

Final Expense Whole Life Insurance

Agent checklist

Complete these forms and return to the home office:

- Application
- HIPAA form – and applicant keeps a copy
- Replacement form – and applicant keeps a copy
- Producer statement
- Electronic check authorization – if not using electronic funds transfer (EFT) for initial payment
- A fax cover sheet, payment form and new business envelope are enclosed for your convenience.

Important:

A few states require completion of state specific forms. If there is a state specific form(s) in the sales kit that you are utilizing, please follow the instructions on the form for completion and submittal.

Applicant keeps this information

- Brochure
- HIPAA form – and return a copy to home office
- Replacement form – and return a copy to home office
- Final Arrangements Planning Guide

DON'T FORGET

Complete on and include with application:

- Applicant's information: Social Security number, signature, and email address (email preferred, optional)
- ALL** pages of the application
- Plan selected, options, riders, benefit amounts, effective date, and signature date
- Premium mode
- EFT information and voided check if drafting from checking
- Initial premium payment (direct) made out to correct underwriting company
- Agent name printed, signature, and writing number

For agent use only

Available on the agent side of aetnaseniorproducts.com:

- **Producer guide and drug list**
- **Aetna Quote & Enroll** – It's fast and easy to complete and submit electronic applications for all products with this one tool

Fax cover sheet

from **Accendo Insurance Company** part of the CVS Health® family of companies and Aetna affiliate

• Indicate intended recipient below.

Pages
(including cover)

To: (check one)

New application submission

(Use only for the original submission of the New Business application packet)

Fax: **877-380-2777**

Follow up documentation requested

(Use when sending additional information/pages for an existing New Business policy submission or if requested by a case manager.)

Attn: _____

Fax: **855-447-0391**

Underwriting information requested

(Use after new application submission only if contacted by Underwriting for additional information)

Attn: _____

Fax: **855-411-9633**

From

Email

• _____

• _____

Phone

Fax

Date

• _____

• _____

• _____

I have included the following:

Application Transmittal form Bank draft requirements Other required forms Trailing documentation

Applicant name

Policy number

• _____

• _____

Comments

Due to HIPAA privacy of information, faxed responses will not include the name of a policyholder or applicant but, when appropriate, will reference the policy/application tracking number. Information will only be provided if your inquiry pertains to policyholders or applications for which you are either the writing agent or otherwise associated with the policy or application for coverage.

The information contained in this facsimile transmission is intended only for the use of the individual or entity named above and may contain information that is privileged or confidential. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. Receipt by anyone other than the intended recipient is not a waiver of any attorney-client or work-product privilege. If you have received this communication in error, please notify us immediately at the number listed below.

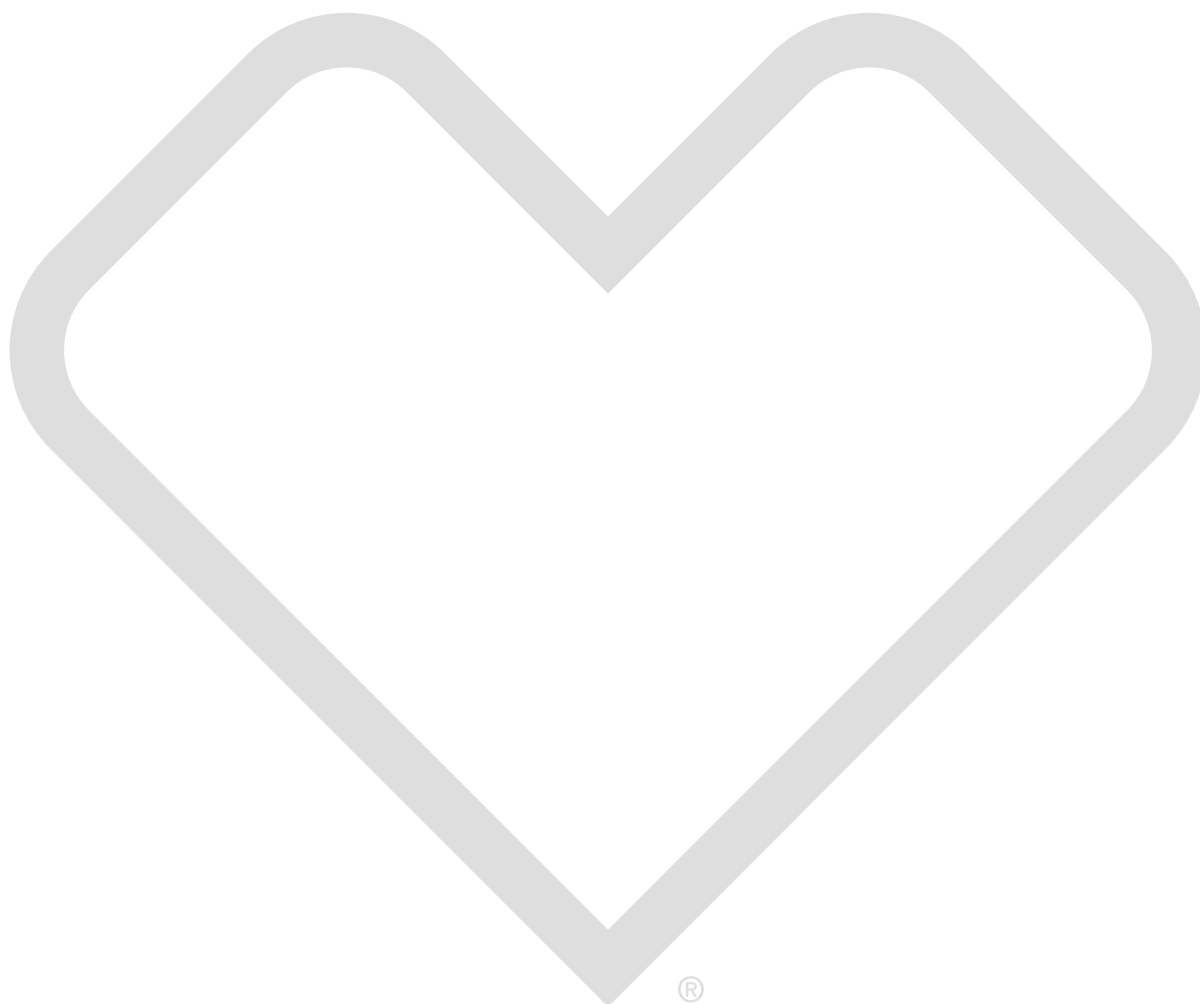


Application for **Individual Whole Life Insurance**

Accendo Insurance Company

part of the CVS Health® family of companies and Aetna affiliate

Policy administered by Aetna Life Insurance Company and its affiliates



Application for Individual Whole Life Insurance

- Print clearly and use blue or black ink.
- Use section 7 for additional remarks, requests, or explanations.

• Mail application and check in the provided business reply envelope to **P.O. Box 14399, Lexington, KY 40512.**

Section 1. Proposed insured information

Proposed insured's name (first, M.I., last)		Phone
.		.
Residential address (must be a physical address)		Apt/suite number
.		.
City	State	Zip
.	.	.
Mailing address (if different than residential address)		Apt/suite number
.		.
City	State	Zip
.	.	.
E-mail	Social Security Number	Birth date* (mm/dd/yyyy)
.	.	.
Place of birth	Age	<input type="checkbox"/> Male
.	.	<input type="checkbox"/> Female

- Are you a legal resident of the United States?** Yes No
- Have you used any form of tobacco in the past 12 months? (Including vaping and e-cigarettes)** Yes No
- Do you have an existing Medicare Supplement policy with Aetna?** Yes No
- If Yes, what is your policy number?**

Section 2. Health questions

For the purposes of these questions "you" means the proposed insured. "Diagnosed", "advised", "tested" and "treatment" mean by a licensed physician or medical practitioner. "Terminal condition" means an illness, disease or disorder which would reasonably be expected to cause death within 12 months.

Part A - If you answer "yes" in part A, you are not eligible. Do not complete or submit this application.

- 1. Are you currently:**
- A.** confined in or been advised to enter a hospital, nursing home, skilled nursing facility, psychiatric facility, correctional facility? Yes No
 - B.** receiving or been advised to receive home health care or hospice care? Yes No
-
- 2. Do you use a wheelchair or mobility scooter or do you have any physical or mental impairment requiring assistance from anyone with the following activities of daily living: taking medications, bathing, dressing, eating, toileting, getting in or out of bed or chair, or moving about?** Yes No
-
- 3. Within the past year have you:**
- A.** used or been advised to use oxygen equipment to assist with breathing (excluding CPAP for sleep apnea) or had or been advised to have kidney dialysis? Yes No
 - B.** been advised to have any medical procedure, surgery or a diagnostic test which has not yet been started, completed, or for which results are not known, excluding tests related to the Human Immunodeficiency Virus (HIV)? Yes No
-
- 4. Have you ever received, or been advised to receive, an organ or bone marrow transplant or an amputation due to any disease or complications of diabetes?** Yes No

Section 2. Health questions *continued*

5. Have you ever been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus), AIDS Related Complex (ARC), or Acquired Immune Deficiency Syndrome (AIDS)? Yes No

6. Have you ever been diagnosed with, received or been advised to receive treatment or medication for:

A. Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease), Huntington's Disease, or sickle cell anemia? Yes No

B. Alzheimer's disease, dementia or mental incapacity? Yes No

C. congestive heart failure, pulmonary fibrosis, any terminal condition or end-stage disease? Yes No

D. cerebral palsy, cystic fibrosis, muscular dystrophy or un-operated heart defects? Yes No

7. Within the past 2 years have you been diagnosed with, received or been advised to receive chemotherapy or radiation for any form of cancer (excluding Basal or Squamous cell skin cancer)? Yes No

8. Have you ever been diagnosed with more than one occurrence of the same or different type of cancer? Yes No

Part B - If any "yes" answers in part B, select ***Modified Plan***.

1. Within the past 2 years have you been diagnosed with, received or been advised to receive treatment or medication for:

A. alcohol or drug abuse (prescribed or illegal), or used illegal drugs; or been convicted of or plead guilty to driving under the influence? Yes No

B. complications of diabetes such as diabetic coma, insulin shock, retinopathy (eye disorder), nephropathy (kidney disorder), or neuropathy (nerve, circulatory disorder)? Yes No

C. kidney or liver disease? Yes No

2. Within the past year have you been diagnosed with, received or been advised to receive treatment for:

A. angina (chest pain), heart attack, cardiomyopathy, or any type of heart or circulatory procedure or surgery? Yes No

B. stroke or transient ischemic attack (TIA/mini-stroke), aneurysm or brain tumor? Yes No

Part C - If any "yes" answers in part C, select ***Standard Level Plan***.
If all "no" answers in Parts A, B and C select ***Preferred Level Plan***.

1. Within the past 2 years have you been diagnosed with, received or been advised to receive treatment for:

A. angina (chest pain), heart attack, cardiomyopathy, or any type of heart or circulatory procedure or surgery? Yes No

B. stroke or transient ischemic attack (TIA/mini-stroke), aneurysm or brain tumor? Yes No

2. Have you ever been diagnosed with, received or been advised to receive treatment or medication for:

A. Parkinson's disease, Multiple Sclerosis or Systemic Lupus (SLE)? Yes No

B. chronic obstructive pulmonary disease (COPD), chronic bronchitis, emphysema or any other chronic respiratory condition? Yes No

Section 3. Benefits and premium information

Initial amount of insurance applied for \$ _____ **Plan requested**
 Preferred Level Plan Standard Level Plan Modified Plan

Riders requested (not available with Modified Plan)
 Accidental Death Benefit Rider Accelerated Death Benefits Rider Children's Term Insurance Rider

Requested effective date* (mm/dd/yyyy) _____ **Nonforfeiture options****
 Automatic premium loan Paid-up insurance Extended term insurance

Initial premium
 Draft initial premium upon policy approval Draft initial premium on policy effective date

I would like subsequent payment withdrawn on the ____ day of the month **OR** the 2nd 3rd 4th Wednesday of the month.

Initial premium amount \$ _____ **Payment mode**
 Annually Quarterly Semi-annually Monthly EFT

Initial premium method
 EFT (Electronic Funds Transfer) Check or money order

The insurance for which you qualify may have a return of premium death benefit for the first two (2) years. The amount of coverage applied for may be less than the amount approved and not all riders are available on all plans.

Check here if you are willing to accept any plan shown above.

Which do you prefer?

Adjust the face amount to match the premium Keep the same amount of insurance and adjust the premium

*Unless otherwise requested, the effective date is the application signature date as long as the application is received at the administrative office within 15 days.
 **If a nonforfeiture option is not selected, extended term insurance is the default.

Mail policy to: Applicant Agent

Payment modes

You have a choice of four payment modes for paying your premium. The Company may charge you more based on the premium mode you select. There may be reasons, such as the time value of money, you would want to consider in making a decision on which premium mode to choose. Your agent can explain the differences in modes and help you decide which is best for you.

Section 4. Beneficiary

If a trust, give Trustee name, Trust name and Trust date. Percent share must total 100%.

Primary beneficiary name (first, M.I., last)	Relationship to insured	Phone	Share
•	•	•	• %

Address	Social Security Number
•	•

Primary beneficiary name (first, M.I., last)	Relationship to insured	Phone	Share
•	•	•	• %

Address	Social Security Number
•	•

Section 4. Beneficiary *continued*

Contingent beneficiary name <i>(first, M.I., last)</i>	Relationship to insured	Phone	Share
•	•	•	• %
Address		Social Security Number	
•		•	
Contingent beneficiary name <i>(first, M.I., last)</i>	Relationship to insured	Phone	Share
•	•	•	• %
Address		Social Security Number	
•		•	

Section 5. Replacement information

1. Does the proposed insured currently have any life insurance or annuity in force? Yes No
2. Will insurance applied for in this application replace, reduce or modify premiums paid for any existing life insurance or an annuity in force? Yes No

If the answer to either question is "yes", please provide the information below:

Company name	Face amount	Policy number
•	•	•
Company mailing address <i>(to send notice of replacement)</i>		
•		

Section 6. Health history optional comments *(not required)*

Provide any additional information available regarding underwriting questions (diagnosis, dates, durations, medications, dosages).

Section 7. Remarks

Section 8. Producer compensation

When you purchase insurance from us, we pay compensation to the licensed agent. Intermediaries through whom the licensed agent works may also receive compensation.

The agent or intermediary represents us by taking your insurance application, collecting your initial premium and, if applicable, delivering your policy.

Agent compensation may vary depending on the type of insurance plan you purchase or the specific options included with your policy. The agent can receive compensation by:

- commissions when a policy is purchased or renewed
- fees for marketing and administrative services
- educational opportunities

Some agents and/or their intermediaries may also receive discounts on their own policy premiums and bonuses. We may also offer incentive trips or prizes associated with sales contests based on sales criteria. Types of sales criteria include overall sales volume of an agent or intermediary with our companies or percentage of completed sales.

Intermediaries may also pay compensation directly to the licensed agent. If the licensed insurance agent can sell insurance policies from other insurance carriers, those carriers may pay compensation that differs from ours.

Section 9. Applicant agreement

This agreement is to acknowledge that I am applying for an insurance policy from Accendo Insurance Company that will be issued based on my answers to the questions on this application and information obtained by the company as described below. I have read, or had read to me, and understand all statements and answers and acknowledge that to the best of my knowledge and belief, they are all accurate, complete and correctly documented. I understand that I will receive a copy of the signed application.

I understand and agree that this application and any policy issued will be the entire contract of insurance. The company will not be bound by any statements, promises, or information made or given by any agent or other person at any time unless it is in writing, submitted to the company's administrative office, and made a part of the contract of insurance. An officer of the company is the only one who can make, modify or discharge contracts or waive any of the company's rights or requirements. Any modifications must be documented in writing.

I also understand that, unless otherwise specified in the Conditional Receipt, I do not have coverage until this application is approved, the first full modal premium is paid, there has been no change in my health as stated in the application, and a policy has been issued by the company and coverage has become effective.

I understand and agree that, if I choose to pay my premium by electronic funds transfer (EFT) from my checking or savings account, I am accepting the terms and conditions of the EFT authorization attached to this application.

I understand and agree that information regarding my

insurability will be treated as confidential. Accendo Insurance Company or its reinsurers may, however, make a brief report of my protected health information to MIB, Inc., a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. I understand and agree that if I 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 in its file.

Upon receipt of a request from me, MIB will arrange disclosure of any information it may have in my file. I may contact MIB at 866-692-6901. If I question the accuracy of information in MIB's file, I 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, MA 02184- 8734. Information for consumers about MIB may be obtained on its website at www.mib.com.

I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, consumer reporting agency, pharmacy, pharmacy benefit manager, MIB, Inc. ("MIB") or other organization, institution or person, that has any records or knowledge of me or my health, to give to Accendo Insurance Company, or its reinsurers, any such information.

A photographic copy of this authorization shall be as valid as the original.

Applicant signature

X

Date signed

.

Owner signature* (if not proposed insured)

Date signed

X

.

Owner Social Security Number

Signed in (city and state)

.

.

*If owner or payor is different than proposed insured, indicate name, address and relationship to proposed insured in Remarks (section 7).

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.

Section 10. Bank account information

Complete this section **if you are requesting electronic funds transfer (EFT)** for premium payment.
Include a voided check with the application.

Account owner name (if different than proposed insured's)

Account owner relationship to proposed insured

- Family member; please specify: _____
- Living trust Employer Power of Attorney Conservator/guardian Business owned by proposed insured

Financial institution name

Account type

- Checking Savings

Routing number

Account number

--	--	--	--	--	--	--	--	--	--

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Section 11. Electronic funds transfer (EFT) authorization

I understand and accept these terms and conditions:

- We are authorized to withdraw funds periodically from your account to pay insurance premiums for the insured.
- If your financial institution does not honor an EFT request, we will NOT consider your premium paid.
- If your financial institution does not honor an EFT request, we may make a second attempt within five business days.
- We have the right to end EFT payments at any time and bill you directly either quarterly or less frequently for premiums due.

- Information as to each EFT charge will be provided by entry on your account statement or by any other means provided by your financial institution. You will not receive premium notices from us.
- If you want to cancel or change this authorization, you must contact us at least three business days before a scheduled withdrawal.
- Any refund of unearned premium will be made to the policy owner or the policy owner's estate.

Signature only required if the account owner is different than the proposed insured.

Account owner signature

Date signed

X

.

Section 12. Agent information

I certify that:

1. The insurance being applied for is suitable for the owner's insurance needs.
2. I have explained to the applicant the premium mode options.
3. I have provided all required forms on or before the date the application was taken.
4. I have accurately recorded the information supplied by the applicant.

Number 4 is applicable only if agent has personally recorded the information on the application.

Does the proposed insured have any existing life insurance or annuity contracts? Yes No

Will the policy applied for be a replacement or change existing life insurance or an annuity? Yes No

If the answer to either question is "yes", have you complied with the requirements of the company and your state regarding this replacement? Yes No

All information must be completed. The writing number reflects where commissions will be paid.

Agent name *(printed)*

Writing number *(agent or company)*

•

•

Agent signature

X

Phone

Email

•

•

Section 13. Agent request to split commissions

If this application results in an issued policy through Accendo Insurance Company (ACC), the agents listed below have agreed to split the commissions earned on the policy.

- Both agents must be properly licensed and appointed with ACC in the policy's state of issue.
- Split commissions are calculated as a percentage of commissionable premium and will apply while the policy remains in force.
- The percentage of the premium split can be for any amount but must be stated in whole numbers and total 100%. (For example, the percentage for the premium split can be from 1% to 99% but cannot be 0% or 100%.)
- Calculation of each agent's commissions are based on their respective ACC commission schedule.

Writing agent name *(printed)*

Percentage

•

• %

Writing agent signature

X

Secondary agent

Writing number

Percentage

•

•

• %

This section must be completed with this application in order to split commissions. By signing this form, the writing agent agrees to split his/her commission with the secondary agent as indicated above.

Application for Individual Children's Term Insurance Rider

from Accendo Insurance Company part of the CVS Health® family of companies and Aetna affiliate

- Print clearly using blue or black ink.
- Mail application and check in the provided business reply envelope to **P.O. Box 14399, Lexington, KY 40512.**
- Coverage amount selected will be the same for all covered children.
- You can apply for coverage on a maximum of 9 children as defined below. Attach a second application to list more than 5 proposed insured children.
- Coverage amount may not exceed the face amount of the base policy.

Primary Insured's name _____ **Policy number (if known)** _____ **Amount of coverage per child**
.
.
 \$2,500 \$5,000 \$7,500 \$10,000

1. Children proposed for insurance

Name natural born children, stepchildren, legally adopted children, grandchildren, legally adopted grandchildren, great grandchildren, proposed for insurance. Insurance will not be provided for newborns less than 30 days of age, children greater than 17 years of age, or children that are not US citizens.

Proposed Insured's name _____ **Social Security Number** _____ **Birth date** _____ **Age last birthday** _____ **U.S. citizen**
.
.
 Yes No

Proposed Insured's name _____ **Social Security Number** _____ **Birth date** _____ **Age last birthday** _____ **U.S. citizen**
.
.
 Yes No

Proposed Insured's name _____ **Social Security Number** _____ **Birth date** _____ **Age last birthday** _____ **U.S. citizen**
.
.
 Yes No

Proposed Insured's name _____ **Social Security Number** _____ **Birth date** _____ **Age last birthday** _____ **U.S. citizen**
.
.
 Yes No

Proposed Insured's name _____ **Social Security Number** _____ **Birth date** _____ **Age last birthday** _____ **U.S. citizen**
.
.
 Yes No

2. Beneficiary

If a trust, give Trustee name, Trust name and Trust date. If no beneficiary is named for any child, the beneficiary designation defaults to the Insured of the base policy. Attach a separate sheet if necessary.

Primary beneficiary name (first, M.I., last) _____ **Phone** _____ **Share** _____
.
.
%

Address _____ **Social Security Number** _____
.
.

Primary beneficiary name (first, M.I., last) _____ **Phone** _____ **Share** _____
.
.
%

Address _____ **Social Security Number** _____
.
.

Percent share must total 100%.

Contingent beneficiary name (first, M.I., last) _____ **Phone** _____ **Share** _____
.
.
%

Address _____ **Social Security Number** _____
.
.

Contingent beneficiary name (first, M.I., last) _____ **Phone** _____ **Share** _____
.
.
%

Address _____ **Social Security Number** _____
.
.

3. Health history

If any of these questions are answered "yes" that child will be excluded from coverage.

1. Is any Proposed Insured child currently institutionalized or in a care facility? Yes No

2. Has any Proposed Insured child ever been diagnosed or been treated by a member of the medical profession for: cancer, diabetes, heart or circulatory disorder, mental or nervous disorder, mental retardation, cerebral palsy, muscular dystrophy, spina bifida, cystic fibrosis, un-operated heart defects, epilepsy, asthma, disorders of the muscles or bones, anemia or other disorders of the blood, bladder, kidneys, liver or lungs, or been recommended for an organ transplant? Yes No

3. Has any Proposed Insured child ever been diagnosed by a member of the medical profession or tested positive for an Immune Deficiency Disorder, Human Immunodeficiency Virus (AIDS virus), AIDS Related Complex (ARC), or Acquired Immune Deficiency Syndrome (AIDS)? Yes No

4. Has any Proposed Insured child ever used or received treatment, advice or counseling from a physician or other practitioner relating to the usage of alcohol, heroin, cocaine, narcotics, hallucinogens, tranquilizers, barbiturates, amphetamines, or other similar drugs except as prescribed by a physician? Yes No

List the children for which "yes" answers were given.

.....
.....

4. Acknowledgement

I declare and represent that the foregoing statements and answers have been correctly recorded and that they are full, complete and true to the best of my knowledge and belief and shall constitute a part of the application.

Primary Insured signature	City and state where signed	Date
X	.	.

.....

Agent signature	Writing number	Date
X	.	.

.....

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.

DISCLOSURE STATEMENT FOR ACCELERATED BENEFITS RIDER

Accendo Insurance Company part of the CVS Health® family of companies and Aetna affiliate
1021 Reams Fleming Boulevard, Franklin, TN 37064

(Note: this disclosure only applies where the base policy has a face value of \$5000 or greater, in which case the Accelerated Benefits Rider is provided free of any additional premium charge.)

1. What is an accelerated benefit? An accelerated benefit is a portion of the death benefit paid because the insured is diagnosed as being terminally ill which results in the insured having a life expectancy of twelve months or less.
2. What payment options are available? Up to a maximum of 50% of the face amount if the insured is diagnosed with a terminal illness which results in the insured having a life expectancy of twelve months or less. The minimum benefit that may be requested is \$1,000. The maximum benefit that may be requested is \$15,000. This amount will be paid as a lump sum. The company may apply a portion of the accelerated death benefit to repay an outstanding policy loan but only up to the amount of the outstanding policy loan multiplied by the percentage of the policy death benefit that has been accelerated. There is an administrative fee of up to \$200 to use this benefit.
3. What is the premium for the Accelerated Benefits Rider? No additional premium is charged for an Accelerated Benefits Rider. Policy premiums are still due after taking the accelerated benefit.
4. How will taking an accelerated benefit affect my policy? The cash value, premium, and death benefits will be reduced by the same percentage as the accelerated benefit is to the face amount of the policy. An example is as follows:

Values prior to acceleration	50% acceleration calculation	After receiving 50% acceleration
Face amount.....\$10,000	1. Face amount = \$10,000	Net face amount.....\$5,000
Premium.....\$400	2. Maximum benefit available: 50% of face amount = \$5,000	Premium.....\$200
Cash value.....\$1,000	3. Minus 50% of outstanding loan: \$5,000 – 100 = \$4,900	Cash value.....\$500
Loan balance.....\$200	4. Minus administration fee: \$4,900 - \$200 = \$4,700 (accelerated benefit amount paid)	Loan balance.....\$100

The net face amount remaining at the insured's death will be paid to the named beneficiary at the insured's death if the policy is in force at that time. Upon a request to accelerate the policy death benefits and upon the payment of the accelerated death benefit, specific information about the effect of an accelerated benefit on policy values, death benefit, premium and loans will be provided to the policyowner and any irrevocable beneficiary. An amended policy schedule page will then be provided to the policyowner to reflect changes in death benefit and policy values as a result of any accelerated benefit payment.

5. Are there any limitations on the use of the accelerated benefit proceeds? There are no restrictions or limitations, except such proceeds may be subject to child support liens.
6. Are the accelerated benefit proceeds taxable? Benefits under this rider are intended to qualify for favorable tax treatment. However, there are circumstances under which these benefits may be taxable. You should consult a personal tax advisor. Receipt of accelerated benefit proceeds may adversely affect the recipient's eligibility for Medicaid or other governmental benefits or entitlements. The accelerated benefit proceeds do not and are not intended to qualify as long-term care insurance.
7. Is the exercise of the rider voluntary? You are not required to exercise the Accelerated Benefit and have the right to waive this benefit.

Applicant signature

Date

Owner signature (if not proposed insured)

Date

Agent signature

Date

Conditional receipt

from **Accendo Insurance Company** part of the CVS Health® family of companies and Aetna affiliate

No coverage will become effective prior to policy delivery unless and until all conditions of the receipt are met. No agent has the authority to alter the terms or conditions of this agreement.

All premium checks must be made payable to Accendo Insurance Company. **DO NOT** make any check payable to the agent and **DO NOT** leave the payee blank on the check.

Received from the sum of \$
by check or preauthorized electronic funds transfer (EFT) as first payment on this application.

Agent name	Date
.....

- If:**
- (1) an amount equal to the first full premium is submitted; and
 - (2) all representations made in the application are true and complete in all material respects; and
 - (3) the proposed insured is, on the date of application, a risk acceptable for insurance exactly as applied for without modification of plan, premium rate, or amount under Accendo Insurance Company's rules and practices,

then insurance under the policy applied for shall become effective on the latest of:

- (1) the date of application, or
- (2) the effective date requested in the application.

The amount of life insurance, including any amount in force or being applied for, which may become effective prior to the delivery of the policy shall in no event exceed \$25,000.00. No amount shall be paid under the Accidental Death Benefit Rider or other rider.

If any of the above conditions are not met, the liability of Accendo Insurance Company shall be limited to the return of any amount paid.

Proposed Insured's name	Proposed Insured signature	
.....	X	
Initial payment collected	City and state where signed	Date
\$
Proposed Owner signature (if not proposed insured)		
X		
Agent signature	Agent number	
X	



NOTICE REGARDING REPLACEMENT OF YOUR LIFE INSURANCE POLICY

Accendo Insurance Company

part of the CVS Health® family of companies and Aetna affiliate
P.O. Box 14399 Lexington, KY 40512 • 800-264-4000

Are you thinking about buying a new life insurance policy and discontinuing or changing an existing one? If you are, your decision could be a good one – or a mistake. You will not know for sure unless you make a careful comparison of your existing benefits and the proposed benefits.

EXISTING INSURANCE WHICH MAY BE REPLACED OR CHANGED

Full name of insurance company including home office location	Policy/contract number*	Insured
_____	_____	_____
_____	_____	_____
_____	_____	_____

*If no number has been assigned by the existing insurer, indicate alternative identification, such as an application or receipt number.

Make sure you understand the facts. You should ask the company or agent that sold you your existing policy to give you information about it. You are urged not to take action to terminate, assign or alter your existing life insurance coverage until you have been issued the new policy, examined it and have found it acceptable.

Hear both sides before you decide. This way you can be sure you are making a decision that is in your best interest.

IF YOU SHOULD FAIL TO QUALIFY FOR THE LIFE INSURANCE FOR WHICH YOU HAVE APPLIED, YOU MAY FIND YOURSELF UNABLE TO PURCHASE OTHER LIFE INSURANCE OR ABLE TO PURCHASE IT ONLY AT **SUBSTANTIALLY HIGHER RATES**.

We are required by law to notify your existing company that you may be replacing their policy.

_____	_____	_____	_____
Applicant's signature	Date	Agent's signature (if any)	Date

_____	_____
Applicant's name (printed)	Agent's name (printed) and license number

_____	_____
Address	Address

_____	_____
City, state, zip code	City, state, zip code

_____	_____
Telephone number	Telephone number

PRODUCER STATEMENT

Accendo Insurance Company

part of the CVS Health® family of companies and Aetna affiliate
P.O. Box 14399 Lexington, KY 40512 • 800-264-4000

In connection with a Replacement of Insurance Transaction:
I certify that:

- I have used only Accendo Insurance Company approved sales material
- I have left all sales materials and the Replacement Notice with the applicant, and
- This sale conforms with the company's replacement policy.

The form number(s) of the sales materials left with the applicant are noted below. If no sales materials were used, state "none".

_____	_____
_____	_____
_____	_____

Date

Producer's signature

Producer's name

Replacement policy

We believe that the replacement of an existing life insurance policy must be appropriate for the customer and must meet his or her needs or financial objectives. From a customer's perspective, an appropriate replacement is one that is justified from either an economic or personal standpoint. The costs, provisions, features and benefits of both the current and proposed policy should be considered in relation to the customer's needs, circumstances and goals.

Some examples of the types of provisions that should be considered are premium rate differences and differences in suicide and incontestability provisions. In addition, factors such as the age and health of the customer must be considered. Producers are expected to provide all material information that the customer needs in order to ascertain whether replacement of an existing policy or contract is appropriate.

All replacements must be in compliance with applicable regulations and company rules. Many states require accurate written comparisons of existing and proposed contracts be provided to the customer when proposing a replacement. Producers are expected to know and comply with these requirements.

Health information authorization

from **Accendo Insurance Company** part of the CVS Health® family of companies and Aetna affiliate

- This is a HIPAA required authorization.
- Please read these statements carefully. Print clearly using blue or black ink.
- Applicant / insured should keep a copy for their records.
- Applicant / insured must submit a completed, signed copy to the home office.
- Policy administered by Aetna Life Insurance Company and its affiliates

Applicant / insured declarations

I authorize the use and disclosure of health information about me as described below.

Health Information to be Used or Disclosed:

I understand this authorization applies to information about my past, present or future physical or mental health or condition and may include facts about my other insurance coverage, hazardous activities, finances, vocation, and other personal traits. This information may come from my medical records including, but not limited to, my prescription history, diagnoses and treatment for illnesses, medical conditions, mental illness, substance abuse and tobacco use, but excluding psychotherapy notes and information about previously administered tests for t-cell counts, HIV antibodies, AIDS or ARC.

Who May Request or Use Information: This information may be disclosed to and used and or disclosed by: Aetna and the members of its Affiliated Covered Entity ("Aetna ACE"). An Affiliated Covered Entity is a group of Covered Entities under common ownership or control that designates itself as a single entity for purposes of compliance with the Health Insurance Portability and Accountability Act ("HIPAA"). The members of the Aetna ACE will share Protected Health Information ("PHI") with each other for the treatment, payment and health care operations of the Aetna ACE and as permitted by HIPAA and this authorization; Aetna ACE's insurance support organizations and reinsurers; providers, treatment facilities, insurers, pharmacies, pharmacy benefit managers and consumer reporting agencies.

Who is Authorized to Disclose Information: All of the following persons or entities are authorized to disclose health information or records about me: care providers or evaluators, physicians, chiropractors, physical therapists, psychologists, mental health and substance abuse counselors and other health professionals; treatment facilities including hospitals, clinics, substance abuse treatment or consultation facilities, nursing homes, mental health facilities, ambulatory care centers and other medical or medically related facilities, reinsurers, other insurance companies and consumer reporting agencies.

Purpose: This health information may be used or disclosed to: evaluate and underwrite my insurance application; determine premium amounts, adjudicate claims and to support the operations of Aetna's life and health insurance plans.

Statements of Understanding: I understand that: (1) I will receive a copy of this Authorization and that a copy of it is as valid as the original; (2) this Authorization is valid for 24 months from the date signed; (3) if I do not sign this Authorization or I revoke it by writing to Aetna at its administrative office, my application may be declined; (4) if I revoke this Authorization, my revocation is not effective for any information that might have been used or disclosed in reliance on this Authorization; and (5) some of the health information obtained may be disclosed to persons or organizations that are not subject to federal health information privacy laws, resulting in the information no longer being protected under such laws. I further understand that such information may be redisclosed only in accordance with applicable laws or regulations.

Applicant / insured complete this section.

Signature of applicant / insured

Date

X

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Printed name of applicant / insured

X

City

State

Zip

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Policy number of insured (if known)

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Electronic check authorization

from **Accendo Insurance Company** part of the CVS Health® family of companies and Aetna affiliate

• Print clearly using blue or black ink. • P.O. Box 14399 Lexington, KY 40512-9700

1. Usage guidelines

Requirements:

- The faxed check method can only be used for **initial premium** payments when the recurring method of payment will be **electronic funds transfer**. This method cannot be used for a one time direct bill quarterly, semi-annual or annual mode.
- The check must be entirely completed. We will not accept faxed checks with missing information such as: pay to, date, written amount, dollar amount, signature, etc.
- The agent will properly destroy the original check once faxed and received at the home office.
- Please submit a copy of the check and this form with your New Business submissions.

2. Authorization

Your agent will submit your application for insurance and your initial payment request to the home office via facsimile (fax).

By signing this form, you authorize Accendo to initiate an electronic funds transfer from your bank account according to the terms of the check. This means your check will be converted to an electronic transaction. Your agent will destroy your original check after it is faxed and received at the home office.

I hereby authorize Accendo to draw an electronic funds transfer from my checking account to pay for this insurance policy. **Future premiums for this insurance policy will be deducted from this checking account until you notify us to change your billing.**

Please include any applicable policy fees (per applicant). Make check payable to the appropriate underwriting company.

Applicant / account holder signature (as it appears on bank records)

Date

Amount to apply

X

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