JEFFERSON PILOT
FINANCIAL

APPLICATION FOR LIFE INSURANCE

JEFFERSON-PILOT LIFE INSURANCE COMPANY

JEFFERSON PILOT FINANCIAL INSURANCE COMPANY

BJF-01734-32 (2/05)
(TEXAS)

(instr. rev. 3/06)

JEFFERSON PILOT FINANCIAL

Jefferson-Pilot Life Insurance Company, Service Office: PO Box 21008, Greensboro, NC 27420-1008
Jefferson Pilot Financial Insurance Company, Service Office: PO Box 515, Concord, NH 03302-0515

APPLICATION FOR LIFE INSURANCE

GENERAL INSTRUCTIONS FOR COMPLETING THE APPLICATION

Please follow these instructions carefully. If you have any questions, please contact your Marketing Department for assistance before completing this application. Thank you for the opportunity to underwrite your business.

Completing the Application

- If applying for Variable Life Insurance, the Premium Allocation and Disclosure Form for Variable Life must accompany the application.
- **When applying for the JPF Ensemble® EXEC 2006 policy and completing the question applicable to the deduction of monthly insurance and administrative charges:** Please note that the Long Term Fixed Account may not be designated as the **only** account for the deduction of monthly insurance and administrative charges, **nor** can it be used for these deductions on a pro-rata basis with the General Account and the divisions of the Separate Account. The deduction of monthly insurance and administrative charges will only be deducted from the Long Term Fixed Account if there is insufficient value in the divisions of the Separate Account or the General Account to cover the monthly deduction.
- If applying for an Advantage Platform product, the billing options are: DRAFT/PAC; List Bill - 5 or more insureds; Direct - Annual only.
- Answer all questions on each page, and record each answer in complete detail using black or blue ink.
- While completion of Section X is not required if a full paramedical or medical examination is necessary, answering all medical questions (including the full name, address and phone number for each physician consulted) will enable the underwriter to promptly begin the underwriting process. Please complete Section X if a full paramedical or medical exam is over 90 days old but less than 180 days old.
- **DO NOT USE WHITEOUT.** If you need to change an answer put a line through the mistake and have the change initialed by the Owner. If a health question is changed, draw a line through the mistake and have the change initialed by the Proposed Insured.
- Have the Proposed Insured(s) and Owner read the application to confirm that all questions are answered accurately, sign and date the application.
- The **LICENSED AGENT OR BROKER** must complete and date the **AGENT'S REPORT.**

Authority

No agent, broker, registered representative or medical examiner has the authority to make or modify any Company contract or to waive any of the Company's requirements.

Conditional Receipt

If payment is made with the application, you must give the Owner the Conditional Receipt. Do not accept money orders or cash, only checks payable to the applicable Jefferson Pilot Financial company checked at the top of page 1 are acceptable. If you are submitting applications for alternate policies, the Owner cannot submit payment with the application nor can you give a Conditional Receipt.

- **Payment with Application May Not Be Submitted if:**
  1. The Life insurance applied for plus existing insurance with all Jefferson Pilot Financial affiliated insurance companies exceeds $1,000,000 on any one life including optional benefit riders.
  2. Any Proposed Insured's age is less than 15 days or in excess of 70 years.
  3. Either of the Health Questions at the beginning of the Conditional Receipt is answered YES or LEFT BLANK.
- **If the Payment with Application Rules allow payment to be submitted, please follow these guidelines:**
  1. Submit payment with application only in the form of a currently dated check made payable to the applicable Jefferson Pilot Financial company checked at the top of page 1.
  2. Enter the full amount submitted on page 2, question 47 of the Application for Life Insurance.
  3. Receipt must be signed and dated by the licensed agent, broker or registered representative taking the application along with the Proposed Insured(s) and Owner.
  4. Give Part II of the Receipt to the Owner and submit Part I with the application.
  5. Submit the payment with the application.

JEFFERSON PILOT FINANCIAL

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(hereinafter referred to as "the Company")

APPLICATION FOR LIFE INSURANCE — PART I

I. PROPOSED INSURED

1. Name of Proposed Insured ☐ Male ☐ Female (First, Middle, Last)	2. Date of Birth (mm/dd/yy)	3. Place of Birth (State, Country)	4. Social Security Number 5. Driver License # & State
6. Home Address (Street, City, State, Zip Code)			7. Years At This Address
8. Employer	9. Business Address (Street, City, State, Zip Code)		
10. Occupation/Duties	11. Home Telephone	12. Business Telephone	13. Citizen of (Country)

II. PROPOSED ADDITIONAL INSURED - Complete for Survivorship Life Policy or Term Rider on Spouse/Other Insured for Individual Life Policy.

14. Name of Proposed Insured ☐ Male ☐ Female (First, Middle, Last)	15. Date of Birth (mm/dd/yy)	16. Place of Birth (State, Country)	17. Social Security Number 18. Driver License # & State
19. Home Address (Street, City, State, Zip Code)			20. Years At This Address
21. Employer	22. Business Address (Street, City, State, Zip Code)		
23. Occupation/Duties	24. Home Telephone	25. Business Telephone	26. Citizen of (Country)

III. COVERAGE INFORMATION

27. Plan of Insurance (If Ensemble® , also complete Question 32)	28. Amount of Insurance: $

29. (i) Death Benefit Option ☐ Level ☐ Increasing ☐ Specified Amount plus premiums less withdrawals
(ii) Death Benefit Qualification Test - For IRS purposes, premiums will be tested using the Guideline Premium Test unless ☐ Cash Value Accumulation Test is checked (not available on all products). **Cannot be changed after issue.**

30. Additional Benefits:
☐ Waiver of Premium
☐ Accidental Death Benefit $ _____
☐ Guaranteed Insurability $ _____
☐ Waiver of Specified Premium $_____
☐ Accelerated Benefit Rider
☐ Supplemental Coverage/ Additional Specified Amount Rider $ _____
☐ Term on Spouse/Other Insured Rider $_____
☐ Children's Rider $ _____ / Units _____ (Complete Child's Supplement)
☐ Other _____
☐ Other _____
☐ Other _____

31. Automatic Premium Loan ☐ Yes ☐ No **(This question applies to Whole Life Nonpar products only.)**

32. **Complete only if applying for Variable Life Insurance with Jefferson Pilot Financial Insurance Company. Submit Premium Allocation and Disclosure Form for Variable Universal Life with Application:**
(i) Monthly insurance and administrative charges will be deducted from the General Account and divisions of the Separate Account on a pro rata basis unless the box is checked below (not available on all VUL products):

☐ Deduct all charges from the _____ division (any single division or the General Account may be noted).

(ii) **Suitability**

	Yes	No
1. Have you, the Proposed Insured(s) and the Owner, if other than the Proposed Insured(s), received a current Prospectus dated _____ for the policy applied for and have you had sufficient time to review it?	☐	☐
2. Do you understand that the amount and duration of the death benefit may increase or decrease depending on the investment performance of funds in the Separate Account?	☐	☐
3. Do you understand that the cash values may increase or decrease depending on the investment performance of the funds held in the Separate Account?	☐	☐
4. With this in mind, do you believe that the policy applied for is in accord with your insurance objective and your anticipated financial needs?	☐	☐

CASH VALUES MAY INCREASE OR DECREASE IN ACCORDANCE WITH THE EXPERIENCE OF THE SEPARATE ACCOUNT. THE DEATH BENEFIT MAY BE VARIABLE OR FIXED UNDER SPECIFIED CONDITIONS.

IV. OWNER INFORMATION (Complete if Different from Proposed Insured(s))

33. (i) Owner Name (First, Middle, Last)	(ii) Citizen of (Country)

34. Owner Address

35. Owner Social Security or Tax ID #	36. Relationship to Proposed Insured(s)	37. Trust Date (only if Trust is Owner)

V. BENEFICIARY DESIGNATION

38. Primary Beneficiary(ies):	39. Social Security or Tax ID #:	40. Relationship(s) to Proposed Insured(s):
41. Contingent Beneficiary(ies):	42. Social Security or Tax ID #:	43. Relationship(s) to Proposed Insured(s):

44. Beneficiary for Spouse/Other Insured Term Rider:	46. Relationship to Spouse/Other Insured:
45. Social Security or Tax ID #:	

VI. BILLING INSTRUCTIONS

47. Payment with Application $ Was the Conditional Receipt Given? ☐ Yes ☐ No

48. Planned Premium: $ 49. Lump Sum: $ ☐ 1035 Exchange

50. Premiums to be Paid: ☐ Annually ☐ Semi-Annually ☐ Quarterly ☐ Monthly ☐ List Bill # _____
☐ DRAFT/PAC ☐ PDF (Complete Transmittal) ☐ Other: _____

51. Premium Bill to be Sent to:
☐ Proposed Insured at:
☐ Home Address
☐ Business Address; or
☐ Other ("Care Of" Name and Mailing Address)
☐ Proposed Additional Insured at:
☐ Home Address
☐ Business Address; or
☐ Other ("Care Of" Name and Mailing Address)
☐ Owner at address listed in #34

52. Special Instructions:

Complete each question for the Proposed Insured and any Additional Insured.

VII. PERSONAL FINANCE	Proposed Insured	Additional Insured
53. Annual Earned Income:	a) $	b) $
54. Annual Unearned Income (if none, please indicate $0):	a) $	b) $
55. Total Assets:	a) $	b) $
56. Total Liabilities:	a) $	b) $
57. Net Worth:	a) $	b) $
58. In the last 5 years have you filed for bankruptcy? If "Yes", COMPLETE the Financial Supplement.	a) ☐ Yes ☐ No	b) ☐ Yes ☐ No
VIII. LIFE INSURANCE IN FORCE		
59. Have you ever applied for life, health or disability insurance and been declined, postponed or charged an increased premium?	a) ☐ Yes ☐ No	b) ☐ Yes ☐ No
60. Do you have any applications pending with any other life insurance company now?	a) ☐ Yes ☐ No	b) ☐ Yes ☐ No

If answered "Yes" to question 59-60, please give details here for each Proposed Insured.

Proposed Insured: _____

_____

_____

Additional Insured: _____

_____

_____

61. i.) Are you considering stopping premium payments, surrendering, replacing, forfeiting, assigning to the insurer or reducing your benefits under an existing policy or contract? ☐ Yes ☐ No

ii.) Are you considering using or borrowing funds from your existing policies or contracts to pay premiums due on the new or applied for policy? ☐ Yes ☐ No

If yes to either question, please complete and sign all required replacement forms and complete Question 62.

62. List all insurance in force on any Proposed Insured. **If none, check this box.** ☐

Insured's Name & Company	Face Amount	Policy Number	Issue Year	Replacement or Change of Policy?	Check here if 1035 Exchange
	$			☐ Yes ☐ No	☐
	$			☐ Yes ☐ No	☐
	$			☐ Yes ☐ No	☐
	$			☐ Yes ☐ No	☐

Complete each question for the Proposed Owner, the Proposed Insured (if other than Owner) and any Additional Insured:	Proposed Insured, if other than Owner	Additional Insured	Proposed Owner
63. Have you been involved in any discussion about the possible sale or assignment of this policy to a life settlement, viatical or other secondary market provider?	a) ☐ Yes ☐ No	b) ☐ Yes ☐ No	c) ☐ Yes ☐ No
64. Have you in the past two years sold a policy to a life settlement, viatical or other secondary market provider?	a) ☐ Yes ☐ No	b) ☐ Yes ☐ No	c) ☐ Yes ☐ No

If answered "YES" to any part of question 63 or 64, please give details for each "YES" answer.

_____

_____

_____

_____

_____

_____

IX. GENERAL RISK INFORMATION	Proposed Insured	Additional Insured
65. In the past 3 years, have you smoked a cigarette, cigar or pipe, chewed tobacco or used tobacco or nicotine in any form? If "Yes", last used (form) Month, Year	a) ☐ Yes ☐ No _____ _____	b) ☐ Yes ☐ No _____ _____
66. Do you plan to travel or reside outside the US or Canada within the next 12 months?	a) ☐ Yes ☐ No	b) ☐ Yes ☐ No
67. Are you a member of, or applied to be a member of, or received a notice of required service in, the armed forces, reserves or National Guard? If "Yes", please list: branch of service, rank, duties, mobilization category and current duty station.	a) ☐ Yes ☐ No	b) ☐ Yes ☐ No
68. In the past 3 years, have you engaged in, or in the future do you plan to engage in, flying in non-commercial aircraft; racing of any kind; skin or scuba diving; parachuting or sky diving; hang gliding; mountain, rock or technical climbing? If "Yes", complete Aviation-Avocation Supplement.	a) ☐ Yes ☐ No	b) ☐ Yes ☐ No
69. Have you ever been convicted of a felony or misdemeanor (except for a minor traffic violation)?	a) ☐ Yes ☐ No	b) ☐ Yes ☐ No
70. In the past 5 years, have you been convicted of (i) two or more moving violations, (ii) driving under the influence of alcohol or other drugs, or (iii) had your driver's license suspended or revoked?	a) ☐ Yes ☐ No	b) ☐ Yes ☐ No
71. Have you ever been diagnosed by a medical professional as having human immune deficiency virus (HIV) infection, Acquired Immunodeficiency Syndrome (AIDS), or have you received treatment from a medical professional for AIDS?	a) ☐ Yes ☐ No	b) ☐ Yes ☐ No

If answered "Yes" to questions 65-71, please give details here for each Proposed Insured.

Proposed Insured: _____

_____

_____

_____

Additional Insured: _____

_____

_____

_____

X. MEDICAL INFORMATION

Proposed Insured:

72. Name/address/phone number of your personal physician and/or health care facility? (If none, indicate "None".) _____

_____

a. Date and reason last consulted? _____

b. Treatment or medication prescribed? _____

73. Height _____ ft. _____ in. Weight _____ lbs.

a. Has your weight changed by more than 10 pounds during the past 12 months? ☐ Yes ☐ No

b. If "Yes", by how many pounds? _____ ☐ Gain ☐ Loss

Additional Insured:

74. Name/address/phone number of your personal physician and/or health care facility? (If none, indicate "None".) _____

_____

a. Date and reason last consulted? _____

b. Treatment or medication prescribed? _____

75. Height _____ ft. _____ in. Weight _____ lbs.

a. Has your weight changed by more than 10 pounds during the past 12 months? ☐ Yes ☐ No

b. If "Yes", by how many pounds? _____ ☐ Gain ☐ Loss

Medical Information questions continue on next page.

X. MEDICAL INFORMATION

	Proposed Insured	Additional Insured
76. Have you ever had, or been told by a medical professional to seek treatment because of, any of the following:		
i. Chest pain, high blood pressure, heart attack, heart murmur, disease of the heart or blood vessels?	a) ☐ Yes ☐ No	b) ☐ Yes ☐ No
ii. Cancer, tumor, leukemia, blood disorder, melanoma, or lymphoma?	a) ☐ Yes ☐ No	b) ☐ Yes ☐ No
iii. Diabetes or high blood sugar?	a) ☐ Yes ☐ No	b) ☐ Yes ☐ No
iv. Shortness of breath, asthma, sleep apnea, emphysema, tuberculosis, or other lung disease?	a) ☐ Yes ☐ No	b) ☐ Yes ☐ No
v. Disease of the nervous system, stroke, seizure, paralysis?	a) ☐ Yes ☐ No	b) ☐ Yes ☐ No
vi. Mental or nervous disorder, depression, anxiety?	a) ☐ Yes ☐ No	b) ☐ Yes ☐ No
vii. Hepatitis, cirrhosis, or other disease of the liver or pancreas?	a) ☐ Yes ☐ No	b) ☐ Yes ☐ No
viii. Ulcer, colitis, or other disorder of the stomach or intestines?	a) ☐ Yes ☐ No	b) ☐ Yes ☐ No
ix. Disease or disorder of the kidneys, bladder or prostate, or a sexually transmitted disease?	a) ☐ Yes ☐ No	b) ☐ Yes ☐ No
x. Arthritis, disease or injury of the muscles, bones, or joints?	a) ☐ Yes ☐ No	b) ☐ Yes ☐ No
xi. Any other health impairment, congenital deformity or medically or surgically treated condition not mentioned above?	a) ☐ Yes ☐ No	b) ☐ Yes ☐ No
77. Have you ever used or experimented with cocaine, marijuana, or other non-prescription stimulants, depressants, or narcotics?	a) ☐ Yes ☐ No	b) ☐ Yes ☐ No
78. Have you ever been treated, or advised to receive treatment, for use of alcohol or drugs?	a) ☐ Yes ☐ No	b) ☐ Yes ☐ No
79. In the past 30 days, have you taken any medication or non-prescription drug?	a) ☐ Yes ☐ No	b) ☐ Yes ☐ No
80. Are you now planning to seek medical advice or treatment for any reason?	a) ☐ Yes ☐ No	b) ☐ Yes ☐ No

Proposed Insured:

81. Family Record	Age if Living	Present Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Additional Insured:

82. Family Record	Age if Living	Present Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

If answered "Yes" to questions 73, 75, 76-80, please give complete details including date of last treatment and name/address/phone number of the attending physician.

Proposed Insured: _____

_____

_____

Additional Insured: _____

_____

_____

XI. SERVICE OFFICE ENDORSEMENTS (Attach an additional sheet of paper, if necessary)

AGREEMENT AND ACKNOWLEDGEMENT

I, the Owner, declare that my tax identification or social security number as shown is correct. I also certify that I am not subject to backup withholding.

Each of the Undersigned declares that:

1. This Application consists of: a) Part I Application; b) Part II Medical Application, if required; c) any amendments to the application(s) attached thereto; and d) any supplements, all of which are required by the Company for the plan, amount and benefits applied for.
2. Unless otherwise provided by the Conditional Receipt, the Company will have no liability under this application unless and until: a) it has been received and approved by the Company at its Service Office; b) the policy has been issued and delivered to the policyowner; c) the first premium has been paid to and accepted by the Company; and d) at the time of delivery and payment, the facts concerning the insurability of each person proposed for insurance are as stated in this application.
3. No agent, broker or medical examiner has the authority to make or modify any Company contract or to waive any of the Company's requirements.
4. Corrections, additions or changes to this application may be made by the Company. Any such changes will be shown under "Service Office Endorsements". Acceptance of a policy issued with such changes will constitute acceptance of the changes. No change will be made in classification (including age at issue), plan, amount, or benefits unless agreed to in writing by the Applicant.
5. I ACKNOWLEDGE receipt of the Notices on the Medical Information Bureau and Fair Credit Reporting Act.
6. I HAVE READ, or have had read to me, the completed Application for Life Insurance before signing below. All statements and answers in this application are correctly recorded, and are full, complete and true. I UNDERSTAND that any false statements or material misrepresentations may result in the loss of coverage under the policy.

STATE DISCLOSURE

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, commits insurance fraud, which is a crime and subjects the person to civil and criminal penalties.

TO BE COMPLETED BY AGENT ONLY

(i) Do you know or have you any reason to believe that replacement of insurance is involved? ☐ Yes ☐ No

If a replacement is involved, I certify that only company approved sales materials were used in this sale and that copies of all sales materials were left with the applicant.

(ii) I declare that I asked the Proposed Insured(s) each question on the application. The answers have been recorded by me exactly as stated and I know of nothing affecting the insurability of the Proposed Insured(s) which is not fully recorded in this application.

(iii) I declare that I have accurately answered any questions contained in the Agent's Report completed by me in connection with this application.

(iv) I declare that I have provided each Proposed Insured and Owner with the Notices on the Medical Information Bureau and Fair Credit Reporting Act as well as a copy of the Privacy Practices Notice.

(v) I verified the Owner/Applicant's identity by viewing the individual's photograph on a driver's license, passport or other official document and have transcribed the number of such identification below. If applicant is a business or trust entity, I viewed documentation confirming the entity's legal status and state of formation.

☐ Yes ☐ No Driver's License, Passport or Other ID#: _____

(vi) I declare I have not been involved in any discussion of the possible sale or assignment of the policy to a life settlement, viatical or other secondary market provider. If otherwise, please explain: _____ .

(vii) I have verified that this policy will not replace a policy that has already been sold to a life settlement, viatical or other secondary market provider. If otherwise, please explain: _____ .

AUTHORIZATION

Each of the undersigned declares that:

I authorize any licensed physician, medical practitioner, hospital, clinic or any other medically related facility, insurance support organizations, insurance company, Medical Information Bureau (MIB), state motor vehicle division, or other organization, institution or person that has any records or knowledge of:

Proposed Insured/Patient _____ Date of Birth _____

Proposed Additional Insured/Patient _____ Date of Birth _____

or the proposed insured's health, including but not limited to transaction records, employment records, financial records, and complete medical records (including information regarding insurance, demographics, referral documents and records from other facilities), motor vehicle information, or if other, indicate here: _____
to give all such information to Jefferson-Pilot Life Insurance Company or Jefferson Pilot Financial Insurance Company (the Company), their licensed representatives and/or their reinsurers, MediConnect.net Inc, GiS, or if other, indicate here: _____
_____.

I understand that an authorization for release or disclosure of psychotherapy notes may not be combined with an authorization for release or disclosure of any other information (a separate Authorization Page must be completed for release or disclosure of psychotherapy notes).

I understand that the information obtained may be used by the Company to determine eligibility for insurance, or to administer my coverage. The Company may not give the information to any person or entity except: 1) a reinsurer, or other insurers to whom I have applied or may apply; 2) MIB; or 3) any other person or entity who performs business or legal services in connection with the administration of my insurance coverage. I understand that some of these people or entities may not be covered by federal or state privacy regulations and that the information they receive may be redisclosed, however the Company contractually requires them to protect the information we disclose to them. Information may be disclosed as allowed by law or regulation.

I have received a Privacy Practices Notice which details the method I must use to exercise my right to access, correct, and amend any information gathered about me or my children which relates to this application. I understand that I can provide written revocation of this Authorization to the Company at any time, except: 1) if the Company has taken action in reliance on the Authorization; or 2) the Company is using the Authorization in connection with a contestable claim under my policy.

I understand that if I refuse to sign this authorization to release my complete medical record, the Company may not be able to process my application.

I agree that a copy of this authorization shall be as valid as the original and this authorization shall be valid for 24 months from the date shown below. I may have a copy upon request.

☐ I elect to be interviewed if an Investigative Consumer Report is prepared.

SIGNATORY SECTION

Signed at _____, this _____ day of _____ _____
(state) (month) (year)

_____ _____
Signature of Proposed Insured
(Parent or Guardian if under 14 years of age)

Signature of Proposed Additional Insured (If coverage applied for)

_____
Signature of Owner (If other than Proposed Insured)

_____ _____
Signature of Licensed Agent, Broker or Registered Representative

Name of Licensed Agent, Broker or Registered Representative
(Please Print)

APPLICABLE TO VARIABLE LIFE ONLY

I have reviewed the Application, New Account Form and Premium Allocation and Disclosure Form and find the transaction suitable.

_____ _____
Signature of Registered Principal of Broker/Dealer

Name of Registered Principal of Broker/Dealer (Please Print)

Jefferson Pilot Financial

Please check appropriate underwriting company:
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(hereinafter referred to as "the Company")

CONDITIONAL RECEIPT Part I - Return to the Company Service Office
This page must accompany the completed application.

This Conditional Receipt provides a **limited amount of life insurance coverage,** for a **limited period of time,** subject to the terms of this receipt. This **Conditional Receipt may not be given if the insuring age of any proposed insured is under 15 days or over 70 years of age (nearest birthday).**

You cannot submit payment, nor give this Conditional Receipt, if you are submitting applications for alternate policies.

All checks must be made payable to Insurance Company checked above.
Do not make checks payable to the agent or leave the payee blank.

Name Proposed Insured

_____
(First) (Middle) (Last)

Name Additional Proposed Insured

_____
(First) (Middle) (Last)

Health Questions	**Proposed Insured**	**Additional Insured**
Have you:		
1. Had or been treated for heart disease, stroke or cancer within the past twelve (12) months?	☐ Yes ☐ No	☐ Yes ☐ No
2. Been admitted to a hospital or other medical facility or been advised by a medical practitioner that you need to be hospitalized for any reasons other than for normal pregnancy within the past ninety (90) days?	☐ Yes ☐ No	☐ Yes ☐ No

Unless both questions are answered "No" for both Insureds, payment cannot be submitted and the Conditional Receipt may not be given.

SIGNATORY SECTION

Signed at _____, this _____ day of _____ _____
(state) (month) (year)

I have read the terms of this Conditional Receipt. I understand that the insurance applied for will not be effective unless and until all conditions of this Conditional Receipt are met. I have read and received a copy of Part II of the Conditional Receipt.

_____
Signature of Proposed Insured
(Parent or Guardian if under 14 years of age)

_____
Signature of Proposed Additional Insured

_____
Signature of Owner

_____
Signature of Licensed Agent, Broker or Registered Representative Receiving Check Payable To Company

JEFFERSON PILOT FINANCIAL

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CONDITIONAL RECEIPT Part II

If payment is received, complete this page and leave with applicant.

The company acknowledges receipt of $_____ paid in connection with an Application for

Life Insurance dated _____, on Proposed Insured _____,

Additional Proposed Insured _____.

_____ _____

Signature of Licensed Agent, Broker or Registered Representative Receiving Check Payable To Company — Date

Conditions and Limitations

Amount Limitation - $1,000,000 Total Insurance: The maximum amount of life insurance which may become effective under this Conditional Receipt on any person proposed for insurance shall not exceed $1,000,000 minus all life insurance provided under other Conditional Receipts and in force policies with the Jefferson Pilot Financial affiliated companies listed above. Life insurance includes any benefits for accidental death.

Conditions:

- A minimum payment with application equal to one month premium for the insurance applied for must be made.
- Any check given in payment must be honored when first presented to the bank.
- All medical examinations and tests required by the Company's initial underwriting requirements must be completed and received at its Service Office during the lifetime of the Proposed Insured and prior to the Company's termination of the application, but in any case within 60 days from the completion of Part I of the application.
- If any person proposed for insurance dies by suicide or if the application or this receipt contains any material misrepresentations, then the Company's liability under this receipt is limited to a refund of the premium paid.
- Each person proposed for insurance must be a risk insurable on the beginning date in accordance with the Company's rules, limits and standards for the plan and the amount applied for without modification either as to plan, amount, riders, supplemental agreements and/or the rate of premium paid.

Beginning Date: If all conditions in this receipt have been fulfilled, coverage under the policy applied for, subject to the Amount Limitations may begin on the insurability date, which is the latest of (a) the date of completion of Part I of the application, or (b) the date of completion of all medical examinations, tests and other evidence required by the Company, or (c) the policy date, if any, requested in the application.

Termination Date - 90 Day Maximum: If the conditions have been met and coverage begins, coverage under this receipt will terminate 90 days from the date of this receipt unless prior to that date the insurance policy is issued and accepted.

If insurance is declined or the policy, if any, as issued is not accepted, any premium paid will be returned to the party(ies) that remitted the payment. If the policy is accepted, any premium paid will be credited to the premiums due under such policy.

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IMPORTANT NOTICES

(Please Give A Copy of These Notices to Each Proposed Insured)

Underwriting

Once we receive your application we will begin the underwriting process to determine whether you are eligible for insurance, and, if so, the rate you should pay for that insurance. We may find that we are unable to give you the insurance you have applied for or that we are able to give to you such insurance only on a modified basis or at a premium rate greater than our lowest premium rate. Your application will be our primary source of information; therefore, it must be true, complete and accurate. We may seek information from other sources to help us evaluate the information you give us on your application.

Contestability

We strongly urge you to review the completed application closely for accuracy. A claim may be denied if the application contains false statements or misrepresentations or fails to disclose material facts. In such a case, the policy could be void and coverage could be lost.

Fair Credit Reporting Act

Pursuant to Sec. 606 of the Fair Credit Reporting Act, this notice is to inform you that as a component of our underwriting process of the application for insurance on your life, we may request an investigative consumer report which may include information related to your character, general reputation, personal characteristics and mode of living.

You have a right to request in writing, within a reasonable period of time after receipt of this notice, a complete and accurate disclosure of the nature and scope of the investigation requested and a written summary of your rights under Sec. 609 of the Fair Credit Reporting Act.

The disclosure information from us will be in writing and mailed to you along with the written summary of your rights within five (5) business days after the later of receipt by the Company of your written request or our request for an investigative consumer report.

Medical Information Bureau

Information on your insurability or that of your spouse or minor children will be treated confidentially. We or our reinsurers may make a brief report on it to the Medical Information Bureau, Inc. (MIB). This is a non-profit organization to which a number of life and health insurers belong. It runs an exchange of information for its members. If you, your spouse or any of your minor children apply to other MIB members for life or health insurance, or file a claim with one of them, the MIB, if asked, will give the member the information in its file.

If you ask, the MIB will disclose any information it may have in its files on you, your spouse or minor children. If you think the file is wrong, you may write or telephone and ask that it be changed. Your rights are set forth in the Federal Fair Credit Reporting Act. You can write to the MIB at: Box 105, Essex Station, Boston, Mass. 02112. You can reach MIB by phone toll-free at (866) 692-6901 (TTY [866] 346-3642).

We, or our reinsurers, may also give information in our files to life and health insurers to which you, your spouse or minor children provide authorization in connection with an application for life or health insurance or a filed claim.

JEFFERSON PILOT FINANCIAL

Jefferson-Pilot Life Insurance Company, Service Office: PO Box 21008, Greensboro, NC 27420-1008
Jefferson Pilot Financial Insurance Company, Service Office: PO Box 515, Concord, NH 03302-0515

IMPORTANT NOTICES

(Please Give A Copy of These Notices to Each Proposed Insured)

Underwriting

Once we receive your application we will begin the underwriting process to determine whether you are eligible for insurance, and, if so, the rate you should pay for that insurance. We may find that we are unable to give you the insurance you have applied for or that we are able to give to you such insurance only on a modified basis or at a premium rate greater than our lowest premium rate. Your application will be our primary source of information; therefore, it must be true, complete and accurate. We may seek information from other sources to help us evaluate the information you give us on your application.

Contestability

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JEFFERSON PILOT FINANCIAL

Jefferson-Pilot Life Insurance Company, PO Box 21008, Greensboro, NC 27420-1008
Jefferson Pilot Financial Insurance Company, PO Box 515, Concord, NH 03302-0515
(hereinafter referred to as "the Company")

AGENT'S REPORT Date _____ (Completed Form Must Accompany Application for Life Insurance)

GENERAL INFORMATION

1. (i) Name of Owner/Applicant | (ii) Name of Insured(s)

   (iii) How long and how well have you known the Proposed Insured(s) and Owner?

2. Are you related to the Proposed Insured(s)? ☐ Yes ☐ No If "Yes", Give details:

3. Do the Proposed Insured(s) and Owner read and understand the English Language? ☐ Yes ☐ No If "No", how was the application completed?

4. If LifeComp program was used, have you completed the required paperwork? ☐ Yes ☐ No

5. Answer only if Proposed Insured is under age 15.

   a. Father's Life Insurance: Amount In Force: $ Amount Applied for: $

   b. Mother's Life Insurance: Amount In Force: $ Amount Applied for: $

   c. Are siblings also being insured? ☐ Yes ☐ No If "No", please explain:

BUSINESS FINANCES (Complete only if this is business insurance)

6. Type of business: ☐ Corporation ☐ Partnership ☐ Sole Proprietorship ☐ Other:

7. Proposed Insured is: ☐ Employee ☐ Owner of % of business

8. Total Business Assets: $ | Total Business Liabilities: $ | Total Business Net Worth: $

9. Net Income (Profit) for the past 2 years: Last year $ Previous year $

10. Is application signed by authorized officer or partner other than Proposed Insured? ☐ Yes ☐ No
    If "Yes", please explain:

11. Are applications being submitted on other business associates? ☐ Yes ☐ No

12. What insurance does the business maintain on the lives of each corporate officer/key person/partner and the amount of business insurance on each?

Name	Title	% of Ownership	Amount In Force	Amount Applied For
			$	$
			$	$
			$	$
			$	$

AGENT INFORMATION

13. Agents who participated in this application:

Full Name of Agent entitled to commission:	Agent Number	% Comm. Share	Agent's Phone Number: (include area code)	Agent's Fax Number: (include area code)
		%		
		%		
		%		

14. Primary Agent's E-Mail Address:

15. Identify any special compensation instructions (i.e. trail commission schedule) or ☐ Check here if there is no special commission program: _____