



Great Western Final Expense Insurance

SALES KIT BOOKLET

AGENT INSTRUCTIONS

Please complete the following:

- Application for Final Expense Insurance Policy
- Bank Draft Information
- Additional forms which may be required. See forms marked Complete and Send with Application. All other forms should be left with the applicant.

Submit applications electronically by MyEnroller, Mail or Fax.

MyEnroller

Electronic Application Submission Tool
Website: my.gwic.com/online

Mail

Great Western Insurance Company
P.O. Box 14410
Des Moines, IA 50306-3410

Fax

515-247-2500

If you have any questions, please call 866-252-5594.

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New coverage Reinstatement of policy # _____

Agent number: _____

P.O. Box 14410, Des Moines, IA 50306-3410

Fax: 515-247-2500 • Phone: 1-800-733-5454

Email: FENEW@GWIC.COM • Website: www.gwic.com

Application for Individual Life Insurance

Part A: Proposed Insured (Full legal name)

Full name of applicant - first name, M.I., last, suffix		Date of birth (MM/DD/YYYY)	Gender
Address	City	State	ZIP code
Phone number	Email address	Social Security number	

Part B: Owner (Complete only if other than proposed insured)

Full name of owner - first name, M.I., last, suffix		Date of birth (MM/DD/YYYY)	Gender
Address	City	State	ZIP code
Phone number	Email address	Relationship to insured	Social Security number

Part C: Policy Information

If all of the questions in Part D can be answered "NO," then the proposed insured is eligible for a Level Death Benefit. If one or more of the health questions are answered "YES," are not answered, or it is determined during the underwriting process they should have been answered "YES," then the policy will be issued with a Graded Death Benefit.

Level Death Benefit Graded Death Benefit Requested effective date: _____

Face amount: \$ _____ Ultimate Death Benefit: \$ _____
For Level Death Benefit, multiply face amount by 125% to determine the Ultimate Death Benefit.

Payment mode: Monthly Quarterly
 Semiannually Annually Base premium amount: \$ _____

Dependent child/Grandchild rider (complete separate application)
 \$5,000 face amount on base policy is required Rider premium amount: \$ _____

Total premium amount: \$ _____

Part D: Medical Information (Do not complete if applying for Guaranteed Assurance - Graded Death Benefit)

- In the last 24 months have you been confined to a bed, received hospice care, been in a hospital or a nursing home for 5 or more days in total? Yes No
- Do you require assistance or supervision to perform routine daily activities such as bathing, dressing, eating, toileting, or transferring to or from a bed or chair? Yes No
- In the past 24 months have you consulted a member of the medical profession, been treated for, been diagnosed with or taken medication for any of the following:
 - diabetes requiring insulin, with complications, or requiring 3 or more medications;
 - internal cancer, malignant melanoma, leukemia, Hodgkin's Disease, or lymphoma;
 - heart surgery including bypass, angioplasty or stent placement, congestive heart failure, heart attack, stroke, peripheral vascular disease, or aneurysm;
 - emphysema, chronic obstructive pulmonary disease (COPD), or oxygen use;
 - a neuromuscular disease, Amyotrophic Lateral Sclerosis (ALS), Parkinson's, or Multiple Sclerosis;
 - kidney failure or dialysis;
 - liver disease such as chronic hepatitis or cirrhosis;
 - dementia, Alzheimer's disease, or schizophrenia;
 - alcohol or drug abuse; or
 - organ transplant? Yes No
- Have you ever been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)? Yes No
 - In the last 24 months have you received treatment from a member of the medical profession for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)? Yes No

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Part D: Medical Information - continued

Please provide the name and phone number of your Primary Care Physician (required for Level Death Benefit):

Primary Care Physician's name

Phone number

Part E: Beneficiary

Primary (full legal name)

Relationship to insured

Phone number

Address

City

State

ZIP code

Contingent (full legal name)

Relationship to insured

Phone number

Address

City

State

ZIP code

Part F: Application Agreement

By signing below, I agree: (1) I represent statements in this application are complete and true. (2) When the policy is delivered, the insured must be alive and in the same health as described above or there will be no insurance. (3) The full premium for the chosen mode must be paid by the time the policy is delivered. (4) By keeping the policy past the free look period, my written consent is hereby given to any change(s), correction(s), or addition(s) that have been made to the policy for which I am applying.

Authorization: I authorize any healthcare provider, medical facility, pharmacy benefit manager or other pharmacy related services organization, health plan, insurance company, MIB, Inc., claims administrator, government agency, or other person or firm, to disclose to Great Western Insurance Company (GWIC) or its authorized representative, any records or information it needs about the insured's health, including copies of records concerning physical or mental illness, advice, diagnosis, prognosis, prescription information, care or treatment provided to the insured. I understand that such information will be used by GWIC for the purpose of evaluating my application for insurance. A copy of this approval will be as effective as the original. Health information obtained will not be redisclosed without my authorization unless permitted by law, in which case it may not be protected under federal privacy rules. I authorize GWIC, or its reinsurers, to make a brief report of my personal health information to MIB, Inc. I understand that I or any authorized representative will receive a copy of this authorization upon request. This approval is valid for twenty-four (24) months from the date signed. This time limit complies with the time limit, if any, permitted by applicable law in the state where the policy is delivered or issued for delivery. This authorization may be revoked by me in writing, which I may do at any time by contacting GWIC.

I affirm that no illustration was used in the sale of this product.

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.

Do you have any existing insurance policies or annuity contracts?

Yes No

Will the insurance applied for replace or change any insurance or annuity that is now or has recently been in force? *If "Yes," complete required replacement form(s).*

Yes No

X

Proposed insured's signature

Date (MM/DD/YYYY)

X

Owner's signature (If other than proposed insured)

Date (MM/DD/YYYY)

Part G: Agent Certification

I certify that the answers from the proposed insured to Part D were recorded accurately.

Does the applicant have any existing insurance policies or annuity contracts?

Yes No

Will the insurance applied for replace or change any insurance or annuity that is now or has recently been in force?

Yes No

X

Agent full name (please print)

Agent number

X

Agent's signature

Date (MM/DD/YYYY)

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P.O. Box 14410 Des Moines, IA 50306-3410
 Fax: 515-247-2500 • Phone: 1-800-733-5454
 Email: FENEW@GWIC.COM • Website: www.gwic.com

Child/Grandchild Protection Plan

State _____ (Print) Agent Name _____ Agent Number _____ Date _____

Insured's Information			
First Name	Middle Initial	Last Name	
Street Address	City	ST	Zip
Phone #	Date of Birth (mm/dd/yyyy)	Social Security #	
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Email Address		

Child / Grandchild Protection Rider Information	
Existing Policy #	Rider Premium \$1.00 per month
Does the applicant have any existing policy or annuity? <input type="checkbox"/> YES <input type="checkbox"/> NO Will the proposed insurance replace any existing policy or annuity? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, please complete a replacement form</i>	

Conditions of Child / Grandchild Protection Plan
<p>I apply for the Child / Grandchild Protection Plan and understand that only the Covered Child / Grandchild(ren) who are listed below and who meet the following conditions will be covered.</p> <ul style="list-style-type: none"> • The Covered Child / Grandchild is living with a parent, grandparent, or guardian at the time of death and has never married. • The Covered Child / Grandchild is at least one year of age and has not attained the age of eighteen (18) years. • The Covered Child / Grandchild dies while the Insured on the base Policy is alive. • The coverage under the base Policy to which this Rider is attached is active and current in its premium payments.

Child/Grandchild's Full Name	Date of Birth	Child/Grandchild's Full Name	Date of Birth
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Agreement	
<p>Agree by signing below, I agree that (1) to the best of my knowledge and belief, statements in this Application are complete and true. (2) When the Policy is delivered, the Applicant and listed child / grandchild(ren) must be alive. Also, the full premium must be paid by the time the Policy is delivered. (3) By keeping the Policy past the free look period, my written consent is hereby given to any change(s), correction(s), or addition(s) that GWIC may make to the Policy for which I am applying.</p>	
X _____ Insured's Signature	Signed on _____ (mm/dd/yyyy) Signed at _____ (City, State)
X _____ Owner's Signature (If other than the Proposed Insured)	X _____ Agent's Signature
For the Agent: Is replacement of insurance involved? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<p>To the Applicant: You should hear from the Company within sixty days of the application date. If you don't, state the facts of your application in a letter to the Secretary of the Great Western Insurance Company at the address listed above.</p>	

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Phone: 1-800-733-5454
www.gwic.com

Life Replacement Advertising

AGENT'S STATEMENT

I, _____ have complied with the following in connection with the replacement sales transaction:

- a. I have used only company approved sales advertising.
- b. I have given a copy of all sales advertising used during the presentation to the applicant, including printed copies of any electronically presented sales materials.

X _____
Agent Signature

Agent Number

Date

Page intentionally left blank.

Life Replacement Advertising

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I, _____ have complied with the following in connection with the replacement sales transaction:

- a. I have used only company approved sales advertising.
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X

Agent Signature

Agent Number

Date

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Notice Regarding Replacement

INFORMATION STATEMENT

THE LIFE INSURANCE I INTEND TO PURCHASE FROM GREAT WESTERN INSURANCE COMPANY MAY REPLACE OR ALTER EXISTING LIFE INSURANCE.

The following policy(ies) may be replaced as a result of this transaction:

1.	_____	_____	_____
	Company Name	Name of Insured	Policy/Contract No.
		_____	_____
		Type of policy (generic name)	Face Amount
2.	_____	_____	_____
	Company Name	Name of Insured	Policy/Contract No.
		_____	_____
		Type of policy (generic name)	Face Amount
3.	_____	_____	_____
	Company Name	Name of Insured	Policy/Contract No.
		_____	_____
		Type of policy (generic name)	Face Amount

X _____

Applicant's Signature Date

Applicant's Address City State

I certify that this form and the Notice to Applicants Regarding Replacement of Life Insurance were given to and signed by _____ prior to taking an application and that I am leaving a signed copy for the applicant.
Applicant's Name (printed)

X _____

Agent's Signature Date

Agent's Address City State

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INSURANCE DEPARTMENT BULLETINS

NOTICE TO APPLICANTS REGARDING REPLACEMENT OF LIFE INSURANCE

THIS NOTICE IS FOR YOUR PROTECTION AND IS REQUIRED BY REGULATIONS OF THE MICHIGAN COMMISSIONER OF INSURANCE. PLEASE READ IT CAREFULLY.

Dropping or changing your existing life insurance to replace it with a new life insurance may be disadvantageous because:

A company can deny a claim during the first two years if it can be shown that you withheld information from your application which was important to the decision of whether to insure you. This is called the "**CONTESTABLE PERIOD.**" If you drop or change policies, you may have to go through the two year period again.

You may pay **HIGHER RATES** for identical coverage because of your age. Life insurance rates go up as you get older.

BEFORE YOU DROP, CHANGE OR CASH IN YOUR PRESENT INSURANCE and apply for a new insurance, you should:

1. Compare the policy **BENEFITS** and **OPTIONS**. The agent is required by law to provide you with all pertinent facts of the change and the insurance company you are considering must notify the company that issued your existing policy.
2. Be aware that you may be required to provide **EVIDENCE OF INSURABILITY**. If your health condition has changed since the application was taken on your present policy, you may be required to pay additional premiums under the new policy, or be denied coverage.
3. Compare the **LOAN INTEREST RATE**. The interest rate for new policies is probably higher than for the existing policy. Therefore, you will pay more when you want to borrow the cash value. 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 interest, will be deducted from the benefits of your existing policy.
4. Find out if the existing policy and/or the proposed policy offers **DIVIDENDS OR EXCESS INTEREST**. Dividends or excess interest can have a significant impact on net policy cost. Remember that no company can guarantee the amount of dividends it will pay in the future, nor can excess interest projections be presented as to imply a guarantee.
5. **CONTACT THE AGENT OF YOUR PRESENT COMPANY**. Your present company can often make changes in your existing insurance on terms which are more favorable to you than can another company.
6. Find out if there are income or estate tax consequences if you drop or change your present policy.

You should not drop or change your existing life insurance coverage until after you have been issued the new policy, examined it and found it to be acceptable to you. **REMEMBER YOU HAVE TEN DAYS AFTER RECEIPT OF THE POLICY TO CANCEL AND OBTAIN A FULL REFUND.**

X

Applicant's Signature

Date

Page intentionally left blank.



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		Type of policy (generic name)	Face Amount
2.	_____	_____	_____
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		_____	_____
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3.	_____	_____	_____
	Company Name	Name of Insured	Policy/Contract No.
		_____	_____
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X _____

Applicant's Signature Date

Applicant's Address City State

I certify that this form and the Notice to Applicants Regarding Replacement of Life Insurance were given to and signed by _____ prior to taking an application and that I am leaving a signed copy for the applicant.
Applicant's Name (printed)

X _____

Agent's Signature Date

Agent's Address City State

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3. Compare the **LOAN INTEREST RATE**. The interest rate for new policies is probably higher than for the existing policy. Therefore, you will pay more when you want to borrow the cash value. 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 interest, will be deducted from the benefits of your existing policy.
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X

Applicant's Signature

Date

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Email: FENEW@GWIC.COM • Website: www.gwic.com

Information on the Accelerated Death Benefit Rider

INCLUSION OF RIDER

If you qualify for a Level Death Benefit policy, your policy will automatically include the Accelerated Death Benefit Rider at no additional charge. You qualify for the Level Death Benefit by answering "No" to the health questions on the application and providing your primary care physician's information.

DESCRIPTION OF RIDER

Great Western Insurance Company will pay an Accelerated Death Benefit to the Owner upon proof the insured has a Qualifying Medical Condition. Payment is subject to the terms and conditions of the Policy and this Rider while the Policy and this rider remain in force.

QUALIFYING MEDICAL CONDITION

Qualifying Medical Condition means either: 1.) Terminal Illness - You are terminally ill. You are expected to die within 12 months. Or 2.) Chronic Illness - You cannot perform two Activities of Daily Living for a period of at least 90 days. Or you have permanent severe cognitive impairment and similar forms of dementia requiring substantial supervision.

EFFECT OF RECEIPT OF BENEFITS

The application and receipt of an Accelerated Death Benefit will terminate your policy. You will not receive any additional death benefit on the death of the insured. The policy will not have any cash value after receipt of the Accelerated Death Benefit. You will not be required to pay additional premiums for the policy after receipt of the Accelerated Death Benefit. Any loan on the policy at the time of receipt of Accelerated Death Benefit will be paid off by the benefit before you receive the Accelerated Death Benefit and you will not be able to take future loans from the policy.

BENEFIT

The Accelerated Death Benefit paid to you may be reduced by an administrative charge and interest charges.

TAXES AND GOVERNMENT ASSISTANCE

This Accelerated Death Benefit may be taxable. We have not intended for this Accelerated Death Benefit to qualify for favorable tax treatment. Prior to electing to receive the Accelerated Death Benefit, you should seek assistance from a qualified tax adviser.

Receipt of Accelerated Death Benefits may affect eligibility for public assistance programs, such as Medicaid. Prior to electing to receive the Accelerated Death Benefit, you should consult with the appropriate social services agency concerning how receipt of Accelerated Death Benefits may affect that eligibility.

USE OF PROCEEDS

This benefit will not restrict your use of proceeds. The benefits provided by this Accelerated Death Benefit are not intended to provide, and will never provide, long-term care insurance, nursing home insurance, or home care insurance. If you are interested in long-term care or nursing home or home care insurance, you should consult with an insurance agent licensed to sell that insurance.

ADDITIONAL INFORMATION

When you receive your policy, you will receive the Accelerated Death Benefit Rider form which will explain the benefits and conditions of this option fully.

There is no charge for this rider, and you may choose not to apply for Accelerated Death Benefits even if you have a Qualifying Medical Condition.

X

Applicant's Signature

X

Agent's Signature

Date

Page intentionally left blank.



Information on the Accelerated Death Benefit Rider

INCLUSION OF RIDER

If you qualify for a Level Death Benefit policy, your policy will automatically include the Accelerated Death Benefit Rider at no additional charge. You qualify for the Level Death Benefit by answering “No” to the health questions on the application and providing your primary care physician’s information.

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Receipt of Accelerated Death Benefits may affect eligibility for public assistance programs, such as Medicaid. Prior to electing to receive the Accelerated Death Benefit, you should consult with the appropriate social services agency concerning how receipt of Accelerated Death Benefits may affect that eligibility.

USE OF PROCEEDS

This benefit will not restrict your use of proceeds. The benefits provided by this Accelerated Death Benefit are not intended to provide, and will never provide, long-term care insurance, nursing home insurance, or home care insurance. If you are interested in long-term care or nursing home or home care insurance, you should consult with an insurance agent licensed to sell that insurance.

ADDITIONAL INFORMATION

When you receive your policy, you will receive the Accelerated Death Benefit Rider form which will explain the benefits and conditions of this option fully.

There is no charge for this rider, and you may choose not to apply for Accelerated Death Benefits even if you have a Qualifying Medical Condition.

X _____
 Applicant’s Signature

X _____
 Agent’s Signature

 Date

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BANK DRAFT INFORMATION

Complete this form only if you selected the automatic bank withdrawal payment option.

Ongoing premium - Authorization to bank or other financial institution

Checking Savings

Requested withdrawal date (1st - 28th only) _____

First name (as it appears on account)

M.I.

Last name (as it appears on account)

Billing address

City

State

ZIP code

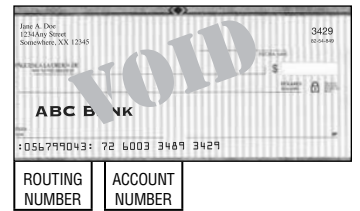
Bank or financial institution name (including branch, if any)

Routing number

Bank or financial institution's address

Account number

Please read: By providing my account information here and signing this form, I authorize the bank whose name and address I am providing to pay and to charge to my account the amount of any check, instrument, or any other funds made by and payable to Great Western Insurance Company (the "Company") for insurance premiums. I authorize the Company to contact my bank or financial institution on my behalf for the sole purpose of obtaining information necessary to administer my preauthorized withdrawals in conjunction with my insurance coverage. This authorization is to remain in effect until revoked by me in writing. Until you receive and have reasonable time to act on such notices, you shall be fully protected in accepting any preauthorized withdrawal against my account.



Account holder's signature

Date

Note: Enrollments using a credit or debit card for premium payments must be submitted electronically. Paper applications cannot contain credit or debit card information.

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Fax: 515-247-2500 • Phone: 1-800-733-5454
Email: FENEW@GWIC.COM • Website: www.gwic.com

Receipt for Initial Premium

Final Expense Receipt

I, the listed agent below, have received an application from _____
(Applicant's Name)

for a Final Expense Whole Life Insurance policy with the following rider:

Dependent Child / Grandchild Rider

Face amount of Life Insurance applied for: \$ _____.

Amount of initial premium received by agent: \$ _____.

This receipt is given and accepted for an application for insurance. This insurance will not be in force until the policy is issued and the first premium is paid in full.

If your application cannot be approved, we will promptly refund your money. ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE INSURANCE COMPANY. DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

If you do not hear from our company within 30 days, please contact us by one of the following methods:

Write to:

Great Western Insurance Company
PO Box 14410 • Des Moines, IA 50306-3410

Call:

Customer Care at 1-800-733-5454

Agent's Signature

Date

Agent's Printed Name

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Guaranteed Assurance Rate Chart

Per Unit Face Annual Premiums		
Age	Male	Female
40	56	45
41	57	46
42	59	48
43	61	50
44	62	51
45	63	52
46	64	53
47	65	54
48	67	55
49	67	56
50	68	56
51	69	57
52	69	59
53	70	60
54	72	62
55	74	64
56	76	67
57	79	69
58	81	71
59	84	73

Per Unit Face Annual Premiums		
Age	Male	Female
60	87	76
61	91	79
62	94	82
63	98	86
64	102	90
65	107	93
66	113	97
67	119	101
68	125	105
69	132	111
70	140	119
71	149	128
72	159	139
73	170	150
74	178	156
75	187	163
76	197	171
77	208	180
78	220	190
79	242	207
80	270	225

Take Face Amount, divide by \$1,000;
 Multiply by Annual Premium;
 Add \$35.00 Policy Fee;
 Divide by:
 2 for Semi-Annual Premium
 4 for Quarterly Premium
 12 for Monthly Premium

Example:
46 Year Old Female;
Face Amount \$15,000; Monthly

$\$15,000 / 1,000 = \15.00
 $\$15.00 \times 53 = \795.00
 $\$795.00 + \$35.00 = \$830.00$
 $\$830.00 / 12 = \69.17 Monthly Premium



Dear Policyholder:

Great Western is the provider of your insurance policy. We appreciate your business and value our relationship with you.

As part of that relationship, be assured that we respect your personal privacy. We don't sell information. Furthermore, we don't share any information regarding our customers with anyone outside of Great Western, other than policy beneficiaries, assignees or agents.

Federal law requires banks, investment and insurance companies to notify their customers annually, of their official Privacy Policy. We encourage you to read our formal Privacy Policy printed below.

It is our pleasure to serve you and we sincerely appreciate your business.

Sincerely,

A handwritten signature in black ink that reads 'Thomas A. Swank'.

Thomas A. Swank, President

Privacy Policy

*Great Western's Customer Commitment Includes
Respect for Your Personal Privacy*

Great Western has a long-standing commitment to our customer's personal privacy. Any information we collect relates only to our business with you.

Nonpublic Personal Information

In the course of processing and maintaining your insurance policy, Great Western may collect nonpublic personal information about you from your application and other forms, from your transactions with us, and from our agents or affiliates. This information includes name, address, Social Security Number, and beneficiary designations.

Nondisclosure of Nonpublic Personal Information

We do not give or sell any nonpublic personal information about our customers or former customers to anyone, except as permitted by law.

Restricted Access to Nonpublic Personal Information

Furthermore, we restrict access to nonpublic personal information about you to only those employees who need to know that information in order to provide products or services to you.

Nondisclosure of Personal Health or Medical Information

We do not give or sell personal health or medical information about you, except as permitted by law or upon your written authorization.

Safeguard Nonpublic Personal Information

We maintain physical, electronic and procedural safeguards that comply with federal regulations to guard your nonpublic personal information.

Be assured that we respect your privacy and that we will continue to secure the information that you have entrusted to us.

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