EQUIS FINANCIAL

Assurant

Level Benefit Whole Life

Pennsylvania

IMPORTANT REMINDER: ALL APPLICATIONS MUST BE UPLOADED TO EQUIS FINANCIAL USING THE AGENT DASHBOARD. PLEASE DO NOT SEND APPLICATIONS DIRECT TO THE CARRIER.

Form Name	*When Do You Need To Complete This Form*
Application for Life Insurance:	**Always Required**
Emergency Contact Sheet:	**Always Required:** Do not submit with application. Use the information on this sheet to alert these individuals of their friend/family member's request to designate them as an emergency contact for this policy.
Important Notice: Replacement Of Life Insurance or Annuities:	*Only Required If* Insured has existing coverage, regardless if replacing or not.
Disclosure Statement:	**Always Required**
Account Verification:	*Only Required If* voided check is not included with the application.

Notes: For additional supplemental forms please go to the carrier website.

DISCARD THIS COVER SHEET - DO NOT SUBMIT COVER SHEET WITH COMPLETED APP

EMERGENCY CONTACT LIST

CLIENT NAME _____

CONTACT NAME	RELATIONSHIP TO CLIENT	PHONE	ADDRESS	EMAIL

Application for Life Insurance

American Memorial Life Insurance Company
P.O. Box 2730 • Rapid City, SD 57709

Proposed Insured: _____

HOME OFFICE USE ONLY # _____

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

1. Proposed Insured

_____
First Middle Initial Last

Address: _____
Street

_____
City State Zip

Telephone Number: (Home) _____ (Cell) _____

Date of Birth: _____ Current Age: _____ State of Birth: _____

SSN#: _____ ❑ Male ❑ Female Height: _____ Weight: _____

Drivers License Number: _____ State: _____

U.S. citizen? ❑ Yes ❑ No If not, do you have an immigration card? ❑ Yes ❑ No Card #: _____

Have you applied for life insurance with any other insurance company in the last two years? ❑ Yes ❑ No

2. Owner Information (If different from Proposed Insured)

_____
First Middle Initial Last

Address: _____
Street

_____
City State Zip

Telephone Number: (Home) _____ (Cell) _____

SSN#: _____ Relationship to Proposed Insured: _____

3. Primary Beneficiary

Full Name: _____

Relationship to Proposed Insured: _____

4. Contingent Beneficiary

Full Name: _____

Relationship to Proposed Insured: _____

5. Policy Information:

Face Amount: $ _____ Premium: $ _____ Effective Date: _____

Plan: ❑ Level Benefit Whole Life

Has the Proposed Insured used nicotine based products in the past 12 months? ❑ Yes ❑ No

Replacement: Will the policy that you are applying for replace any existing life insurance or annuity policy? ❑ Yes ❑ No

If yes, give name and address of existing insurer & policy number, if available: _____

Policy Mailing: ❑ Agent ❑ Owner

6. Health Questions

Part A Questions: If Proposed Insured answers "YES" to any question in Part A or does not meet the height and weight requirements, he/she is not eligible for coverage. If all questions are answered "NO" in Part A, proceed to Part B and answer questions. If all questions are answered "NO" in Parts A and B and the Proposed Insured meets the height and weight requirements, he/she will be considered for the Level Benefit Whole Life Plan.

YES NO

1. ❑ ❑ Do you have any impairment, whether physical or mental, for which you need or receive assistance or supervision in performing normal activities of daily living such as bathing, toileting, eating, dressing, taking medications, or moving without any type of physical assistance, or are you currently hospitalized, confined to a bed or nursing facility, receiving hospice care, or do you require oxygen to assist in breathing?

2. Have you ever:

a. ❑ ❑ Had, or been medically advised to have, an internal organ transplant, or been diagnosed as having a terminal medical condition that is expected to result in death within the next 12 months?

b. ❑ ❑ Taken insulin by injection or other method prior to age 45 or been medically diagnosed, taken medication for, been treated or been advised to have treatment for chronic kidney disease, dialysis, kidney or liver failure, cirrhosis, liver disease, congestive heart failure (CHF), cardiomyopathy, organic brain syndrome, Alzheimer's, dementia, or Lou Gehrig's disease (ALS)?

c. ❑ ❑ Been diagnosed by a medical professional as having, or been medically treated or been advised to have treatment for acquired immune deficiency syndrome (AIDS), AIDS related complex (ARC), or any immune deficiency related disorder or tested positive for the human immunodeficiency virus (HIV)?

d. ❑ ❑ Had more than one occurrence of any cancer or any metastasis in your lifetime (excluding Basal or Squamous cell skin cancer), or are you currently being treated or been advised to have treatment for cancer or recurrence of cancer or had an amputation caused by cancer?

e. ❑ ❑ Been diagnosed with neuromuscular or brain disease (including cerebral palsy, muscular dystrophy, multiple sclerosis, cystic fibrosis), systemic lupus (SLE) or paralysis of two or more extremities?

3. Within the past 24 months have you been medically diagnosed as having, been treated or been advised to have treatment for, taken medication for or been hospitalized for:

a. ❑ ❑ Internal cancer, leukemia, lymphoma, melanoma, Hodgkin's disease or Parkinson's disease?

b. ❑ ❑ Insulin shock, diabetic coma, or diabetic complications (including neuropathy, retinopathy, or amputation)?

Part B Questions:

1. ❑ ❑ Within the past 24 months have you been medically diagnosed as having, been treated or been advised to have treatment for, or been hospitalized for stroke, transient ischemic attack (TIA), angina, coronary artery disease, heart attack, heart or vascular surgery (including coronary artery bypass, pacemaker, heart valve replacement, abdominal aortic aneurysm, angioplasty, stent placement) or any procedure to improve circulation to the legs, heart or brain?

2. Within the past 36 months have you:

a. ❑ ❑ Been medically diagnosed as having, been treated or been advised to have treatment for, or been hospitalized for schizophrenia, bipolar disorder, or alcohol or drug abuse, chronic obstructive pulmonary or lung disease (COPD), emphysema, or chronic bronchitis?

b. ❑ ❑ Been confined three or more times to a hospital, nursing facility, convalescent care facility or mental facility?

c. ❑ ❑ Been declined or postponed for life or health insurance or attempted suicide?

Current Physician and Address: _____

_____

Are you taking any medication for any impairments listed in the above Health Questions? ❑ Yes ❑ No

Proposed Insured: _____

Conditions Relating to the Application: I have read the questions and answers in all parts of this Application. I agree that they are complete and true to the best of my knowledge and belief. I agree that this Application and any supplement to the Application, if required, shall be attached to and form a part of any policy issued.

Acknowledgement: I have read and understand the Conditions Relating to the Application, the Medical Authorization information, and this Acknowledgement. I acknowledge receipt and review of the Notice to the Applicant and (where required by law) a Buyer's Guide and any other required preliminary cost information.

I understand and agree that no insurance agent has the authority to waive an answer to any question in the Application, pass on insurability, make or alter any contract, or waive any of the Company's rights or requirements. I understand that I (or my authorized representative) may receive a copy of this Application. **I understand and agree that any policy applied for shall not take effect (except as provided in the Conditional Premium Receipt bearing the same name as this Application) unless and until**

(a) the Company has received and approved this Application for insurance;
(b) the Company has issued a policy based upon this Application;
(c) the policy has been issued and delivered and the first full premium has been paid and accepted by the Company during the lifetime and condition of health of the Proposed Insured as stated in this Application;
(d) the Company has drafted the designated account for the first premium; and
(e) the person to be insured remains alive at the time the premium payment is honored.

SIGNATURES:

Proposed Insured Signature _____ Date _____

Owner Signature _____ Date _____
(If different from Proposed Insured)

Witness or Licensed Agent Signature _____ Date _____

Signed at: _____
City State

Agent's Statement - I certify that the owner, proposed insured, or any person or entity is not being paid cash or promised services as an inducement to enter into this insurance transaction and that this insurance transaction will not be sold or assigned for any type of viatical settlement, senior settlement, life settlement, or any other secondary market.

Did you see the Proposed Insured at the time this application was completed? ❑ Yes ❑ No

Replacement: Is the insurance applied for intended to replace or change an existing life insurance or annuity policy? ❑ Yes ❑ No

If a replacement is involved, I certify that I only used company approved sales materials.

_____ _____
Primary Writing Agent Signature State License No. Secondary Writing Agent Signature State License No.

_____ _____
Print Primary Writing Agent Name Agent # % Split Print Secondary Writing Agent Name Agent # % Split

_____
Primary Writing Agent Telephone Number

7. Payment Options

Premium Amount $ _____

• Pre-Authorized Check Automatic Withdrawal (PAC) is the automatic withdrawal from your checking or savings account.

❑ **Monthly:**

• PAC is ***only*** available with a premium payment frequency of monthly.
• Future payment by check is **not** available with a premium payment frequency of monthly.
• All future payments must be PAC regardless of first payment method.

First Payment:

❑ Check* (Payable to AML)

❑ PAC First Pre-Authorized Withdrawal Date _____
Month / Day

The first pre-authorized withdrawal must be within 30 calendar days of the date you sign this application. Withdrawal dates are available from the 1st - 28th of the month only. *All future pre-authorized withdrawal dates will coincide with the date requested for the first pre-authorized withdrawal.*

Future PAC Payments from ❑ Checking ❑ Savings

Name of Financial Institution _____

Routing Number _____ Account Number _____

Account Holder's Printed Name _____

Account Holder's Signature _____

If first payment method is check, the PAC withdrawal date will coincide each month on or about the effective date of the policy unless another day of the month is specified _____.
Day

❑ **Quarterly,** ❑ **Semi-Annual or** ❑ **Annual:**

• Future payment by check is available with a premium payment frequency of quarterly, semi-annual or annual.

First Payment:

❑ Check* (Payable to AML)

Future Payments:

❑ Check* (Payable to AML)

*When you provide a check as payment, you authorize us either to use information from your check to make a one-time electronic fund transfer from your account or to process the payment as a check transaction. When we use information from your check to make an electronic fund transfer, funds may be withdrawn from your account as soon as the same day you make your payment, and you may not receive your check back from your financial institution. For inquiries please call 1-800-621-7162.

Medical Authorization

Proposed Insured: _____

For use with Life Insurance Applications.
This Authorization complies with the HIPAA Privacy Rule.

_____ _____

Name of primary proposed insured/patient Date of birth

_____ _____

Name of unemancipated minors Date of birth

I authorize any health plan, physician, medical practitioner, health care professional, hospital, clinic, pharmacy benefit manager, pharmacy, MIB, Inc., laboratory, medical facility, insurance company, insurance support organization (or any of its members or affiliates), the Veteran's Administration, my employer, consumer reporting agency, or any other health care provider that has provided payment, treatment or services to me or on my behalf or on the behalf of my unemancipated minor children (collectively, "My Providers") to disclose the entire medical record and any other protected health information concerning me or my above named unemancipated minor children to American Memorial Life Insurance Company ("the Company") or its reinsurers, their agents, employees, and representatives. I authorize the Company, or its reinsurers, to make a brief report of my personal health information to MIB. 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. I acknowledge receipt of the MIB, Inc. Pre-Notice and Fair Credit Reporting Act Pre-Notice.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information or that of my unemancipated minor children do not apply to this authorization and I instruct My Providers to release and disclose the entire medical record without restriction.

This protected health information is to be disclosed under the authorization at my request, as permitted by §164.508 of the privacy regulations issued pursuant to the Health Insurance Portability and Accountability Act ("HIPAA Privacy Rule").

This authorization shall remain in force for 24 months following the date of my signature below, regardless of my condition and whether living or deceased, and a copy of this authorization is as valid as the original. I understand that I have the right to obtain a copy of this authorization and to revoke this authorization in writing, at any time, by sending a written request for revocation to the Company at Attention: Privacy Task Force, P.O. Box 2730, Rapid City, SD 57709. 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 disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal regulations governing privacy and confidentiality of health information (such as the HIPAA Privacy Rule). However, the company will protect the privacy of health information in accordance with other applicable state and/or federal privacy laws and its own privacy policies.

I understand that My Providers may not refuse to provide treatment or payment for health care services because I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record or that of my unemancipated minor children, 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 acknowledge that I have received a copy of this authorization.

_____ _____

Signature of Primary Proposed Insured Date

_____ _____

Signature of Primary Proposed Insured Date

THIS PAGE TO BE LEFT WITH THE APPLICANT

Proposed Insured: _____

Notice to the Applicant

You have made a wise decision to apply for life insurance. The possibility exists that premiums paid over several years may exceed the death benefit. This notice is given to you at the time you apply for life insurance to tell you about that type of information the Company may obtain in connection with your application. We will treat all personal information about you as confidential.

Underwriting. Your application, together with the medical history you give, provides the initial basis for evaluation. The Company relies on the accuracy and completeness of your answers and may make inquiries, both before and after a policy is issued, to verify this information.

Sources of Information. The Company may request additional information from your physician(s) or hospital(s) or other medical professionals, or medical care institutions, pharmacy benefit manager, pharmacy, the Medical Information Bureau (MIB), other insurance institutions to which you have applied for insurance, your employers, agents of the Company, business associates, a governmental entity, financial institution, or consumer reporting agency. Your signature on the Acknowledgement and Medical Authorization Form permits the Company to make these inquiries. Such inquiries may be made by telephone, written correspondence, or personal interview. If the Company requests information from another insurance company, it will not request underwriting action. You have the right to know what information we have about you, to copy it, and if it is incorrect, to have it corrected. If the Company received information about you from an insurance support organization, such information may be retained by the organization and released to others. In this connection, the following notice is given to you as required by the federal and various state Fair Credit Reporting Acts. You have the right to access and correction with respect to this information. If you wish a more detailed explanation of information practices, please send your written request to **American Memorial Life Insurance Company, P.O. Box 2730, Rapid City, SD 57709.**

Fair Credit Reporting Act Pre-Notice. In some cases, the Company may ask an independent agency to prepare an investigative consumer report for you. This report may include information about your character, general reputation, personal characteristics such as health, finances, and mode of living, except as may be related directly or indirectly to your sexual orientation. Any information obtained by an investigative agency may be kept in its file and later given to others who have a business need for it. If an investigative consumer report is ordered by the Company, the report will include information obtained through interviews with your neighbors, friends, or others with whom you are acquainted. You may request to be interviewed in connection with the preparation of the investigative consumer report. You may request, in writing, to receive information from the Company about the nature and scope of an investigative consumer report. Within five (5) business days of receipt of such request, the Company will provide you with the name, address, and phone number of any agency the Company asks to prepare such a report. You should contact them to obtain a copy of the report.

Medical Information Bureau, Inc. Pre-Notice. Information regarding your insurability will be treated as confidential. American Memorial Life Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

American Memorial Life Insurance Company, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life and health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

Conditional Premium Receipt

THIS RECEIPT PROVIDES COVERAGE ONLY IF CONDITIONS BELOW ARE MET.

The Company hereby acknowledges receipt of the initial premium from the Proposed Insured for which an application for insurance is made to American Memorial Life Insurance Company on the date of application and for the premium collected as stated on the application for insurance.

Life insurance and any additional benefits in the amount applied for shall be deemed to take effect as of the date of this application, subject to the terms and conditions printed below.

Conditions of Life Insurance Coverage (Please read carefully).

Subject to the limitations of this receipt and the terms and conditions of the policy that may be issued by the Company on the basis of the application, the life insurance and any additional benefits applied for will not be deemed to take effect unless the Company, after investigation and such medical examination (if any) as it may require, is satisfied that on the date of the application the person proposed for insurance was insurable for the amount of life insurance and any additional benefits applied for according to the Company's rules and practice of selection; provided, however, that approval by the Company of the insurability of the Proposed Insured for a plan of insurance other than that applied for shall not invalidate the terms and conditions for the receipt relating to life insurance and any other additional benefit applied for.

The amount received shall be refunded if the application is declined or if a policy is issued other than as applied for and is not accepted. Any check or Pre-Authorized Check Automatic Withdrawal (PAC) is received subject to collection of funds.

American Memorial Life Insurance Company or its reinsurers may also release limited information in its file to other properly authorized life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted.

ASSURANT Solutions®

American Memorial
Life Insurance Company
440 Mt. Rushmore Road
Rapid City, SD 57701

Notice Regarding Replacement of Life Insurance and Annuities

You have indicated that you intend to replace existing life insurance or annuity coverage in connection with the purchase of our life insurance or annuity policy. As a result, we are required to send you this notice. Please read it carefully.

Whether it is to your advantage to replace your existing insurance or annuity coverage, only you can decide. It is in your best interest, however, to have adequate information before a decision to replace your present coverage becomes final so that you may understand the essential features of the proposed policy and your existing insurance or annuity coverage.

You may want to contact your existing life insurance or annuity company or its agent for additional information and advice or discuss your purchase with other advisors. Your existing company will provide this information to you. The information you receive should be of value to you in reaching a final decision.

If either the proposed coverage or the existing coverage you intend to replace is participating, you should be aware that dividends may materially reduce the cost of insurance and are an important factor to consider. Dividends, however, are not guaranteed.

You should recognize that a policy which has been in existence for a period of time may have certain advantages to you over a new policy. If the policy coverages are basically similar, the premiums for a new policy may be higher because rates increase as your age increases. Under your existing policy, the period of time during which the issuing company could contest the policy because of a material misrepresentation or omission concerning the medical information requested in your application, or deny coverage for death caused by suicide, may have expired or may expire earlier than it will under the proposed policy. Your existing policy may have options which are not available under the policy being proposed to you or may not come into effect under the proposed policy until a later time during your life. Also, your proposed policy's cash values and dividends, if any, may grow slower initially because the company will incur the cost of issuing your new policy. On the other hand, the proposed policy may offer advantages which are more important to you.

If you are considering borrowing against your existing policy to pay the premiums on the proposed policy, you should understand that in the event of your death, the amount of any unpaid loan, including unpaid interest, will be deducted from the benefits of your existing policy thereby reducing your total insurance coverage.

After we have issued your policy, you will have 20 days from the date the new policy is received by you to notify us you are cancelling the policy issued on your application and you will receive back all payments you made to us.

You are urged not to take action to terminate or alter your existing life insurance or annuity coverage until you have been issued the new policy, examined it and have found it acceptable to you.

Signature of Applicant	Signature of Agent

AMERICAN MEMORIAL
Life Insurance Company®
440 Mt. Rushmore Rd • Rapid City, SD 57701
1-800-621-7162

DISCLOSURE STATEMENT

THIS DISCLOSURE STATEMENT WITH ALL APPLICABLE BLANKS FILLED IN IS FOR YOUR PROTECTION. IT GIVES YOU BASIC INFORMATION ABOUT THE COST AND COVERAGE OF THE INSURANCE BEING SOLICITED. READ IT CAREFULLY BEFORE SIGNING ANY AGREEMENT TO BUY LIFE INSURANCE.

This disclosure statement shall not be considered as an offer to contract or as altering or modifying any policy or rider that may be issued.

Name of proposed insured_____Age_____Sex_____

Name of agent preparing disclosure_____

Agent home or agency address_____

Telephone number of agent_____

Name of Insurer: American Memorial Life Insurance Company, Rapid City, South Dakota.
Direct all correspondence to the address shown above.

	Descriptive Title Of Coverage	**Face Amount Of Coverage**	**Premium For Mode Quoted**
Policy	Level Benefit Whole Life Insurance Premiums Payable for Life	$_____	$_____

Total premium for the policy will be $_____. ❑ Annual ❑ Semi-annual ❑ Quarterly ❑ Monthly
(Check appropriate payment mode.)

GUARANTEED CASH VALUE. If you continuously pay your premiums on this policy as they come due, you will have the following guaranteed cash value for each $1000 of initial face amount. You may borrow against this cash value at an annual 8.0% loan interest charge.

Number of Years Policy has been in force	**5 Years**	**10 Years**	**20 Years**	**Age 65**
Total accumulated cash value per $1000 of initial face amount	$_____	$_____	$_____	$_____

A surrender comparison index will be provided upon delivery of the policy or earlier if requested. This index provides one means of comparing the relative costs of two or more similar products.

The prospective insured ❑ has / ❑ has not requested an earlier delivery of the index. ❑ None is required.

Upon request, either the company or the agent will furnish you with additional information about the insurance described.

I certify that the proposed insured was given a copy of this Disclosure Statement when the application was signed.

_____ _____
Signature of Agent Date

Pennsylvania
Preferred and Modified
Cash Values
Final Need
2013

Pennsylvania Cash Values

Modified Male Non-Nicotine

Guaranteed cash value per $1000 of initial face amount at end of policy year.

	Number of Years Policy Has Been Inforce			
Age	5	10	20	Age 65
40	32.22	97.99	259.88	351.86
41	33.90	102.66	269.93	344.65
42	35.63	107.53	280.14	337.03
43	37.47	112.59	290.47	328.97
44	39.52	117.84	300.90	320.46
45	41.78	123.22	311.47	311.47
46	44.22	128.73	322.23	301.97
47	46.79	134.36	333.24	291.91
48	49.42	140.14	344.52	281.20
49	52.00	146.06	356.08	269.75
50	54.49	152.11	367.92	257.49
51	56.87	158.25	380.01	244.41
52	59.22	164.42	392.22	230.45
53	61.63	170.56	404.46	215.57
54	64.18	176.69	416.81	199.72
55	66.93	182.89	429.36	182.89
56	69.82	189.26	442.15	165.02
57	72.72	195.84	455.12	145.99
58	75.47	202.66	468.09	125.64
59	77.98	209.73	480.83	103.78
60	80.31	217.09	493.27	80.31
61	82.58	224.72	505.34	55.16
62	85.01	232.56	517.07	28.29
63	87.78	240.54	528.60	0.00
64	91.47	249.15	540.15	0.00
65	97.65	259.72	552.35	
66	104.23	270.64	563.99	
67	110.93	281.77	574.87	
68	117.50	292.86	584.86	
69	123.97	303.63	593.88	
70	130.39	313.93	601.98	
71	136.92	323.68	609.61	
72	143.68	332.97	617.57	
73	150.63	342.06	626.46	
74	157.39	350.82	637.10	
75	163.72	359.01	650.89	

Final Need Cash Values

Use with ADM-5001-FN-PA

Pennsylvania Cash Values

Modified Female Non-Nicotine

Guaranteed cash value per $1000 of initial face amount at end of policy year.

	Number of Years Policy Has Been Inforce			
Age	5	10	20	Age 65
40	26.60	83.65	220.45	300.23
41	28.20	87.43	228.49	293.58
42	29.83	91.26	236.73	286.54
43	31.46	95.13	245.20	279.09
44	33.11	99.05	253.92	271.22
45	34.76	103.03	262.90	262.90
46	36.43	107.07	272.14	254.10
47	38.10	111.17	281.67	244.81
48	39.78	115.35	291.50	235.00
49	41.47	119.64	301.62	224.64
50	43.18	124.06	312.06	213.71
51	44.91	128.66	322.80	202.17
52	46.67	133.46	333.81	190.00
53	48.47	138.47	345.11	177.16
54	50.33	143.75	356.71	163.60
55	52.27	149.27	368.60	149.27
56	54.35	155.08	380.80	134.13
57	56.57	161.18	393.33	118.13
58	58.95	167.59	406.18	101.20
59	61.49	174.27	419.37	83.25
60	64.17	181.22	432.92	64.17
61	66.96	188.40	446.55	43.83
62	69.89	195.76	459.95	22.16
63	72.93	203.32	473.17	0.00
64	76.05	211.04	486.32	0.00
65	79.25	218.94	499.33	
66	82.51	227.02	512.51	
67	85.77	235.30	525.62	
68	89.08	243.82	538.15	
69	94.87	254.64	551.41	
70	100.82	265.85	564.65	
71	106.96	277.17	579.80	
72	113.37	288.20	598.04	
73	120.07	299.05	618.60	
74	127.10	309.85	641.20	
75	134.55	320.53	666.17	

Pennsylvania Cash Values

Modified Male Nicotine

Guaranteed cash value per $1000 of initial face amount at end of policy year.

	Number of Years Policy Has Been Inforce			
Age	5	10	20	Age 65
40	39.74	116.39	292.95	384.96
41	41.27	121.17	302.16	376.50
42	42.81	126.11	311.30	367.58
43	44.50	131.19	320.29	358.18
44	46.49	136.35	329.13	348.29
45	48.79	141.54	337.90	337.90
46	51.33	146.71	346.71	326.96
47	54.00	151.87	355.68	315.40
48	56.62	157.05	364.85	303.10
49	58.98	162.25	374.22	289.91
50	60.99	167.44	383.84	275.78
51	62.69	172.53	393.70	260.69
52	64.19	177.40	403.65	244.62
53	65.69	181.97	413.59	227.57
54	67.42	186.28	423.74	209.53
55	69.42	190.52	434.20	190.52
56	71.56	194.82	444.94	170.47
57	73.58	199.36	455.91	149.29
58	75.18	204.11	466.83	126.73
59	76.14	209.09	477.41	102.53
60	77.93	215.52	488.32	77.93
61	80.73	223.33	499.43	52.93
62	83.91	231.55	510.31	26.63
63	87.77	240.13	521.21	0.00
64	92.54	249.33	532.22	0.00
65	98.16	259.10	543.05	
66	104.42	269.28	553.26	
67	110.84	279.67	562.58	
68	117.04	289.91	570.80	
69	123.14	299.61	577.82	
70	129.17	308.61	583.65	
71	135.13	316.83	588.84	
72	141.27	324.52	594.35	
73	147.53	332.09	600.95	
74	153.32	339.46	609.55	
75	158.42	346.24	621.64	

Pennsylvania Cash Values

Modified Female Nicotine

Guaranteed cash value per $1000 of initial face amount at end of policy year.

	Number of Years Policy Has Been Inforce			
Age	5	10	20	Age 65
40	36.32	107.54	264.66	349.41
41	38.23	111.66	272.38	341.37
42	40.12	115.70	280.15	332.84
43	41.97	119.67	288.00	323.80
44	43.73	123.54	295.97	314.23
45	45.37	127.32	304.09	304.09
46	46.90	131.02	312.36	293.36
47	48.33	134.64	320.81	282.01
48	49.67	138.27	329.44	270.04
49	50.97	141.96	338.28	257.45
50	52.24	145.76	347.32	244.21
51	53.48	149.68	356.52	230.30
52	54.70	153.74	365.82	215.68
53	55.96	157.98	375.20	200.32
54	57.30	162.46	384.64	184.17
55	58.71	167.20	394.21	167.20
56	60.24	172.22	403.95	149.35
57	61.89	177.54	413.89	130.55
58	63.62	183.07	424.01	110.71
59	65.48	188.80	434.32	89.72
60	67.49	194.71	444.88	67.49
61	69.61	200.69	455.24	43.90
62	71.87	206.66	464.87	18.85
63	75.22	213.46	474.42	0.00
64	79.88	221.20	484.09	0.00
65	84.62	228.94	493.24	
66	89.34	236.74	502.44	
67	93.95	244.61	511.44	
68	98.45	252.63	519.46	
69	102.80	260.82	526.69	
70	107.12	269.30	533.90	
71	111.57	277.57	543.85	
72	116.27	285.00	558.32	
73	121.28	291.70	576.43	
74	126.69	297.81	598.15	
75	132.53	303.34	623.26	

Final Need Cash Values
Use with ADM-5001-FN-PA

01/2013

Pennsylvania Cash Values

Preferred Male Non-Nicotine

Guaranteed cash value per $1000 of initial face amount at end of policy year.

	Number of Years Policy Has Been Inforce			
Age	5	10	20	Age 65
0	0.00	10.22	42.90	468.23
1	0.00	11.70	45.22	467.43
2	0.00	12.93	47.40	466.44
3	0.00	14.03	49.56	465.33
4	0.00	15.03	51.73	464.11
5	0.12	15.93	53.97	462.81
6	0.59	16.74	56.30	461.44
7	1.05	17.50	58.72	460.02
8	1.47	18.20	61.25	458.52
9	1.86	18.88	63.94	456.94
10	2.16	19.60	66.79	455.29
11	2.35	20.36	69.80	453.56
12	2.48	21.20	73.03	451.76
13	2.58	22.15	76.49	449.90
14	2.70	23.20	80.16	447.98
15	2.94	24.43	84.12	446.03
16	3.33	25.84	88.39	444.06
17	3.86	27.40	92.96	442.05
18	4.52	29.13	97.80	439.99
19	5.26	31.02	102.87	437.84
20	6.05	33.05	108.17	435.60
21	6.87	35.21	113.68	433.24
22	7.69	37.50	119.38	430.74
23	8.54	39.90	125.26	428.11
24	9.47	42.43	131.32	425.34
25	10.47	45.08	137.57	422.42
26	11.57	47.88	144.01	419.35
27	12.79	50.82	150.69	416.13
28	14.08	53.89	157.62	412.73
29	15.41	57.04	164.85	409.13
30	16.78	60.30	172.36	405.30
31	18.17	63.64	180.14	401.24
32	19.60	67.05	188.15	396.92
33	21.05	70.55	196.40	392.35
34	22.54	74.13	204.87	387.50
35	24.07	77.77	213.51	382.37
36	25.64	81.49	222.30	376.94
37	27.25	85.32	231.28	371.19
38	28.89	89.31	240.51	365.11
39	30.55	93.54	250.06	358.68
40	32.22	97.99	259.88	351.86
41	33.90	102.66	269.93	344.65
42	35.63	107.53	280.14	337.03

	Number of Years Policy Has Been Inforce			
Age	5	10	20	Age 65
43	37.47	112.59	290.47	328.97
44	39.52	117.84	300.90	320.46
45	41.78	123.22	311.47	311.47
46	44.22	128.73	322.23	301.97
47	46.79	134.36	333.24	291.91
48	49.42	140.14	344.52	281.20
49	52.00	146.06	356.08	269.75
50	54.49	152.11	367.92	257.49
51	56.87	158.25	380.01	244.41
52	59.22	164.42	392.22	230.45
53	61.63	170.56	404.46	215.57
54	64.18	176.69	416.81	199.72
55	66.93	182.89	429.36	182.89
56	69.82	189.26	442.15	165.02
57	72.72	195.84	455.12	145.99
58	75.47	202.66	468.09	125.64
59	77.98	209.73	480.83	103.78
60	80.31	217.09	493.27	80.31
61	82.58	224.72	505.34	55.16
62	85.01	232.56	517.07	28.29
63	87.78	240.54	528.60	0.00
64	91.47	249.15	540.15	0.00
65	97.65	259.72	552.35	
66	104.23	270.64	563.99	
67	110.93	281.77	574.87	
68	117.50	292.86	584.86	
69	123.97	303.63	593.88	
70	130.39	313.93	601.98	
71	136.92	323.68	609.61	
72	143.68	332.97	617.57	
73	150.63	342.06	626.46	
74	157.39	350.82	637.10	
75	163.72	359.01	650.89	
76	169.37	366.33	670.84	
77	174.32	372.58	702.28	
78	178.91	377.70	754.10	
79	183.34	381.81	842.79	
80	187.53	385.04	1000.00	
81	191.35	388.15		
82	194.52	392.26		
83	196.63	398.20		
84	197.62	407.44		
85	197.68	422.68		

Pennsylvania Cash Values

Preferred Female Non-Nicotine

Guaranteed cash value per $1000 of initial face amount at end of policy year.

	Number of Years Policy Has Been Inforce			
Age	5	10	20	Age 65
0	0.00	6.96	35.56	411.41
1	0.00	7.98	37.70	410.57
2	0.00	8.90	39.80	409.62
3	0.00	9.76	41.92	408.57
4	0.00	10.60	44.12	407.45
5	0.00	11.43	46.39	406.27
6	0.00	12.28	48.76	405.03
7	0.00	13.15	51.22	403.73
8	0.00	14.07	53.80	402.37
9	0.00	15.02	56.49	400.95
10	0.10	15.99	59.29	399.46
11	0.46	17.02	62.21	397.90
12	0.84	18.12	65.27	396.28
13	1.24	19.28	68.48	394.59
14	1.68	20.55	71.85	392.84
15	2.15	21.90	75.37	391.02
16	2.68	23.32	79.02	389.12
17	3.24	24.82	82.84	387.13
18	3.84	26.39	86.83	385.06
19	4.50	28.04	91.00	382.89
20	5.19	29.77	95.37	380.62
21	5.91	31.56	99.91	378.23
22	6.65	33.43	104.65	375.72
23	7.42	35.38	109.58	373.08
24	8.21	37.39	114.70	370.30
25	9.03	39.47	120.01	367.38
26	9.88	41.61	125.50	364.30
27	10.77	43.85	131.19	361.08
28	11.70	46.19	137.06	357.69
29	12.67	48.64	143.11	354.13
30	13.67	51.21	149.33	350.39
31	14.69	53.90	155.72	346.44
32	15.74	56.72	162.28	342.30
33	16.84	59.66	168.98	337.93
34	18.02	62.74	175.85	333.34
35	19.27	65.95	182.89	328.52
36	20.60	69.29	190.09	323.44
37	22.02	72.75	197.45	318.11
38	23.50	76.31	204.95	312.48
39	25.03	79.95	212.61	306.52
40	26.60	83.65	220.45	300.23
41	28.20	87.43	228.49	293.58
42	29.83	91.26	236.73	286.54

	Number of Years Policy Has Been Inforce			
Age	5	10	20	Age 65
43	31.46	95.13	245.20	279.09
44	33.11	99.05	253.92	271.22
45	34.76	103.03	262.90	262.90
46	36.43	107.07	272.14	254.10
47	38.10	111.17	281.67	244.81
48	39.78	115.35	291.50	235.00
49	41.47	119.64	301.62	224.64
50	43.18	124.06	312.06	213.71
51	44.91	128.66	322.80	202.17
52	46.67	133.46	333.81	190.00
53	48.47	138.47	345.11	177.16
54	50.33	143.75	356.71	163.60
55	52.27	149.27	368.60	149.27
56	54.35	155.08	380.80	134.13
57	56.57	161.18	393.33	118.13
58	58.95	167.59	406.18	101.20
59	61.49	174.27	419.37	83.25
60	64.17	181.22	432.92	64.17
61	66.96	188.40	446.55	43.83
62	69.89	195.76	459.95	22.16
63	72.93	203.32	473.17	0.00
64	76.05	211.04	486.32	0.00
65	79.25	218.94	499.33	
66	82.51	227.02	512.51	
67	85.77	235.30	525.62	
68	89.08	243.82	538.15	
69	94.87	254.64	551.41	
70	100.82	265.85	564.65	
71	106.96	277.17	579.80	
72	113.37	288.20	598.04	
73	120.07	299.05	618.60	
74	127.10	309.85	641.20	
75	134.55	320.53	666.17	
76	142.03	331.50	695.39	
77	149.02	342.44	732.93	
78	155.60	352.58	787.57	
79	161.91	362.04	871.19	
80	167.79	371.42	1000.00	
81	174.08	383.80		
82	180.92	401.40		
83	187.27	423.23		
84	193.12	448.93		
85	199.37	479.20		

Pennsylvania Cash Values

Preferred Male Nicotine

Guaranteed cash value per $1000 of initial face amount at end of policy year.

	Number of Years Policy Has Been Inforce			
Age	5	10	20	Age 65
15	7.53	34.87	107.86	495.66
16	7.83	36.22	112.65	493.21
17	8.29	37.76	117.81	490.72
18	8.90	39.53	123.31	488.18
19	9.59	41.50	129.08	485.56
20	10.33	43.69	135.12	482.84
21	11.11	46.10	141.39	480.00
22	11.91	48.69	147.86	477.03
23	12.78	51.49	154.51	473.93
24	13.77	54.47	161.32	470.68
25	14.92	57.65	168.26	467.28
26	16.24	61.04	175.38	463.73
27	17.72	64.61	182.70	460.01
28	19.33	68.33	190.25	456.09
29	20.98	72.14	198.12	451.93
30	22.66	76.02	206.25	447.50
31	24.37	79.93	214.59	442.78
32	26.08	83.87	223.09	437.76
33	27.81	87.81	231.69	432.43
34	29.55	91.75	240.35	426.77
35	31.31	95.65	248.98	420.77
36	33.06	99.53	257.57	414.40
37	34.81	103.46	266.16	407.65
38	36.52	107.51	274.87	400.51
39	38.17	111.83	283.82	392.96
40	39.74	116.39	292.95	384.96
41	41.27	121.17	302.16	376.50
42	42.81	126.11	311.30	367.58
43	44.50	131.19	320.29	358.18
44	46.49	136.35	329.13	348.29
45	48.79	141.54	337.90	337.90
46	51.33	146.71	346.71	326.96
47	54.00	151.87	355.68	315.40
48	56.62	157.05	364.85	303.10
49	58.98	162.25	374.22	289.91

	Number of Years Policy Has Been Inforce			
Age	5	10	20	Age 65
50	60.99	167.44	383.84	275.78
51	62.69	172.53	393.70	260.69
52	64.19	177.40	403.65	244.62
53	65.69	181.97	413.59	227.57
54	67.42	186.28	423.74	209.53
55	69.42	190.52	434.20	190.52
56	71.56	194.82	444.94	170.47
57	73.58	199.36	455.91	149.29
58	75.18	204.11	466.83	126.73
59	76.14	209.09	477.41	102.53
60	77.93	215.52	488.32	77.93
61	80.73	223.33	499.43	52.93
62	83.91	231.55	510.31	26.63
63	87.77	240.13	521.21	0.00
64	92.54	249.33	532.22	0.00
65	98.16	259.10	543.05	
66	104.42	269.28	553.26	
67	110.84	279.67	562.58	
68	117.04	289.91	570.80	
69	123.14	299.61	577.82	
70	129.17	308.61	583.65	
71	135.13	316.83	588.84	
72	141.27	324.52	594.35	
73	147.53	332.09	600.95	
74	153.32	339.46	609.55	
75	158.42	346.24	621.64	
76	162.70	351.95	640.40	
77	166.20	356.31	671.98	
78	169.50	359.30	726.66	
79	173.04	361.05	823.66	
80	176.57	361.67	1000.00	
81	179.59	362.04		
82	181.69	363.44		
83	182.26	366.69		
84	181.00	373.43		
85	178.29	386.52		

Pennsylvania Cash Values

Preferred Female Nicotine

Guaranteed cash value per $1000 of initial face amount at end of policy year.

	Number of Years Policy Has Been Inforce			
Age	5	10	20	Age 65
15	6.41	32.36	100.94	457.97
16	7.03	34.08	105.38	455.68
17	7.71	35.92	110.04	453.29
18	8.44	37.85	114.89	450.80
19	9.22	39.88	119.97	448.20
20	10.06	42.01	125.29	445.48
21	10.93	44.24	130.83	442.63
22	11.83	46.57	136.62	439.64
23	12.77	48.99	142.62	436.49
24	13.74	51.48	148.83	433.18
25	14.75	54.05	155.26	429.70
26	15.83	56.71	161.90	426.06
27	16.95	59.46	168.73	422.23
28	18.11	62.34	175.70	418.20
29	19.31	65.35	182.79	413.95
30	20.52	68.52	189.96	409.49
31	21.74	71.82	197.20	404.79
32	23.01	75.30	204.50	399.83
33	24.34	78.91	211.86	394.62
34	25.76	82.68	219.27	389.13
35	27.30	86.61	226.73	383.36
36	28.95	90.69	234.24	377.29
37	30.72	94.88	241.78	370.90
38	32.54	99.13	249.36	364.15
39	34.42	103.35	256.99	356.99
40	36.32	107.54	264.66	349.41
41	38.23	111.66	272.38	341.37
42	40.12	115.70	280.15	332.84
43	41.97	119.67	288.00	323.80
44	43.73	123.54	295.97	314.23
45	45.37	127.32	304.09	304.09
46	46.90	131.02	312.36	293.36
47	48.33	134.64	320.81	282.01
48	49.67	138.27	329.44	270.04
49	50.97	141.96	338.28	257.45

	Number of Years Policy Has Been Inforce			
Age	5	10	20	Age 65
50	52.24	145.76	347.32	244.21
51	53.48	149.68	356.52	230.30
52	54.70	153.74	365.82	215.68
53	55.96	157.98	375.20	200.32
54	57.30	162.46	384.64	184.17
55	58.71	167.20	394.21	167.20
56	60.24	172.22	403.95	149.35
57	61.89	177.54	413.89	130.55
58	63.62	183.07	424.01	110.71
59	65.48	188.80	434.32	89.72
60	67.49	194.71	444.88	67.49
61	69.61	200.69	455.24	43.90
62	71.87	206.66	464.87	18.85
63	75.22	213.46	474.42	0.00
64	79.88	221.20	484.09	0.00
65	84.62	228.94	493.24	
66	89.34	236.74	502.44	
67	93.95	244.61	511.44	
68	98.45	252.63	519.46	
69	102.80	260.82	526.69	
70	107.12	269.30	533.90	
71	111.57	277.57	543.85	
72	116.27	285.00	558.32	
73	121.28	291.70	576.43	
74	126.69	297.81	598.15	
75	132.53	303.34	623.26	
76	138.05	309.01	653.22	
77	142.39	314.42	693.00	
78	145.58	318.44	753.38	
79	147.70	321.26	849.13	
80	148.72	323.85	1000.00	
81	150.24	330.71		
82	152.63	345.20		
83	154.46	366.12		
84	155.86	393.38		
85	158.07	426.77		

ASSURANT®

Account Verification

I hereby request and authorize the withdrawal of funds from the account referenced below for premiums. I am aware that if any charge to my account is dishonored, for any reason, the company shall have no liability whatsoever, even if such dishonor results in the forfeiture of the insurance contract.

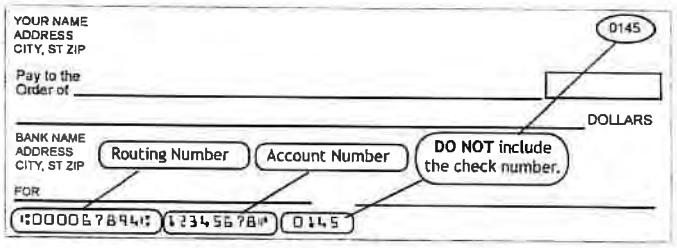
Insured's Name: _____

Payor's Name: _____

Form is required if no voided check or savings withdrawal slip is available.

Financial Institution

Account Type: ☐ Checking ☐ Savings		Financial Institution	
Financial Institution Address	City	State	Phone Number
Routing Number		Account Number	
Account Holder Name		Account Holder Signature	
Date (mm/dd/yy)			



Example of a standard check

NOTE: The routing and account numbers may be in different places on your check.

Do not use the numbers from a deposit slip.

It is recommended that the initial premium draft be scheduled within 5 business days of the application date.

Agent Attestation

☐ I do hereby attest that I personally verified this information	
Agent Name *Print*	Agent Signature
Date (mm/dd/yy)	
Comments	