)
First Name _____ Middle Initial _____ Last Name _____

b. Height _____ ft. _____ in. c. Weight _____ lbs. d. Birth Date (MM/DD/YYYY) _____

e. Has your weight changed by more than 10 pounds in the last 6 months? ☐ Yes ☐ No
If Yes, please provide details: _____

2.a. Name and address of personal physician (or medical facility if used instead): (If none, so state) _____

b. Date and reason for last medical or health consultation (within last five years): _____

c. What treatment was given or recommended? (If none, so state) _____

Please provide full details for all "Yes" answers on Page 2.

3.	Are you being treated by diet, drugs or other means?	☐ Yes	☐ No
4.	Have you been diagnosed or been treated by a physician for:		
a.	High blood pressure, chest discomfort, stroke, circulatory or heart disorder?	☐ Yes	☐ No
b.	Diabetes, sugar in the urine, thyroid, or other glandular (endocrine) disorder?	☐ Yes	☐ No
c.	Kidney, bladder, urinary, reproductive organ or prostate disorder?	☐ Yes	☐ No
d.	Protein (albumin), blood or pus in the urine, sexually transmitted disease or venereal disease?	☐ Yes	☐ No
e.	Cancer, tumor, polyp, or disorder of the skin or breast?	☐ Yes	☐ No
f.	Asthma, pneumonia, emphysema, or any other respiratory or lung disorder?	☐ Yes	☐ No
g.	Seizure, convulsion, fainting, loss of consciousness, tremor, paralysis, or other disorder of the nervous system?	☐ Yes	☐ No
h.	Anxiety, depression, stress or any psychological or emotional condition or disorder?	☐ Yes	☐ No
i.	Colitis, hepatitis, ulcers, or other disorders of the stomach, liver or digestive system?	☐ Yes	☐ No
j.	Arthritis, gout, back or joint pain, bone fracture, or muscle disorder?	☐ Yes	☐ No
k.	Anemia, bleeding, or blood disorder?	☐ Yes	☐ No
l.	Acquired Immune Deficiency Syndrome (AIDS)?	☐ Yes	☐ No
m.	A positive blood test for antibodies to the HIV virus?	☐ Yes	☐ No
5.	Have you:		
a.	Used amphetamines, marijuana, cocaine, hallucinogens, heroin or other drugs except as prescribed by a physician?	☐ Yes	☐ No
b.	Been treated or counseled for alcoholism or drug abuse?	☐ Yes	☐ No
c.	Been advised to reduce your consumption of alcohol?	☐ Yes	☐ No
6.	Other than previously stated, have you within the past five years:		
a.	Consulted a physician or any other practitioner, had a checkup, illness, surgery or been hospitalized?	☐ Yes	☐ No
b.	Had an electrocardiogram, stress or exercise test, x-ray, blood test or other diagnostic test?	☐ Yes	☐ No
c.	Been advised to have, or scheduled, any diagnostic test, hospitalization or surgery which was not completed?	☐ Yes	☐ No
7.	Have you, within the last five years:		
a.	Smoked cigarettes? ☐ Yes ☐ No Date of last use? _____		
b.	Used any other form of tobacco? ☐ Yes ☐ No What type? _____		

8. Family History:	Age(s) if Living	Age(s) at Death	Cause of Death
Father			
Mother			
Brother(s) /Sister(s)			

9. Please provide full details for all "Yes" answers to questions 3-6. (Include the dates, the results and the names and addresses of all attending physicians and medical facilities.)

Question	Details

I declare that I have made no statement to the medical examiner, agent, or any other person connected with the Company that in any way qualifies or modifies the above answers and statements. I have read and confirm that the above answers and statements are complete and true to the best of my knowledge and belief. I understand that 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

Date (MM/DD/YYYY)

Signature of Proposed Insured

X

Witness (Medical or paramedical examiner will please sign here)

X

Medical Report on Proposed Insured

Name of Proposed Insured _____ Birth Date (MM/DD/YYYY) _____ Age _____

10. Height

Height	Weight (Clothed)	Chest (Full Inspiration)	Chest (Forced Expiration)	Abdomen Relaxed at Umbilicus
ft. in.	lbs.	in.	in.	in.

Did you weigh? ☐ Yes ☐ No Did you measure? ☐ Yes ☐ No

Weight change in past year? _____ lbs. ☐ Gain ☐ Loss-Cause

Is appearance unhealthy or older than stated age? ☐ Yes ☐ No

11. Blood Pressure (if 140/90 or over, must give at least two additional readings)

	First Reading	Second Reading	Third Reading
Systolic			
Diastolic			

12. Pulse

Pulse	At Rest	After Exercise	3 Minutes Later
Rate			
Irregularities Per Min.			

13. Heart

a Is there any cardiovascular disorder? ☐ Yes ☐ No

b Is heart enlarged? ☐ Yes ☐ No (If Yes, describe) _____

c Is murmur present? ☐ Yes ☐ No (If Yes, complete 12d)

d Murmur is: ☐ Constant ☐ Inconstant

☐ Transmitted ☐ Systolic ☐ Apical ☐ Soft (Gr. 1-2)

☐ Localized ☐ Presystolic ☐ Basal ☐ Mod. (Gr. 3-4)

☐ Diastolic ☐ Other ☐ Loud (Gr. 5-6)

☐ Unchanged ☐ Increased

☐ Decreased ☐ Absent

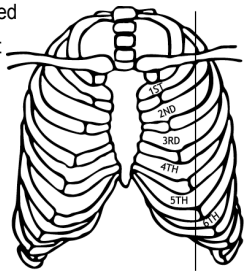
Show location of:

Apex by X

Area of murmur by ◌

Point of greatest intensity by O

Transmission by →



e Diagnostic Impression:

Examiner's remarks and description of positive findings:

14. Is there any abnormality of the following: (Circle applicable items and give details)

a	Eyes, ears, nose, mouth, pharynx (If vision or hearing markedly impaired, indicate degree and correction)	☐ Yes	☐ No
b	Skin (incl. scars): lymph nodes; blood vessels (Incl. varicose veins)	☐ Yes	☐ No
c	Nervous system (Include reflexes, gait, paralysis)	☐ Yes	☐ No
d	Respiratory system	☐ Yes	☐ No
e	Abdomen (Including scars or hernias)	☐ Yes	☐ No
f	Genitourinary system	☐ Yes	☐ No
g	Endocrine system (Include thyroid and breasts)	☐ Yes	☐ No
h	Musculoskeletal system (Include spine, joints, amputations, deformities)	☐ Yes	☐ No

15. Have you any pertinent information not brought out above? ☐ Yes ☐ No

Medical Examiner:

X _____

Signature of Medical Examiner

When paying fees we are required to show and report Social Security or Employer I.D. Number. Please give us this information below.

Include All Hyphens → _____

Examined at: ☐ My Office ☐ Other: _____

Date and Hour of Examination _____ _____ ☐ A.M. ☐ P.M.

Identification

Proposed Insured must show acceptable form of identification:

☐ Driver's License ☐ Passport ☐ Green card

☐ Employment I.D. ☐ Other picture/signature I.D.

In my opinion, the item checked is positive identification of Proposed Insured ☐ Yes ☐ No

Proposed Insured speaks and understands the English language ☐ Yes ☐ No

*If either question answered "No," give details of negative reply:

Supplement to Part I of Application for Life Insurance - for Flexible Premium Adjustable Life Insurance Policy with Index - Linked Interest Options

ZURICH®

Zurich American Life Insurance Company

Administrative Office
7045 College Boulevard
Overland Park, KS 66211-1523

Phone: 877.678.7534
Fax: 888.871.7537
www.zlifeusa.com

First Proposed Insured Name

First Name _____ Middle Initial _____ Last Name _____

Second Proposed Insured Name

First Name _____ Middle Initial _____ Last Name _____

1. Section 7702 Compliance Method

The following method will be used for compliance with Internal Revenue Service Code Section 7702 for the life of the policy (check one box):

☐ Cash Value Accumulation Test (CVAT) ☐ Guideline Premium Test (GPT)

2. Optional Riders

Zurich Index UL™

I (We) elect the following optional rider(s): ☐ Lapse Protection Period Extension Rider ☐ Other _____

☐ Check box if no optional riders are elected.

These are my (our) Premium Allocation instructions for the percentage of each net premium to be allocated to the Short Term Holding Account, Long Term Fixed Account, or the Index Account(s) on the Issue Date and on any subsequent Premium Allocation Dates.

3. Premium Allocation Instructions (Percentage of Net Premium to be allocated to the Short Term Holding Account, Long Term Fixed Account, or the Index Account(s) after a Premium Payment).

Indicate a percentage from 5 to 100% for each of the Accounts below. Percentages must be whole numbers, and must total 100%.

☐ Check box if there are no premium allocations to Index Interest Account Account(s).

☐ Check box if there are no premium allocations to Long Term Fixed Account.

A.	Short Term Holding Account	%	D.	Russell 2000® Index	%
B.	Long Term Fixed Account	%	E.	MSCI EAFE Index	%
C.	S&P 500® Composite Stock Price Index	%	F.	MSCI Emerging Markets Index	%

The Premium Allocation percentages shown above will remain in effect for future premium payments unless You send Us Written Notice.

4. Monthly Automatic Transfer Instructions

These are my (our) instructions for Monthly Automatic Transfers from the Short Term Holding Account to the Long Term Fixed Account, or the Index Interest Account(s). If this section is completed, these instructions replace any premium allocation instructions provided in Section 3 above with respect to new net premiums. Monthly Automatic Transfers can be stopped at any time.

Indicate a percentage from 5 to 100% for each of the Accounts below. Percentages must be whole numbers, and must total 100%:

A.	Long Term Fixed Account	%	D.	MSCI EAFE Index	%
B.	S&P 500® Composite Stock Price Index	%	E.	MSCI Emerging Markets Index	%
C.	Russell 2000® Index	%			%

Note that Monthly Automatic Transfers will occur on a Monthly Date and will result in the total allocation of the Short Term Holding Account to the receiving accounts gradually over the Policy Year. The Monthly Automatic Transfer percentages shown above will remain in effect unless You send Us Written Notice.

5. Remarks

6. Acknowledgements:

I (We) acknowledge that:

- **I (We) am (are) applying for a Flexible Premium Adjustable or Flexible Premium Adjustable Survivorship Life Insurance Policy with Index-Linked Interest Options. This policy includes a Short Term Holding Account, Long Term Fixed Account and Index Interest Accounts (each an "Account" and collectively the "Accounts"). The Index Interest Accounts use an outside financial index (indices) to calculate the total annual crediting rate.**
- **I (We) understand the policy is not designed to be an investment vehicle and is not a variable product or any type of investment contract. I (We) further understand that the policy values may be affected by external index (indices), and the policy itself is not an investment in the stock market.**
- **Net premiums will be initially credited to the Short Term Holding Account and will, if I (We) elect, be allocated to the Index Interest Accounts and Long Term Fixed Account on the next eligible Premium Allocation Date.**
- **The Premium Allocation instructions listed above indicate my (our) request for premium allocations to the Short Term Holding Account, Long Term Fixed Account, or the Index Interest Account(s). I (We) may change my (our) instructions by Written Request to Zurich American Life Insurance Company's Administrative Office. Such Written Requests must be received at least five business days prior to a Premium Allocation Date.**
- **Even though values of the policy may be determined, in part, by reference to an external index (indices), the policy does not directly participate in any stock or equity investments, or dividends on the external index (indices).**
- **Please check appropriate box:**
  - ☐ **I (We) have received an illustration of the policy for which I (We) applied.**
  - ☐ **I (We) have NOT received an illustration of the policy for which I (We) applied. I (We) acknowledge that an illustration conforming to the policy as issued will be provided no later than at the time of policy delivery.**
- **Any values shown in the policy or illustration, other than guaranteed values, are not guarantees, promises, or warranties.**

7. Signatures

If You are signing on behalf of an entity, You represent that You are authorized to execute this document and to make the representations herein. If the entity is a corporation, You further represent that all requirements under applicable law and under the corporation's governing documents have been satisfied concerning the execution of this document, including the use of the corporate seal and number of signing officers.

Signed and dated in:

City/State _____ Date (MM/DD/YYYY) _____

X _____
Signature of Proposed Policy Owner*

X _____
Witness

X _____
Signature of Second Proposed Policy Owner (if applicable)

* If a corporation, the signature and title of any authorized representative is required. If a trust, all required trustees must sign according to the trust agreement.

8. Key Terms Used Above

Long Term Fixed Account: The Long Term Fixed Account credits interest to the portion of Policy Value allocated to it. The Long Term Fixed Account has a Guaranteed Interest Rate that is specified in Your policy. The Long Term Fixed Account may credit interest at a rate in excess of the Guaranteed Interest Rate.

Index Interest Accounts: The portion of the contract's Policy Value allocated to the Index Interest Accounts may earn interest based on the percentage change(s) in the value(s) of an external index (indices), subject to the Index Interest Account Guaranteed Interest Rate, Growth Cap and Participation Rate. The Growth Cap is the maximum Index Growth Rate (after adjustment by the Participation Rate) that will be used in calculating the total interest credited to an Index Interest Segment. The Participation Rate is the percentage of the Index Growth Rate that will be used in calculating the total interest credited to an Index Interest Segment.

Indices:

1. "Standard & Poor's®", "S&P®", "S&P 500®", and "Standard & Poor's 500™" are trademarks of Standard & Poor's Financial Services LLC and have been licensed for use by ZFUS Services, LLC and its affiliates. The S&P 500® Index Interest Account (the "Product") is not sponsored, endorsed, sold or promoted by S&P or its third party licensors. Neither S&P nor its third party licensors makes any representation or warranty, express or implied, to the owner of the Product or any member of the public regarding the advisability of investing in securities generally or in the Product particularly or the ability of the S&P 500 index to track general stock market performance. S&P's and its third party licensor's only relationship to ZFUS Services, LLC is the licensing of certain trademarks and trade names of S&P and of the S&P 500 index which is determined, composed and calculated by S&P or its third party licensors without regard to ZFUS Services, LLC or the Product. S&P and its third party licensors have no obligation to take the needs of ZFUS Services, LLC or the owners of the Product into consideration in determining, composing or calculating the S&P 500 index. Neither S&P nor its third party licensors is responsible for and has not participated in the determination of the prices and amount of the Product or the timing of the issuance or sale of the Product or in the determination or calculation of the equation by which the Product is to be converted into cash. S&P has no obligation or liability in connection with the administration, marketing or trading of the Product.

   NEITHER S&P, ITS AFFILIATES, NOR THEIR THIRD PARTY LICENSORS GUARANTEE THE ADEQUACY, ACCURACY, TIMELINESS OR COMPLETENESS OF THE INDEX OR ANY DATA INCLUDED THEREIN OR ANY COMMUNICATIONS, INCLUDING BUT NOT LIMITED TO, ORAL OR WRITTEN COMMUNICATIONS (INCLUDING ELECTRONIC COMMUNICATIONS) WITH RESPECT THERETO. S&P, ITS AFFILIATES AND THEIR THIRD PARTY LICENSORS SHALL NOT BE SUBJECT TO ANY DAMAGES OR LIABILITY FOR ANY ERRORS, OMISSIONS OR DELAYS THEREIN. S&P MAKES NO EXPRESS OR IMPLIED WARRANTIES, AND EXPRESSLY DISCLAIMS ALL WARRANTIES OF MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE OR USE WITH RESPECT TO THE INDEX OR ANY DATA INCLUDED THEREIN. WITHOUT LIMITING ANY OF THE FOREGOING, IN NO EVENT WHATSOEVER SHALL S&P, ITS AFFILIATES OR THEIR THIRD PARTY LICENSORS BE LIABLE FOR ANY INDIRECT, SPECIAL, INCIDENTAL, PUNITIVE OR CONSEQUENTIAL DAMAGES, INCLUDING BUT NOT LIMITED TO, LOSS OF PROFITS, TRADING LOSSES, LOST TIME OR GOODWILL, EVEN IF THEY HAVE BEEN ADVISED OF THE POSSIBILITY OF SUCH DAMAGES, WHETHER IN CONTRACT, TORT, STRICT LIABILITY OR OTHERWISE.

2. Russell 2000 Index® - Russell Investment Group is the source and owner of the trademarks, service marks and copyrights related to the Russell Indexes. Russell® is a trademark of Russell Investment Group.

3. MSCI Emerging Markets Index & MSCI EAFE - The products or securities referred to herein are not sponsored, endorsed, or promoted by MSCI, and MSCI bears no liability with respect to any such products or securities or any index on which such products or securities are based. The Schedule Page contains a more detailed description of the limited relationship MSCI has with Zurich American Life Insurance Company and any related products.

Premium Allocation Date: The date on which net premiums are allocated to an Account(s).

Zurich American Life Insurance Company

7045 College Boulevard • Overland Park, Kansas 66211-1523

State of Washington

Notice and Consent for Oral Fluid, Urine and/or Blood Testing Which May Include Testing for AIDS Virus (HIV) Antibody/Antigen and Other Communicable Diseases

To determine your insurability, the insurer named above, (Insurer), may request that you provide a sample of your oral fluid, urine and/or blood for testing and analysis. All tests will be performed by a licensed laboratory.

The consent you give by signing this form authorizes the insurer to obtain an oral fluid and/or urine specimen and/or withdraw blood and order laboratory tests only in regard to your present application for insurance.

No adverse underwriting decision will be made on the basis of positive HIV-related tests unless based on a testing protocol including, but not limited to, two reactive enzyme-linked immunosorbent assays (ELISA) tests, followed by confirmatory Western Blot testing.

All test results will be treated confidentially. They will be reported by the laboratory to the insurer. When necessary for business reasons in connection with insurance you have or have applied for with the insurer, the insurer may disclose test results to others involved solely in the underwriting process such as its affiliates, reinsurers, employees or contractors. If the insurer is a member of the MIB, Inc. and your urine test result for HIV antibodies/antigens is positive, a generic code will be reported indicating additional testing has been requested. If your subsequent blood test for HIV antibodies/antigens is negative, the insurer will cancel the reported code. All abnormal oral fluid and/or blood test results for HIV antibodies/antigens will be reported to MIB, Inc. by a generic code which signifies only a non-specific test abnormality. If the HIV test is normal, no report will be made about it to the MIB, Inc. Other test results may be reported to the MIB, Inc. in a more specific manner. The organizations described in this paragraph may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or as authorized by you, including but not limited to the release of information to the Department of Health Services as may be provided by law.

The testing laboratory and/or insurer may also be required to report positive tests for other communicable diseases, such as Hepatitis B and C, to the Department of Health Services. The Department of Health Services may contact you about your results, if positive.

If your HIV test results are normal, no routine notification will be sent to you. If the HIV test results are other than normal, the insurer will contact you. The insurer may also contact you if there are other abnormal test results which, in the insurer's opinion, are significant. The insurer will ask you for the name of a physician or other health care provider to whom you may authorize disclosure of positive or indeterminate HIV results for interpretation and post-test counseling. Post-test counseling, as specified under WAC 248 100-209(4), is required if an HIV test is positive, or indeterminate. If you do not designate a physician or other health care provider, the insurer is required to provide positive or indeterminate HIV results to the local health department. Positive or indeterminate test results will not be sent directly to you.

Positive HIV antibody or antigen test results or other significant oral fluid, urine or blood abnormalities will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

I have read and I understand this **Notice and Consent for Oral Fluid, Urine and/or Blood Testing Which May Include Testing for HIV Antibody/Antigen and Other Communicable Diseases**. I voluntarily submit an oral fluid and/or urine specimen and/or consent to the withdrawal of blood from me by needle, the testing of that oral fluid and/or urine and/or blood, and the disclosure of the test results as described above.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

_____ _____

Proposed Insured (Please Print) Date of Birth

I authorize the release of my test results, which may include positive or abnormal HIV, Hepatitis B and/or Hepatitis C results, to my physician, Health Care Provider or Health Care Agency named below:

_____

Name and Address of designated Physician, Health Care Provider or Health Care Agency

_____

_____

_____ _____ _____

Signature of Proposed Insured or Parent/Guardian Date State of Residence

HIV Information Form for Insurance Applicant

Before consenting to testing, please read the following important information:

The HIV test is not a test for Acquired Immune Deficiency Syndrome (AIDS). It is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus.

Persons at high risk of contracting AIDS include males who have had sexual contact with another man, intravenous drug users, hemophiliacs, and sexual contacts with any of these persons.

To determine your insurability Zurich American Life Insurance Company may request that you provide a sample of your oral fluid, urine and/or blood for HIV testing and analysis.

A positive test result may cause you significant anxiety. A positive test may result in uninsurability for life, health, or disability insurance policies you may apply for in the future. Although prohibited by law, discrimination in housing, employment, or public accommodations may result if your test results were to become known to others. A negative result may create a false sense of security.

For information on where to obtain pretest counseling and for other AIDS Information or concerns, please contact your state or local health department, the counseling services listed below or the following AIDS hotlines:

In Washington: 1-800-272-AIDS National AIDS Hotline: 1-800-342-AIDS

HIV Antibody Testing/Counseling Services

Adams County Health Department
103 West Main
Ritzville, Washington 99169
(509) 659-3315

Asotin County Health District
431 Elm Street
Clarkston, Washington 99403
(509) 758-3344

Benton-Franklin Health District
471 Williams Blvd
Richland, Washington 99352
(509) 943-2614 (Richland)
(509) 547-9737 (Pasco)
(509) 586-0207 (Kennewick)

Bremerton-Kitsap County Health Dept.
109 Austin Drive
Bremerton, Washington 98312
1-800-874-2437

Chelan-Douglas County Health Dist.
200 Valley Mall Parkway
East Wenatchee, Washington 98802
(509) 886-6400

Clallam County Health Department
223 East Fourth Street
Port Angeles, Washington 98362
(360) 417-2352

Garfield County Health District
121 South 10th
Pomeroy, Washington 99347
(509) 843-3412

Grant County Health District
County Courthouse
First & C St. NW
Ephrata, Washington 98823
(509) 754-6060

Grant County Health District
1021 West Broadway
Moses Lake, Washington 98837
(509) 766-7960

Grays Harbor County Health Dept.
2109 Sumner Avenue
Aberdeen, Washington 98520
(360) 532-8631

Island County Health Department
410 North Main
Coupeville, Washington 98239 (360) 679-7351
Appointments only (No walk ins)

Jefferson County Health Department
Castle Hill Center
615 Sheridan
Port Townsend, WA 98368-2439
(360) 385-9400

Kittitas County Health Department
507 Nanum
Ellensburg, Washington 98926
(509) 962-7515

Lewis County Health District
Health Services Building
360 N.W. North St. (P.O. Box 706)
Chehalis, Washington 98532
(360) 740-1223

Lincoln County Health Department
90 Nichols Street
Davenport, Washington 99122
(509) 725-1001

Mason County Health Department
303 North 4th
Shelton, Washington 98584
(360) 427-9670, Ext. 400

Northeast Tri-County Health District
240 East Dominion (P.O. Box 270)
Colville, Washington 99114
(509) 684-5048

Okanogan County Health District
1234 South 2nd Avenue
Okanogan, Washington 98840
(509) 422-7140; 1-800-222-6410

Pacific County Health Department
1216 W. Robert Bush Drive
South Bend, Washington 98586
(360) 875-9343

San Juan County Health Dept.
145 Rhone St. (P.O. Box 607)
Friday Harbor, WA 98250-0607
(360) 378-4474

Seattle-King County Health Dept.
AIDS Prevention Unit
(gay/bisexual men preferred)
2124 Fourth Avenue, 4th Floor
Seattle, Washington 98121
(206) 205-7837, TTY (206) 296 4843, 1-800 678-1595

Harborview Hospital
Sexually Transmitted Disease Clinic
325 9th Avenue, 3rd Floor, So. Wing
Seattle, Washington 98104
(206) 731-3590
Harborview Women's Clinic
223-3367

Seattle Gay Clinic
500 – 19th Avenue East
Seattle, Washington 98102
(Tuesday 6:30-9:00 p.m., Sat.,noon-3:00 p.m.)
(206) 461-4540

Low Risk Testing Sites
(Seattle-King Co.)

a) North Seattle Public Health Center
10501 Meridian Avenue North
Seattle, WA – (206) 296-4990

b) Southeast Public Health Center
3001 N.E. 4th Street
Renton, WA – (206) 296-4900

c) Southwest Public Health Center
10821 8th Avenue S.W.
Seattle, WA – (206) 296-4620

d) East Public Health Center
2424 – 156th Avenue N.E.
Bellevue, WA – (206) 296-4920

e) Southeast Public Health Center
20 Auburn Avenue
Auburn, WA – (206) 833-8400

f) Central Clinic
Public Safety Building
610 – 3rd Ave, 14th Floor
Seattle, WA 98104
(206) 296-4772

Skagit County Health Department
Courthouse Administration Building
700 South Second Street, Room 301
Mount Vernon, Washington 98273
(360) 336-9380

Snohomish Health District
3020 Rucker, Suite #208
Everett, Washington 98201
(425) 339-5251

Southwest Washington Health Dist.
Vancouver-Clark Cnty Health Ctr
2000 Fort Vancouver Way
Vancouver, Washington 98663
(360) 397-8215

Spokane County Health District
1101 West College Avenue
Spokane, Washington 99201
(509) 324-1600; 1-800-456-3236

Tacoma-Pierce County Health Dept.
3629 South "D" Street
Tacoma, Washington 98408
(253) 798-6500

Thurston County Health Dept.
529 Southwest Fourth (MS: FQ-11)
Olympia, Washington 98501
(360) 786-5581

Walla Walla County-City Health Dept.
310 West Poplar (P.O. Box 1753)
Walla Walla, Washington 99362
(509) 527-3290

Whatcom County Health Dept.
1500 N. State Street
Bellingham, Washington 98225
(360) 676-4593

Whitman County Health Dept.
Public Service Building
North 310 Main Street
Colfax, Washington 99111
(509) 397-6280

Whitman County Health Dept.
1205 Southeast Pro Mall Blvd
Pullman, Washington 99163
(509) 332-6752

Yakima County Health District
104 North First Street
Yakima, Washington 98901
(509) 249-6518; (509) 249-6559

Privacy Statement

This notice from the member companies of Zurich listed on the back of this statement* describes our privacy practices regarding information about our customers and former customers that obtain financial products or services from us. If we provide more than one financial product or service to you, you may receive more than one privacy statement from us. We do this in order to ensure that you receive a notice of our privacy practices.

No Action Required
We care about your privacy. We believe you have a right to know what we do with the information we gather about you in connection with the products you seek or have from us. We also want to assure you that we are safeguarding this important information. Our privacy policy is based on the laws governing privacy and on our own high standards of protecting privacy. When state law is more protective of individuals than federal privacy laws, we will protect your information in accordance with state law, consistent with the requirements of federal preemption.

Brief Summary of How We Protect Your Information
We protect your non-public personal financial information and your health information (together called "NPI"). We do not sell your NPI. We will restrict access to your NPI by maintaining physical, electronic, and procedural safeguards. The only employees who are authorized to access your NPI are those who need to have it to provide products or services to you. We value your trust and your confidence in our ability to manage and protect your NPI.

We do not share your NPI with companies outside of the Zurich family that would use the information to market their own products or services.

Detailed Summary of NPI We Collect
We need NPI about you so that we can determine your insurability and offer products and services to meet your specific needs at a fair price. We collect NPI about you from different sources including:

- Applications or other forms you complete that contain information such as your name, address, social security number, date of birth, your assets and income, and your beneficiaries;
- Medical professionals who have provided care to you and insurance support organizations regarding your health;
- Telephone calls with you;
- Data we collect when you visit our web sites;
- Third parties that provide NPI to us with your authorization;
- Your business dealings with us, our affiliates, and others; and
- Consumer reporting agencies, governmental agencies, insurance information sharing bureaus, and similar bodies.

NPI We Disclose
We will share your NPI only with authorized employees, representatives, affiliates, and trusted third parties whose services are required to assure the highest level of service to you. Examples of third parties include medical exam providers, third party administrative staff, and reinsurers. We will not disclose NPI about you or about other customers or former customers, except as authorized by law, as described in this privacy statement, or as otherwise communicated to you.

We may disclose the nonpublic personal information we collect about you, as described above, to companies that perform marketing services on our behalf or to other financial institutions with which we have joint marketing agreements and to other third parties, all as permitted by law.

Your financial NPI as well as the financial NPI of other customers and former customers may also be shared with financial institutions, securities broker-dealers, and insurance producers, but only in order to make our products and services available to you.

Examples of NPI that we may disclose include:

- NPI from your application or other forms, such as: your name, address, social security number, assets income, and beneficiaries;
- NPI about your transactions with us, our affiliates or others, such as: your policy coverage, premiums, and payment history; and
- Health information, in order to process your transactions with us, for example, to determine eligibility for coverage, to process claims or to prevent fraud. We are also permitted to disclose health information with your written authorization and as otherwise permitted by law.

Sharing NPI with Affiliates
We may also share financial NPI about you or about other customers and former customers within the Zurich family of companies in order to better serve you and offer you worthwhile products and services. These affiliates may include: life insurers, property and casualty insurers, securities broker-dealers, and insurance producers.

The law allows us to share your financial information with our affiliates to market products or services to you. When your relationship with us ends, we may continue to share information about you as described in this Privacy Statement.

Modifications to Our Privacy Policy
We reserve the right to change our privacy practices in the future. We may change the policies, standards and procedures described in this privacy statement to comply with applicable laws and/or to conform to our current business practices. We will notify you if we make any changes in our privacy practices which broaden when we may share your NPI.

More Information on Our Privacy Policy
If you have questions or concerns about our privacy policy or would like a more detailed explanation of our privacy practices, please contact us through any of the ways listed below. Please include the Company name, your name and policy number when contacting us:

Attention: Compliance Office
13810 FNB Parkway
Omaha, NE 68154
USA
GLCompliance@zurichna.com

E-mail submissions over the Internet may not be secure and are subject to the risk of interception by third parties. Please consider this fact before e-mailing any personal or confidential information.

***This Privacy Statement is sent on behalf of the following affiliated companies**:**
Zurich American Life Insurance Company (formerly known as Kemper Investors Life Insurance Company)
Zurich American Life Insurance Company of New York
Universal Underwriters Life Insurance Company

**The above affiliated companies are the affiliates on whose behalf this privacy statement is being provided. It is not a comprehensive list of all affiliates of the Zurich family of companies.

Policy Illustration Disclosure

Zurich American Life Insurance Company
7045 College Boulevard • Overland Park, Kansas 66211-1523
1-800-821-7803

Instructions:

This form must be completed only if an illustration matching the application and signed by the applicant / policyowner is not submitted with the application.

Proposal not submitted with application:

☐ I acknowledge that no illustration of the policy was provided. I understand that an illustration conforming to the policy as issued will be provided no later than at the time of policy delivery.

or

☐ I acknowledge that the illustration provided to me did not conform to the policy for which I applied. I understand that an illustration conforming to the policy as issued will be provided no later than at the time of policy delivery.

X_____ Signature of Applicant / Policyowner

Date

X_____ Signature of Agent

Date

Original –Zurich American Life Insurance Company Copy-Applicant /Proposed policy owner

Zurich American Life Insurance Company
Administrative Office:
7045 College Boulevard • Overland Park, KS 66211-1523
(888) 634-6780

Required Summary and Disclosure Statement for Accelerated Death Benefits

Important Tax and Public Assistance Disclosures

Receipt of accelerated death benefits may be taxable. You should seek assistance from your personal qualified tax advisor before applying for accelerated death benefits. Zurich American Life Insurance Company cannot give tax advice.

Receiving accelerated death benefits may affect eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children and Supplemental Security Income (SSI). You should consult with the appropriate social services agency concerning how receipt will affect the eligibility of the recipient and/or the recipient's spouse or dependents prior to applying for accelerated death benefits.

Accelerated Death Benefit Rider Information

Accelerating Condition:

Accelerated death benefits are available under the Accelerated Death Benefit Rider for Terminal Illness if the insured has a medically determinable condition that, given reasonable medical treatment, will result in a life expectancy of 24 months or less.

Accelerated death benefits are available under the Accelerated Death Benefit Rider for Chronic Illness if the insured has not exercised the acceleration of benefits under a Terminal Illness rider. If the insured has a medically determinable illness or impairment lasting at least 90 consecutive days, and as a result of such illness or impairment, is unable to perform without substantial assistance at least two Activities of Daily Living, or requires substantial supervision to be protected from threats to health and safety due to Severe Cognitive Impairment, accelerated benefits are available.

Accelerating Option:

The maximum accelerated death benefit amount is 75% of the Eligible Death Benefit up to a maximum of $2,000,000.00 under a Terminal Illness rider. The maximum accelerated death benefit under a chronic illness rider is the smaller of 25% of the Eligible Death Benefit or $500,000 at each election; with a lifetime maximum of the lesser of 100% of the Eligible Death Benefit or $2,000,000.

Premium for the Accelerated Death Benefit Rider:

There is no additional charge associated with the issuance of this rider.

Processing Charge:

When an Accelerated Death Benefit Payment is made, a discount is applied and an administrative fee, not to exceed $300, is required.

Impact on Policy Values—Sample Illustration of Accelerated Death Benefit Payment

Policy Value, Cash Value, Surrender Value, outstanding Policy Debt, Minimum Premium and the policy Death Benefit will be reduced in proportion to the ratio of the accelerated death benefit to the total death benefit. Any adjustment in the Policy Value will be allocated to the Fixed Account(s) and any Index Interest Account(s) on a pro-rata basis.

Limitations of the Accelerated Death Benefit

The accelerated death benefit is **NOT** a long-term care insurance or nursing home insurance policy. The amount this benefit pays You may not be enough to cover Your medical, nursing home or other bills. You may use the money You receive from the rider for any purpose.

Unlike conventional life insurance proceeds, accelerated death benefits payable under this rider MAY BE TAXABLE. You should consult Your personal tax advisor.

Receiving accelerated death benefits under this rider MAY AFFECT MEDICAID AND SUPPLEMENTAL SECURITY INCOME (SSI) eligibility. Owning a policy with an accelerated death benefit will not in and of itself affect Your eligibility for these government programs. However, exercising the option to accelerate benefits and receiving those benefits before You apply for these government programs, or while You are receiving government benefits, may affect Your initial or continued eligibility to receive government benefits. You should contact the Medicaid Unit or Your local Department of Public Welfare and Social Security Administration Office for more information.

I (We) have read and understand this Required Summary and Disclosure Statement for Accelerated Death Benefits, and acknowledge receiving a copy of it prior to signing the application for insurance.

_____

Proposed Insured's Signature Date

_____

Proposed Policy Owner's Signature Date

_____

Agent's Signature Date

Form **W-9**
(Rev. December 2014)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Print or type
See **Specific Instructions** on page 2.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification; check only **one** of the following seven boxes:

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▸ _____

Note. For a single-member LLC that is disregarded, do not check LLC; check the appropriate box in the line above for the tax classification of the single-member owner.

☐ Other (see instructions) ▸

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the instructions for line 1 and the chart on page 4 for guidelines on whose number to enter.

Social security number

			–		–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 3.

Sign Here **Signature of U.S. person** ▸ **Date** ▸

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. Information about developments affecting Form W-9 (such as legislation enacted after we release it) is at *www.irs.gov/fw9*.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following:

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See *What is backup withholding?* on page 2.

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting?* on page 2 for further information.

Note. If you are a U.S. person and a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien;
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States;
- An estate (other than a foreign estate); or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax under section 1446 on any foreign partners' share of effectively connected taxable income from such business. Further, in certain cases where a Form W-9 has not been received, the rules under section 1446 require a partnership to presume that a partner is a foreign person, and pay the section 1446 withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid section 1446 withholding on your share of partnership income.

In the cases below, the following person must give Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States:

- In the case of a disregarded entity with a U.S. owner, the U.S. owner of the disregarded entity and not the entity;
- In the case of a grantor trust with a U.S. grantor or other U.S. owner, generally, the U.S. grantor or other U.S. owner of the grantor trust and not the trust; and
- In the case of a U.S. trust (other than a grantor trust), the U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

Foreign person. If you are a foreign person or the U.S. branch of a foreign bank that has elected to be treated as a U.S. person, do not use Form W-9. Instead, use the appropriate Form W-8 or Form 8233 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
2. The treaty article addressing the income.
3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.
4. The type and amount of income that qualifies for the exemption from tax.
5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity, give the requester the appropriate completed Form W-8 or Form 8233.

Backup Withholding

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 28% of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, payments made in settlement of payment card and third party network transactions, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester,
2. You do not certify your TIN when required (see the Part II instructions on page 3 for details),
3. The IRS tells the requester that you furnished an incorrect TIN,
4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or
5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See *Exempt payee code* on page 3 and the separate Instructions for the Requester of Form W-9 for more information.

Also see *Special rules for partnerships* above.

What is FATCA reporting?

The Foreign Account Tax Compliance Act (FATCA) requires a participating foreign financial institution to report all United States account holders that are specified United States persons. Certain payees are exempt from FATCA reporting. See *Exemption from FATCA reporting code* on page 3 and the Instructions for the Requester of Form W-9 for more information.

Updating Your Information

You must provide updated information to any person to whom you claimed to be an exempt payee if you are no longer an exempt payee and anticipate receiving reportable payments in the future from this person. For example, you may need to provide updated information if you are a C corporation that elects to be an S corporation, or if you no longer are tax exempt. In addition, you must furnish a new Form W-9 if the name or TIN changes for the account; for example, if the grantor of a grantor trust dies.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Line 1

You must enter one of the following on this line; **do not** leave this line blank. The name should match the name on your tax return.

If this Form W-9 is for a joint account, list first, and then circle, the name of the person or entity whose number you entered in Part I of Form W-9.

a. **Individual.** Generally, enter the name shown on your tax return. If you have changed your last name without informing the Social Security Administration (SSA) of the name change, enter your first name, the last name as shown on your social security card, and your new last name.

Note. ITIN applicant: Enter your individual name as it was entered on your Form W-7 application, line 1a. This should also be the same as the name you entered on the Form 1040/1040A/1040EZ you filed with your application.

b. **Sole proprietor or single-member LLC.** Enter your individual name as shown on your 1040/1040A/1040EZ on line 1. You may enter your business, trade, or "doing business as" (DBA) name on line 2.

c. **Partnership, LLC that is not a single-member LLC, C Corporation, or S Corporation.** Enter the entity's name as shown on the entity's tax return on line 1 and any business, trade, or DBA name on line 2.

d. **Other entities.** Enter your name as shown on required U.S. federal tax documents on line 1. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on line 2.

e. **Disregarded entity.** For U.S. federal tax purposes, an entity that is disregarded as an entity separate from its owner is treated as a "disregarded entity." See Regulations section 301.7701-2(c)(2)(iii). Enter the owner's name on line 1. The name of the entity entered on line 1 should never be a disregarded entity. The name on line 1 should be the name shown on the income tax return on which the income should be reported. For example, if a foreign LLC that is treated as a disregarded entity for U.S. federal tax purposes has a single owner that is a U.S. person, the U.S. owner's name is required to be provided on line 1. If the direct owner of the entity is also a disregarded entity, enter the first owner that is not disregarded for federal tax purposes. Enter the disregarded entity's name on line 2, "Business name/disregarded entity name." If the owner of the disregarded entity is a foreign person, the owner must complete an appropriate Form W-8 instead of a Form W-9. This is the case even if the foreign person has a U.S. TIN.

Line 2

If you have a business name, trade name, DBA name, or disregarded entity name, you may enter it on line 2.

Line 3

Check the appropriate box in line 3 for the U.S. federal tax classification of the person whose name is entered on line 1. Check only one box in line 3.

Limited Liability Company (LLC). If the name on line 1 is an LLC treated as a partnership for U.S. federal tax purposes, check the "Limited Liability Company" box and enter "P" in the space provided. If the LLC has filed Form 8832 or 2553 to be taxed as a corporation, check the "Limited Liability Company" box and in the space provided enter "C" for C corporation or "S" for S corporation. If it is a single-member LLC that is a disregarded entity, do not check the "Limited Liability Company" box; instead check the first box in line 3 "Individual/sole proprietor or single-member LLC."

Line 4, Exemptions

If you are exempt from backup withholding and/or FATCA reporting, enter in the appropriate space in line 4 any code(s) that may apply to you.

Exempt payee code.

- Generally, individuals (including sole proprietors) are not exempt from backup withholding.
- Except as provided below, corporations are exempt from backup withholding for certain payments, including interest and dividends.
- Corporations are not exempt from backup withholding for payments made in settlement of payment card or third party network transactions.
- Corporations are not exempt from backup withholding with respect to attorneys' fees or gross proceeds paid to attorneys, and corporations that provide medical or health care services are not exempt with respect to payments reportable on Form 1099-MISC.

The following codes identify payees that are exempt from backup withholding. Enter the appropriate code in the space in line 4.

1—An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2)

2—The United States or any of its agencies or instrumentalities

3—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities

4—A foreign government or any of its political subdivisions, agencies, or instrumentalities

5—A corporation

6—A dealer in securities or commodities required to register in the United States, the District of Columbia, or a U.S. commonwealth or possession

7—A futures commission merchant registered with the Commodity Futures Trading Commission

8—A real estate investment trust

9—An entity registered at all times during the tax year under the Investment Company Act of 1940

10—A common trust fund operated by a bank under section 584(a) 11—

A financial institution

12—A middleman known in the investment community as a nominee or custodian

13—A trust exempt from tax under section 664 or described in section 4947

The following chart shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 13.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt payees except for 7
Broker transactions	Exempt payees 1 through 4 and 6 through 11 and all C corporations. S corporations must not enter an exempt payee code because they are exempt only for sales of noncovered securities acquired prior to 2012.
Barter exchange transactions and patronage dividends	Exempt payees 1 through 4
Payments over $600 required to be reported and direct sales over $5,000[1]	Generally, exempt payees 1 through 5[2]
Payments made in settlement of payment card or third party network transactions	Exempt payees 1 through 4

[1] See Form 1099-MISC, Miscellaneous Income, and its instructions.

[2] However, the following payments made to a corporation and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, gross proceeds paid to an attorney reportable under section 6045(f), and payments for services paid by a federal executive agency.

Exemption from FATCA reporting code. The following codes identify payees that are exempt from reporting under FATCA. These codes apply to persons submitting this form for accounts maintained outside of the United States by certain foreign financial institutions. Therefore, if you are only submitting this form for an account you hold in the United States, you may leave this field blank. Consult with the person requesting this form if you are uncertain if the financial institution is subject to these requirements. A requester may indicate that a code is not required by providing you with a Form W-9 with "Not Applicable" (or any similar indication) written or printed on the line for a FATCA exemption code.

A—An organization exempt from tax under section 501(a) or any individual retirement plan as defined in section 7701(a)(37)

B—The United States or any of its agencies or instrumentalities

C—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities

D—A corporation the stock of which is regularly traded on one or more established securities markets, as described in Regulations section 1.1472-1(c)(1)(i)

E—A corporation that is a member of the same expanded affiliated group as a corporation described in Regulations section 1.1472-1(c)(1)(i)

F—A dealer in securities, commodities, or derivative financial instruments (including notional principal contracts, futures, forwards, and options) that is registered as such under the laws of the United States or any state

G—A real estate investment trust

H—A regulated investment company as defined in section 851 or an entity registered at all times during the tax year under the Investment Company Act of 1940

I—A common trust fund as defined in section 584(a) J—

A bank as defined in section 581

K—A broker

L—A trust exempt from tax under section 664 or described in section 4947(a)(1)

M—A tax exempt trust under a section 403(b) plan or section 457(g) plan

Note. You may wish to consult with the financial institution requesting this form to determine whether the FATCA code and/or exempt payee code should be completed.

Line 5

Enter your address (number, street, and apartment or suite number). This is where the requester of this Form W-9 will mail your information returns.

Line 6

Enter your city, state, and ZIP code.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-member LLC that is disregarded as an entity separate from its owner (see *Limited Liability Company (LLC)* on this page), enter the owner's SSN (or EIN, if the owner has one). Do not enter the disregarded entity's EIN. If the LLC is classified as a corporation or partnership, enter the entity's EIN.

Note. See the chart on page 4 for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local SSA office or get this form online at *www.ssa.gov*. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at *www.irs.gov/businesses* and clicking on Employer Identification Number (EIN) under Starting a Business. You can get Forms W-7 and SS-4 from the IRS by visiting IRS.gov or by calling 1-800-TAX-FORM (1-800-829-3676).

If you are asked to complete Form W-9 but do not have a TIN, apply for a TIN and write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note. Entering "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: *A disregarded U.S. entity that has a foreign owner must use the appropriate Form W-8.*

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items 1, 4, or 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). In the case of a disregarded entity, the person identified on line 1 must sign. Exempt payees, see *Exempt payee code* earlier.

Signature requirements. Complete the certification as indicated in items 1 through 5 below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments made in settlement of payment card and third party network transactions, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account[1]
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor[2]
4. a. The usual revocable savings trust (grantor is also trustee) b. So-called trust account that is not a legal or valid trust under state law	The grantor-trustee[1] The actual owner[1]
5. Sole proprietorship or disregarded entity owned by an individual	The owner[3]
6. Grantor trust filing under Optional Form 1099 Filing Method 1 (see Regulations section 1.671-4(b)(2)(i)(A))	The grantor*
For this type of account:	**Give name and EIN of:**
7. Disregarded entity not owned by an individual	The owner
8. A valid trust, estate, or pension trust	Legal entity[4]
9. Corporation or LLC electing corporate status on Form 8832 or Form 2553	The corporation
10. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
11. Partnership or multi-member LLC	The partnership
12. A broker or registered nominee	The broker or nominee
13. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity
14. Grantor trust filing under the Form 1041 Filing Method or the Optional Form 1099 Filing Method 2 (see Regulations section 1.671-4(b)(2)(i)(B))	The trust

[1] List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

[2] Circle the minor's name and furnish the minor's SSN.

[3] You must show your individual name and you may also enter your business or DBA name on the "Business name/disregarded entity" name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

[4] List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules for partnerships* on page 2.

***Note.** Grantor also must provide a Form W-9 to trustee of trust.

Note. If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Secure Your Tax Records from Identity Theft

Identity theft occurs when someone uses your personal information such as your name, SSN, or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

If your tax records are affected by identity theft and you receive a notice from the IRS, respond right away to the name and phone number printed on the IRS notice or letter.

If your tax records are not currently affected by identity theft but you think you are at risk due to a lost or stolen purse or wallet, questionable credit card activity or credit report, contact the IRS Identity Theft Hotline at 1-800-908-4490 or submit Form 14039.

For more information, see Publication 4535, Identity Theft Prevention and Victim Assistance.

Victims of identity theft who are experiencing economic harm or a system problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

Protect yourself from suspicious emails or phishing schemes. Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to *phishing@irs.gov*. You may also report misuse of the IRS name, logo, or other IRS property to the Treasury Inspector General for Tax Administration (TIGTA) at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at: *spam@uce.gov* or contact them at *www.ftc.gov/idtheft* or 1-877-IDTHEFT (1-877-438-4338).

Visit IRS.gov to learn more about identity theft and how to reduce your risk.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons (including federal agencies) who are required to file information returns with the IRS to report interest, dividends, or certain other income paid to you; mortgage interest you paid; the acquisition or abandonment of secured property; the cancellation of debt; or contributions you made to an IRA, Archer MSA, or HSA. The person collecting this form uses the information on the form to file information returns with the IRS, reporting the above information. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation and to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their laws. The information also may be disclosed to other countries under a treaty, to federal and state agencies to enforce civil and criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism. You must provide your TIN whether or not you are required to file a tax return. Under section 3406, payers must generally withhold a percentage of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to the payer. Certain penalties may also apply for providing false or fraudulent information.

Zurich American Life Insurance Company
7045 College Boulevard • Overland Park, Kansas 66211-1523
800-821-7803

Authorization to Obtain and Disclose Information and Notice of Information Practices

Zurich American Life Insurance Company (referred to as ZALICO), its reinsurers, insurance support organizations and their authorized representatives, may obtain medical and other information to evaluate my (our) application for life insurance.

I (we) hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, the MIB, Inc., the Veteran's Administration, my (our) employer(s) and any consumer reporting agency or insurance company that possess any information regarding medical history, care, treatment, advice, including but not limited to information related to HIV, sexually transmitted disease, nicotine use, drug use or treatment, prescription drug history, alcoholism or mental health disorder, or non-medical information, such as motor vehicle, financial and criminal records, pertaining to me (us) or my (our) children, to furnish such information to ZALICO, its reinsurers, and their authorized representatives upon presentation of this Authorization or a photocopy of this Authorization.

If your state laws address the testing of HIV and use and disclosure of HIV-related information by insurers, you will receive a separate notice regarding the HIV testing, use and disclosure of that information.

This Authorization will be valid from the date signed for a period of 24 months.

I (we) have read this Authorization to Obtain and Disclose Information, including the following Notice of Information Practices and have received a copy; my (our) authorized representative is also entitled to receive a copy.

I (we) agree that a photographic copy of this Authorization to Obtain and Disclose Information and Notice of Information Practices shall be as valid as the original.

Dated At: _____ On: _____

_____ _____
Signature of Proposed Insured or Parent if required | Print Name(s) of Proposed Insured(s)

_____ _____
Signature of Additional Proposed Insured | Print Name of Soliciting Agent

_____ _____
Signature of Witness (Soliciting Agent) | Agent's Number

Notice of Insurance Information Practices

You have certain rights under state and federal law with respect to the privacy of information we obtain about you when you engage in insurance transactions involving insurance primarily for personal, family or household use. Your state gives you additional protections that are explained in this notice. Our information practices, as described in this notice, apply to proposed insureds, insureds, policyholders and former policyholders.

Collection of Information

To properly underwrite and administer your insurance coverage, a certain amount of personal financial and/or health information must be collected. The amount and type of information may vary depending on the amount and type of coverage applied for, but in general, information will be sought about your age, occupation, physical condition, health history, mode of living, avocations and other personal characteristics except as may be related to your sexual orientation. Information collected may include information related to HIV, sexually transmitted disease, nicotine use, drug use or treatment, prescription drug history, alcoholism or mental health disorder, or non-medical information, such as motor vehicle and criminal records. In addition, your Agent may collect information intended to aid in evaluating and updating your insurance program.

You are the most important source of information, but data may also be collected or verified by contacting medical professionals and institutions that have provided care, or who possess information regarding care to you or members of your family proposed for coverage, employers and business associates, friends and neighbors, other insurance companies from which you may have applied for insurance, consumer reporting agencies, insurance support organizations, such as the MIB, Inc., and other organizations. Information may also be collected and transmitted in electronic format, by exchanges of correspondence, by phone or by face-to-face contact.

In some cases, an insurance support organization or consumer reporting agency may be requested to collect information and submit an investigative consumer report to ZALICO. If you are the subject of an investigative consumer report, you may request to be interviewed in connection with the preparation of the report, and you are entitled to receive a copy of the report.

Information We Disclose

In some circumstances, ZALICO or your Agent will make disclosures of personal information to third parties. Following is a brief description of some of the persons or organizations to which information may be disclosed, without your authorization, as permitted by law:

1. Your Agent, who may need the information to service your policy.
2. Persons who need this information to perform professional, business or insurance functions for ZALICO, including performing marketing services on our behalf.
3. Persons who assist ZALICO in determining your eligibility for insurance coverage or payment, or for detecting or preventing criminal activity, fraud, material misrepresentation or material nondisclosure in connection with an insurance transaction.
4. Persons conducting actuarial or scientific research studies, audits or evaluations.
5. Another insurance company or an insurance support organization, to detect or prevent criminal activity or fraud in connection with an insurance transaction, or to perform an insurance transaction.
6. An insurance regulatory, law enforcement, or other governmental authority.
7. Affiliates, as permitted by law.
8. Non-affiliated third parties, as permitted by law. This includes sharing information with non-affiliated third parties with which we perform joint marketing of financial services and products when permitted by state and federal law.

Information obtained from a report prepared by a consumer reporting agency or insurance-support organization may be retained by that organization and may be disclosed to others for which it performs such services, to the extent permitted by state and federal law.

Access and Correction

Procedures have been established by which you can obtain access to personal information about you appearing in your policy file, including any investigative consumer report we have obtained. Other procedures have been instituted by which you may request correction, amendment or deletion of any information in your file that you believe to be inaccurate or irrelevant. A description of these procedures will be sent to you upon request.

Obtaining Additional Information

We take your rights and our responsibilities very seriously. If you have further questions, please write to us at the address provided on this form.

Authorization for Release of Health-Related Information

ZURICH®

Zurich American Life Insurance Company
This authorization complies with the HIPAA Privacy Rule

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, clearinghouse, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf ("My Providers") to disclose my entire medical record, prescription drug history, and any other health or billing information and any other protected health information concerning me to Zurich American Life Insurance Company ("the Company") and its agents, employees, representatives, reinsurers, and those persons or entities providing services to the Company. 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, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, clearinghouse, medical facility or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this authorization so that the Company may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer coverage; and 4) 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, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to Zurich American Life Insurance Company's administrative office at 7045 College Boulevard, Overland Park, Kansas 66211, Attention: Life Underwriting. I understand that a revocation is not effective to the extent that any of My Providers has relied on this authorization or to the extent that the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and is no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment, payment for health care services, or enrollment or eligibility for benefits if I refuse to sign this authorization.

I further 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 I am entitled to receive a signed copy of this authorization.

_____
Doctor/Physician or Facility Name

_____ _____
Name of Proposed Insured (please print) Date of birth

_____ _____
Signature Proposed Insured or Personal Representative Date

_____
Description of Personal Representative's Authority or Relationship to Proposed Insured

Original to Zurich American Life Insurance Company • Copy to Proposed Insured

Zurich American Life Insurance Company
7045 College Boulevard • Overland Park, Kansas 66211-1523
800-821-7803

Washington

Important Notice Regarding Replacement of Insurance

(Save this notice! It may be important to you in the future.)

Statement to Applicant by Insurance Producer:
The decision to buy a new life insurance policy or annuity and discontinue or change an existing one is very important. Your decision could be a good one - or a mistake. It should be carefully considered. The Washington State Insurance Commissioner requires us to give you this notice to help you make a wise decision.

I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following factors, which I call to your attention. **An explanation is provided for all "Yes" answers.**

A. Can there be reduced benefits or increased premiums in later years?

☐ No ☐ Yes

Explanation:

_____

_____

B. Are there penalties, set-up or surrender charges for the new policy?

☐ No ☐ Yes

Explanation: (Emphasis is given to any extra cost for early withdrawal.)

_____

_____

C. Will there be penalties or surrender charges under the existing insurance as a result of the proposed transaction?

☐ No ☐ Yes

Explanation:

_____

_____

D. Are there adverse tax consequences from the replacement under current tax law?

☐ No ☐ Yes

Explanation:

_____

_____

E. Are interest earnings a consideration in this replacement?

☐ No ☐ Yes

Explanation: (Emphasis is given as to what portions of premiums or contributions will produce limited or no earnings, the need for minimum deposits to enhance earnings, and the reduction of earnings that may result from set-up charges, policy fees and other factors.)

_____

_____

F. Are minimum amounts required to be on deposit before excess interest will be paid?

☐ No ☐ Yes

Explanation:

_____

_____

G. If the new program is based on a variable or universal life insurance policy or a single-premium policy or annuity:

1. Are the interest rate quotes before or after fees and mortality charges have been deducted? _____
2. Interest rates are guaranteed for how long? _____
3. The minimum interest rate to be paid is how much? _____%.
4. If applicable, the rate you pay to borrow is _____%, and the limit on the amount that can be borrowed is $_____.
5. The surrender charges are $_____.
6. The death benefit is $_____.

H. Are there other short or long term effects from the replacement that might be materially adverse? ☐ No ☐ Yes

Explanation:

_____

_____

_____ _____

Name of Insurance Producer (Print or Type) Date

_____ _____

Address Signature of Insurance Producer

_____

Applicant _____

The following policy(ies) may be replaced:

Company Name and Address	**Policy Number**	**Name of Insured**

Caution: The Insurance Commissioner suggests you consider these points:

- **Usually, contestable and suicide periods start again under a new policy. Benefits might be excluded under a new policy that would be paid under existing insurance.**
- **Terminating or altering existing coverage, before new insurance has been issued, might leave you unable to purchase other life insurance or let you buy it only at substantially higher rates.**
- **You are entitled to advice from the existing insurance producer or company. Such advice might be helpful.**
- **Study the comments made above by the insurance producer. They apply to you and this proposal. They are important to you and your future.**

This completed form should be filed permanently with your new insurance policy.

Completed copy received: _____ _____

Applicant's Signature Date

Zurich American Life Insurance Company
7045 College Boulevard • Overland Park, KS 66211-1523
800-821-7803

Important Notice

Leave this Disclosure Statement with the Proposed Insured and Second Proposed Insured

We appreciate your Application for Individual Life Insurance with Zurich American Life Insurance Company, and want to assure you that your request will receive prompt consideration. As part of our normal procedure for processing your request, an investigative consumer report may be obtained regarding you. You have the right to be interviewed in connection with this report. The information is secured by an independent inspection company or by Zurich American Life Insurance Company through personal interviews with your friends, neighbors, business associates, and others with whom you may be acquainted. This report, if obtained, contains information as to personal character, general reputation, and mode of living except as may be related directly or indirectly to your sexual orientation. Upon written request to us, further information as to the nature and scope of this report will be provided. You may also request a copy of the report. If inaccuracies exist in the report, you have the right to request correction. Corrections will be made upon our receipt of proof of the inaccuracy. Any adverse underwriting decision based on this report will be disclosed to you in writing.

Information regarding your insurability will be treated as confidential. Zurich American Life Insurance Company or its reinsurers, may however, make a brief report thereon to the MIB, Inc., a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. If you apply to another MIB, Inc. member for life or health insurance coverage, or a claim for benefits is submitted to such a company, the MIB, Inc., upon request, will supply such company with the information it may have in its file.

Upon receipt of a request from you, the MIB, Inc. will arrange disclosure of any information it may have about you in its file. If you question the accuracy of information in the MIB, Inc.'s file, you may contact the MIB, Inc. and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the MIB, Inc.'s information office is: MIB, Inc. 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734; toll-free telephone number: (866) 692-6901 ; www.mib.com.

Zurich American Life Insurance Company, or its reinsurers, may also release information in its file to other life insurance companies to which you may apply for life or health insurance, or to which a claim for benefits may be submitted during the consideration of a claim.

Financial Questionnaire

ZURICH

Zurich American Life Insurance Company

Administrative Office
7045 College Boulevard
Overland Park, KS 66211-1523

Phone: 877.678.7534
Fax: 888.871.7537
www.zlifeusa.com

Name of Proposed Insured _____ Date of Birth _____

The following to be completed by the Proposed Insured (referred to as "you").

What is the purpose of this insurance?

- ☐ Personal / Family Protection
- ☐ Loan Protection
- ☐ Key Person Protection
- ☐ Buy/Sell
- ☐ Other _____

Instructions for completion

Answer sections A, B, F
Answer sections A, B, C, F
Answer sections A, D, F
Answer sections A, E, F

A. Income

Please provide details of the income that you received from all sources for the last 2 years:

	Last year: $	Prior year: $
Salary	$	$
Bonus	$	$
Commission	$	$
Interest/Dividends	$	$
Rental (net)	$	$
Pension/Social Security	$	$
Other:	$	$
Total:	$	$

B. Net Worth

Please provide details of assets and liabilities:

Assets	
Primary Residence	$
Personal Effects	$
Cash	$
Investments	$
Investment Property	$
Business (approximate market value of your share)	$
Other:	$
Total Assets:	$
Liabilities	
Mortgage on Primary Residence	$
Loans	$
Mortgage on Investment Property	$
Other:	$
Total Liabilities:	$
Net Worth:	$

B. Net Worth (continued)

Please provide details of the loan that you wish to protect:

Purpose of Loan	Name/s of Borrower/s	Name of Lender	Loan Amount	Term of Loan	Interest Rate	Have the funds been fully drawn down?	Is this policy required for approval of the loan?
						☐ Yes ☐ No	☐ Yes ☐ No

D. Key Person

1. What is your role? _____
2. Approximately how much revenue is directly attributable to you? _____
3. Are any other persons in the Business also considered key persons? ☐ Yes ☐ No
   If Yes, please provide details and state whether insurance is also being sought on these other persons:

_____

_____

4. Do you have any ownership interest or shareholding in the Business? ☐ Yes ☐ No
   If Yes, please provide relevant details including the value of this interest or shareholding:

_____

_____

5. How was the sum insured calculated? _____

E. Buy/Sell

1. What is the current value of the Business? _____
2. How and when was this value calculated? _____
3. What is your % ownership in the Business? _____
4. Please state the names and % ownership of all other partners or shareholders:

_____

_____

_____

5. Is a partnership, shareholder or buy/sell agreement in place? ☐ Yes ☐ No
6. Is insurance cover being proposed or already in-force on other Business owners? ☐ Yes ☐ No

F. Declaration (signed by proposed insured & signature by CPA/Attorney if reviewed by them)

I confirm that the answers I have given are, to the best of my knowledge, true, and that I have not withheld any material information that may influence the assessment or acceptance of this application.

Name (Please Print)	Signature of Proposed Insured	Date
Name (Please Print)	Signature CPA/Attorney w/ license#	Date

Life Insurance Buyer's Guide

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

- Find a Policy That Meets Your Needs and Fits Your Budget
- Decide How Much Insurance You Need
- 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.

Reprinted by:

Zurich American Life Insurance Company
Home Office:
Schaumburg, Illinois 60196-6801

Administrative Office:
7045 College Boulevard, Overland Park, KS 66211-1523

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 untimely 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:

- 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.
- 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.
- Ask your tax advisor if dropping your policy could affect your income taxes.

- 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.
- You may have valuable rights and benefits in the policy you now have that are not in the new one.
- 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.
- 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:

- 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?
- Do I have children for whom I'd like to set aside money to finish their education in the event of my death?
- How will my family pay final expenses and repay debts after my death?
- Do I have family members or organizations to whom I would like to leave money?
- Will there be estate taxes to pay after my death?
- 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 agent 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 illustration 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:

- Do premiums or benefits vary from year to year?
- How much do the benefits build up in the policy?
- What part of the premiums or benefits is not guaranteed?
- 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:

- How quickly does the cash value grow? Some policies have low cash values in the early years that build 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.)
- Are there special policy features that particularly suit your needs?
- 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.

Form **4506T-EZ**
(Rev. August 2014)
Department of the Treasury
Internal Revenue Service

Short Form Request for Individual Tax Return Transcript

▸ **Request may not be processed if the form is incomplete or illegible.**
▸ **For more information about Form 4506T-EZ, visit *www.irs.gov/form4506tez*.**

OMB No. 1545-2154

Tip. Use Form 4506T-EZ to order a 1040 series tax return transcript free of charge, or you can quickly request transcripts by using our automated self-help service tools. Please visit us at IRS.gov and click on "Get Transcript of Your Tax Records" under "Tools" or call 1-800-908-9946.

1a Name shown on tax return. If a joint return, enter the name shown first.	**1b First social security number or individual taxpayer identification number on tax return**
2a If a joint return, enter spouse's name shown on tax return.	**2b Second social security number or individual taxpayer identification number if joint tax return**

3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code (see instructions)

4 Previous address shown on the last return filed if different from line 3 (see instructions)

5 If the transcript is to be mailed to a third party (such as a mortgage company), enter the third party's name, address, and telephone number. The IRS has no control over what the third party does with the tax information.

Third party name	Telephone number
Zurich, 7045 College Boulevard, 5th Floor, Overland Park, Kansas 66211-1523	**877-678-7534**
Address (including apt., room, or suite no.), city, state, and ZIP code	

Caution. If the tax transcript is being mailed to a third party, ensure that you have filled in line 6 before signing. Sign and date the form once you have filled in this line. Completing this step helps to protect your privacy. Once the IRS discloses your IRS transcript to the third party listed on line 5, the IRS has no control over what the third party does with the information. If you would like to limit the third party's authority to disclose your transcript information, you can specify this limitation in your written agreement with the third party.

6 **Year(s) requested.** Enter the year(s) of the return transcript you are requesting (for example, "2008"). Most requests will be processed within 10 business days.

Note. *If the IRS is unable to locate a return that matches the taxpayer identity information provided above, or if IRS records indicate that the return has not been filed, the IRS will notify you or the third party that it was unable to locate a return, or that a return was not filed, whichever is applicable.*

Caution. Do not sign this form unless all applicable lines have been completed.

Signature of taxpayer(s). I declare that I am the taxpayer whose name is shown on either line 1a or 2a. If the request applies to a joint return, **either** spouse must sign. **Note.** *For transcripts being sent to a third party, this form must be received within 120 days of the signature date.*

Sign Here	▸ **Signature** (see instructions)	Date	Phone number of taxpayer on line 1a or 2a
	▸ **Spouse's signature**	Date	

Section references are to the Internal Revenue Code unless otherwise noted.

Future Developments

For the latest information about developments related to Form 4506T-EZ, such as legislation enacted after it was published, go to *www.irs.gov/form4506tez*.

Caution. Do not sign this form unless all applicable lines have been completed.

Purpose of form. Individuals can use Form 4506T-EZ to request a tax return transcript for the current and the prior three years that includes most lines of the original tax return. The tax return transcript will not show payments, penalty assessments, or adjustments made to the originally filed return. You can also designate (on line 5) a third party (such as a mortgage company) to receive a transcript. Form 4506T-EZ cannot be used by taxpayers who file Form 1040 based on a tax year beginning in one calendar year and ending in the following year (fiscal tax year). Taxpayers using a fiscal tax year must file Form 4506-T, Request for Transcript of Tax Return, to request a return transcript.

Use Form 4506-T to request tax return transcripts, tax account information, W-2 information, 1099 information, verification of non-filing, and record of account.

Automated transcript request. You can quickly request transcripts by using our automated self-help service tools. Please visit us at IRS.gov and click on "Get Transcript of Your Tax Records" under "Tools" or call 1-800-908-9946.

Where to file. Mail or fax Form 4506T-EZ to the address below for the state you lived in when the return was filed.

If you are requesting more than one transcript or other product and the chart below shows two different addresses, send your request to the address based on the address of your most recent return.

If you filed an individual return and lived in:	**Mail or fax to the "Internal Revenue Service" at:**
Alabama, Kentucky, Louisiana, Mississippi, Tennessee, Texas, a foreign country, American Samoa, Puerto Rico, Guam, the Commonwealth of the Northern Mariana Islands, the U.S. Virgin Islands, or A.P.O. or F.P.O. address	RAIVS Team Stop 6716 AUSC Austin, TX 73301 512-460-2272
Alaska, Arizona, Arkansas, California, Colorado, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Utah, Washington, Wisconsin, Wyoming	RAIVS Team Stop 37106 Fresno, CA 93888 559-456-7227
Connecticut, Delaware, District of Columbia, Florida, Georgia, Maine, Maryland, Massachusetts, Missouri, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Vermont, Virginia, West Virginia	RAIVS Team Stop 6705 P-6 Kansas City, MO 64999 816-292-6102

Line 1b. Enter your employer identification number (EIN) if your request relates to a business return. Otherwise, enter the first social security number (SSN) or your individual taxpayer identification number (ITIN) shown on the return. For example, if you are requesting Form 1040 that includes Schedule C (Form 1040), enter your SSN.

Line 3. Enter your current address. If you use a P.O. box, include it on this line.

Line 4. Enter the address shown on the last return filed if different from the address entered on line 3.

Note. If the address on lines 3 and 4 are different and you have not changed your address with the IRS, file Form 8822, Change of Address.

Signature and date. Form 4506T-EZ must be signed and dated by the taxpayer listed on line 1a or 2a. If you completed line 5 requesting the information be sent to a third party, the IRS must receive Form 4506T-EZ within 120 days of the date signed by the taxpayer or it will be rejected. Ensure that all applicable lines are completed before signing.

Transcripts of jointly filed tax returns may be furnished to either spouse. Only one signature is required. Sign Form 4506T-EZ exactly as your name appeared on the original return. If you changed your name, also sign your current name.

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to establish your right to gain access to the requested tax information under the Internal Revenue Code. We need this information to properly identify the tax information and respond to your request. If you request a transcript, sections 6103 and 6109 require you to provide this information, including your SSN. If you do not provide this information, we may not be able to process your request. Providing false or fraudulent information may subject you to penalties.

Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation, and cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by section 6103.

The time needed to complete and file Form 4506T-EZ will vary depending on individual circumstances. The estimated average time is: **Learning about the law or the form,** 9 min.; **Preparing the form,** 18 min.; and **Copying, assembling, and sending the form to the IRS,** 20 min.

If you have comments concerning the accuracy of these time estimates or suggestions for making Form 4506T-EZ simpler, we would be happy to hear from you. You can write to:

Internal Revenue Service Tax Forms and Publications Division
1111 Constitution Ave. NW, IR-6526
Washington, DC 20224

Do not send the form to this address. Instead, see *Where to file* on this page.