Application for Individual Life Insurance

Pacific Life Insurance Company

Lynchburg Operations | 6750 Mercy Rd., Ste. B, Omaha, NE 68106
P.O. Box 2869, Omaha, NE 68103
(844) 276-5759 • Fax (844) 520-1618 • www.PacificLife.com

PACIFIC LIFE

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BK-10517-10 09/2023

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LICENSED INSURANCE PRODUCER CHECKLIST FOR LIFE INSURANCE PART I

- **Please complete the application properly and ensure that you have satisfied all requirements. Follow the submission instructions provided through your marketing distribution channel. We sincerely appreciate your business.**

This checklist is not part of the application. Please remove this page before submitting the application to the Insurer.

Does your applicant qualify for PL Modified Underwriting?

- Applicant is between ages 18-70 (at nearest birthday) and any risk class including Substandard
- Amount of coverage applied for and in force with Pacific Life is less than or equal to $3,000,000 for term insurance or is less than or equal to $2,000,000 for GUL insurance.
- Applicant had a comprehensive physical and bloodwork with their primary care health provider within the last 12 months

If all three requirements can be met, check "Yes" in Section 3 of the Producer's Report indicating your application meets the pre-screen requirements.

Be sure to…

- Give the *Notice to Proposed Insured and Owner* to the Proposed Insured or Owner before completing the application.
- Ask all questions fully and accurately record all given answers – the application will be part of any policy issued.
- Enter the Proposed Insured's SSN, date of birth, address, and phone numbers.
- Enter each beneficiary's SSN, date of birth, address, and phone numbers – it will help us locate the beneficiary at the time of claim.
- Print in dark ink.
- Obtain all necessary signatures.
- Complete and sign the Licensed Insurance Producer's report, located after the application.
- Promptly schedule any required medical exam. (If the Proposed Insured does not qualify for PL Modified Underwriting)
- Obtain proper identification and sufficient information about the customer and source of funds to ensure that money laundering is not involved in the transaction.
- If you accept payment with the application:
  - Accept payment only in the form of a currently dated check or money order made payable to the selected insurer.
  - Enter the full amount accepted in Section 7e on page 2.
  - If the answer to any of the questions is "Yes," the Proposed Insured is not eligible for temporary coverage, and no *Temporary Insurance Application Agreement* (TIAA) form or premium should be accepted.
  - Explain the terms and conditions of the TIAA to the Owner and Proposed Insured and have them sign it. Point out that the date of the policy will be the TIAA date and premiums will be due from that date.
  - Complete and sign the Licensed Insurance Producer's Statement on the TIAA.
  - Give the Owner the COPY of the TIAA. Keep the ORIGINAL with the application.
  - Promptly send the payment and the Application - Part I, including the ORIGINAL of the TIAA.
- For Term – explain that for premiums not paid on an annual basis at the beginning of a policy year, we adjust the annual premium by a modal factor to compensate for the lost investment earnings, additional administrative costs, and expected early lapses. These modal factors are available and will be provided on request.

Do Not…

- Use pencil or correction fluid.
- Attempt to waive any of our requirements or any information that we request; you do not have the authority to make or modify contracts.
- Promise or imply that we will provide insurance.
- Accept payment in the form of cash/currency or Traveler's checks.
- Accept a check or money order made payable to you or with the payee left blank.
- Accept payment when the amount applied for plus existing insurance with the Insurer exceeds $3,000,000 for term insurance or $2,000,000 for GUL insurance.
- Accept payment if the Proposed Insured's age nearest birthday exceeds 70 years.
- Accept payment if any question on the TIAA is answered "Yes" or left blank.

1035 Exchange Proposal/Quote

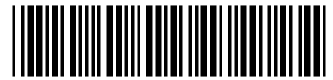
- A wet signed and dated proposal/quote matching the approved policy is required prior to requesting the 1035 Exchange Surrender. This must be wet signed as some carriers do not accept e-signed documents.
- All pages of the proposal/quote must be submitted with the same unique identifier at the bottom of each page.
- Pacific Life may ask the client for premium verification rather than requiring a new wet signed proposal/quote prior to issue and an unsigned proposal/quote may be requested to match the 1035 Exchange funds received.

1035 Exchange Surrenders

- Pacific Life will request the 1035 Exchange Surrender after the policy has been approved and all necessary requirements have been received.
- The 1035 Exchange Form must be wet signed as some carriers do not accept e-signed documents.
- Once the surrender funds have been received, Pacific Life cannot guarantee that the original carrier will take them back in the event the client does not accept the Pacific Life policy. If the client requests the funds to be sent to themselves, Pacific Life will report the amount returned to the IRS after a written letter from the client has been received.

Policy Effective Date

- The policy effective date will be one day prior to the earliest 1035 Exchange fund check date to ensure continuous coverage.
- The policy may be backdated according to our published backdating rules.



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DISCLOSURE & CONSENT TO ELECTRONIC DELIVERY OF DOCUMENTS

Proposed Insured's Name: First MI Last	Date of Birth: (mm/dd/yyyy)
Email Address	Cell Phone/Mobile Number

Proposed Owner's Name (if different than Proposed Insured)	Date of Birth: (mm/dd/yyyy)
Email Address	Cell Phone/Mobile Number

The Producer must present this statement of disclosure and consent to the Applicant(s):

If you consent, Pacific Life Insurance Company (PLIC) will use email and the internet to deliver documents and notices applicable to your life insurance application, or policy contract, including prospectuses, prospectus supplements, reports, statements, confirmations, tax forms, proxy solicitations, privacy notice, and other policy-related correspondence in an electronic format as permitted by law ("Electronic Delivery of Documents"). Your consent is voluntary, PLIC will send paper copies of documents if paper copies are required by state or federal law. Not all policy servicing documentation and notifications may be currently available in electronic format.

By signing below, you understand and expressly, affirmatively, and voluntarily consent to the following:

- You are authorizing PLIC to use Electronic Delivery of Documents for purposes of completing the application process or purchasing insurance from PLIC;
- You are agreeing to set-up a My Life Insurance Account at Life.MyAccount.Pacificlife.com for the purpose of receiving policy servicing documents such as policy statements from PLIC;
- To receive documents electronically from PLIC, you must have a device with ready internet access, an active email account, as well as the ability to read and retain online documents;
- You must provide PLIC current email addresses, current phone numbers, and update PLIC promptly when those changes occur either through online updates at Life.MyAccount.Pacificlife.com or by calling PLIC at (844) 276-5759;
- There is no charge to you from PLIC for the use of paper delivery, or the use of Electronic Delivery of Documents;
- Once you have agreed to receive your documents electronically, PLIC will provide, at no charge to you, one paper copy per year of any document upon your request;
- If PLIC seeks your voluntary consent prior to completion of the application, your voluntary consent must be obtained before the application is completed. However, if you have not consented at the time of the application, then you are still permitted to consent at any time thereafter;
- You are not required to provide consent to PLIC to use Electronic Delivery of Documents as a condition of completing the application process or purchasing insurance, or receiving policy servicing documents from PLIC;
- Signing this agreement is not required as a condition to buy any goods, services or property;
- If emails are returned as undeliverable, we will contact you to obtain an updated email address or we will mail you the undelivered documents; and
- This consent will remain in effect until you revoke it. You may revoke this consent, opt-out of Electronic Delivery of Documents, or request paper copies of information at any time by contacting PLIC at (844) 276-5759. Revoking this consent will not impact your ability to apply for or purchase insurance from PLIC.

Signatures

All signing parties expressly, affirmatively, and voluntarily consent to the use of Electronic Delivery of Documents by PLIC.

Signed and Dated On:

Date (mm/dd/yyyy)

X ______________________________

Proposed Insured Signature

X ______________________________

Proposed Owner Signature, if other than Proposed Insured

Policyowner's Name: First, MI, Last

Producer's Signature

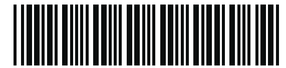
I certify and attest that: (a) the statement above was presented to the Applicant(s); (b) the Applicant(s) expressly, affirmatively, and voluntarily consented to the use to Electronic Delivery of Documents by PLIC.

X ______________________________

Producer Signature

Producer's Name: First, MI, Last

PACIFIC LIFE



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APPLICATION FOR INDIVIDUAL LIFE INSURANCE — PART I

1. Proposed Insured Information

Name: First | Middle | Last

Previously used name(s) (Including maiden name)

Sex ☐ Male ☐ Female	SSN	Date of Birth	State/Country of Birth

Is the Proposed Insured a United States citizen? ☐ Yes ☐ No (If "No," complete the *Resident Alien Supplement* form.)

Home Address: Street | City | State | Zip Code

Mailing Address: Street | City | State | Zip Code

How long at home address?	Driver's License Number/State	Marital Status: Select one: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Email address

Home Phone Number	Cell Phone Number	Alternate Phone Number

Preferred Method of Communication: ☐ Telephone ☐ Text ☐ Email

Occupation (describe duties)

Employer name and address	How long with employer?

2. Policyowner Information (Complete only if Policyowner is someone other than the Proposed Insured. If Trust, give full name of trust and date of trust agreement.)

Policyowner (Full Name)

Relationship to Insured	SSN/TIN	Date of Birth/Trust	State/Country of Birth (If an individual)

Is the Policyowner a United States citizen? ☐ Yes ☐ No (If "No," complete the *Owner Resident Alien Supplement* form.)

Mailing Address: Street | City | State | Zip Code

Email address

Home Phone Number	Cell Phone Number	Alternate Phone Number

Preferred Method of Communication: ☐ Telephone ☐ Text ☐ Email

Policyowner Type: Select One ☐ Individual ☐ Trust ☐ Corporation ☐ Limited Liability Company ☐ Limited Liability Partnership ☐ Charity ☐ General Partnership ☐ Sole Proprietor ☐ Other (Specify):________________

If policyowner above is a business, complete the business information below:

Purpose of Business	State/Country of Incorporation/Formation	Date of Incorporation/Formation

2. Policyowner Information (Continued)(Complete only if Policyowner is someone other than the Proposed Insured. If Trust, give full name of trust and date of trust agreement.)

Contingent Policyowner (Full Name)

Relationship to Insured	SSN/TIN	Date of Birth/Trust	State/Country of Birth (If an individual)

Is the Policyowner a United States citizen? ☐ Yes ☐ No (If "No," complete the *Owner Resident Alien Supplement* form.)

Mailing Address: Street City State Zip Code

Email address

Home Phone Number	Cell Phone Number	Alternate Phone Number

Preferred Method of Communication: ☐ Telephone ☐ Text ☐ Email

Policyowner Type: Select One ☐ Individual ☐ Trust ☐ Corporation ☐ Limited Liability Company ☐ Limited Liability Partnership ☐ Charity ☐ General Partnership ☐ Sole Proprietor ☐ Other (Specify):_________________

If policyowner above is a business, complete the business information below:

Purpose of Business	State/Country of Incorporation/Formation	Date of Incorporation/Formation

3. Beneficiary Information (If percentages are not given, they will be equal. Use section 12 *Remarks* to name additional beneficiaries.)

Primary Beneficiary (Full Name)

Mailing Address: Street City State Zip Code

% Share	Relationship to Proposed Insured	SSN/TIN	Date of Birth/Trust

Email address

Home Phone Number	Cell Phone Number	Alternate Phone Number

Primary Beneficiary (Full Name)

Mailing Address: Street City State Zip Code

% Share	Relationship to Proposed Insured	SSN/TIN	Date of Birth/Trust

Email address

Home Phone Number	Cell Phone Number	Alternate Phone Number

Contingent Beneficiary (Full Name)

Mailing Address: Street City State Zip Code

% Share	Relationship to Proposed Insured	SSN/TIN	Date of Birth/Trust

Email address

Home Phone Number	Cell Phone Number	Alternate Phone Number

Contingent Beneficiary (Full Name)

Mailing Address: Street City State Zip Code

% Share	Relationship to Proposed Insured	SSN/TIN	Date of Birth/Trust

Email address

Home Phone Number	Cell Phone Number	Alternate Phone Number

4. Amount and Plan of Insurance

Plan of insurance	Amount of Insurance $

5. Riders (If available with plan)

☐ Children's Term Insurance ______Units

☐ Waiver of Monthly Premium/Deduction

☐ Accelerated Death Benefit Rider for Chronic Illness

Initial Lifetime Benefit Amount $_________________

Maximum Monthly Percentage, Option: (Select One):

☐ 2% ☐ 4% ☐ Per Diem ☐ Other_______________

6. Death Benefits (Universal Life Only)

☐ Level (specified amount only)

☐ Increasing (specified amount only)

7. Premiums (If Payor is other than the Proposed Insured, payor information is required for electronic policy delivery.)

a. Payment Method: ☐ Electronic Funds Transfer ☐ Direct Bill ☐ Other (Specify):_____________________________

b. Payment Mode: ☐ Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annual

c. Premium Source: ☐ Salary ☐ Investments ☐ Savings ☐ Gifts/Inheritance ☐ Other (Specify):_____________________________

d. Premium Payor: ☐ Insured ☐ Owner ☐ Other (Provide details below if "Other" is selected.)

Payor (Full Name)

Address: Street	City	State	Zip Code

Email address	SSN/TIN	Date of Birth

8. Proposed Insured's Tobacco and Nicotine Use (Additional space for details is available in section 12 ***Remarks***.)

a. When was the last time you used tobacco or nicotine delivery products in any form? (e.g., cigars, cigarettes, vapor products, chewing tobacco, nicotine patches or nicotine gum)

☐ Less than 1 year ☐ 1 or more/less than 2 years ☐ 2 or more/less than 3 years

☐ 3 or more/less than 5 years ☐ 5 or more years ☐ Never

b. If you use cigars, which of the following best describes your cigar use?

☐ More than 1 per month ☐ 1 per month ☐ Less than 1 per month

9. Proposed Insured's Insurance Needs (Complete either the Personal or Business section. Explain "Yes" answers in section 12 ***Remarks***.)

a. **Personal:** ☐ Income Replacement ☐ Debt Repayment ☐ Estate Conservation ☐ Other:_____________________________

1. Personal Finances: $_______________________ $_______________________ $_______________________
   Gross Annual Income / Total Assets / Total Liabilities

	Yes	No
2. Within the past 5 years, have you filed or had filed against you a bankruptcy, collection, judgement and/or lien? .... (If "Yes", select all that apply and provide applicable details.) ☐ Bankruptcy Chapter:________ ☐ Collection ☐ Judgement ☐ Lien	☐	☐
Has the bankruptcy been discharged? .... If "Yes", provide discharged date: ____________ If "No" (the bankruptcy **has not been discharged)**, provide details in Section 12 ***Remarks*** including payment plan.	☐	☐
Has collection/judgement and/or lien been satisfied? .... If "Yes", provide satisfied date: Collection:_____________ Judgement: ____________ Lien: ____________ If "No" (collection/judgement/lien **has not been satisfied),** include amount and party to whom amount is owed in section 12 ***Remarks***.	☐	☐

9. Proposed Insured's Insurance Needs (continued)

(Complete either the Personal or Business section. Explain "Yes" answers in section 12 ***Remarks***.)

b. **Business:** ☐ Buy-Sell ☐ Key Employee ☐ Secure Credit ☐ Other:________________

1. Business Finances: $________________ (Total Assets) $________________ (Total Liabilities) $________________ (Net Worth)
2. What percentage of the business do you own? ______%
3. Your gross annual salary (include bonus) $________________

	Yes	No
4. Is business insurance applied for, or in force on, other key members of the business? (Explain either answer in section 12 ***Remarks***.)	☐	☐
5. Within the past 5 years, has the business filed, or had filed against the business a bankruptcy, collection, judgement and/or lien? (If "Yes", select all that apply and provide applicable details.) ☐ Bankruptcy Chapter:________ ☐ Collection ☐ Judgement ☐ Lien	☐	☐
Has the bankruptcy been discharged? If "Yes", provide discharged date: ____________ If "No" (the bankruptcy **has not been discharged)**, provide details in Section 12 ***Remarks*** including payment plan.	☐	☐
Has collection/judgement and/or lien been satisfied? If "Yes", provide satisfied date: Collection:____________ Judgement:____________ Lien:____________ If "No" (collection/judgement/lien **has not been satisfied),** include amount and party to whom amount is owed in section 12 ***Remarks***.	☐	☐

10. Proposed Insured's Existing Insurance/Replacement (Additional space for details is available in section 12 ***Remarks***.)

	Yes	*No*
a. Do you or anyone else applying for coverage under this policy, such as a child, have existing life insurance or annuities?	☐	☐
b. If "Yes" to question 10.a., will the insurance applied for in this application replace, end or change any existing life insurance or annuities, including any future planned funding or distribution for you or your insured children? *(If "Yes", you may be required to review and sign additional forms.)*	☐	☐

c. If "Yes" to question 10.a., list all existing life insurance policies and annuity contracts. For additional policies/contracts, use section 12 **Remarks.**

Type of Coverage *(Name required if child)*	Name of Beneficiary	Full Company Name	Amount of Insurance	Replacement	
				Yes	*No*
☐ My Policy ☐ Child Coverage________________				☐	☐
☐ My Policy ☐ Child Coverage________________				☐	☐
☐ My Policy ☐ Child Coverage________________				☐	☐
☐ My Policy ☐ Child Coverage________________				☐	☐

11. Proposed Insured's History *(Explain "Yes" answers in section 12* ***Remarks****.)*

	Yes	No
a. Do you have any other application or informal inquiry for life insurance pending in any company or society?	☐	☐
b. Have you ever had an application or reinstatement request for life, long-term care, or disability insurance issued with an exclusion, refused, postponed, limited, rescinded, withdrawn or cancelled, or have you been asked to pay a higher premium?	☐	☐
c. Have you ever been convicted of a misdemeanor or felony, or do you have such charge pending against you? (If "Yes", provide specific details, dates of jail time, if any, and date probation ends or ended in section 12 ***Remarks***.)	☐	☐
d. In the past 5 years, have you ever requested or received a Worker's Compensation, Social Security, or disability income, (excluding pregnancy) related payment?	☐	☐
e. In the past 5 years, has your driver's license been suspended or revoked?	☐	☐
f. In the past 5 years, have you been convicted of, or pled guilty or no contest to, reckless driving or driving under the influence of alcohol or drugs?	☐	☐

11. Proposed Insured's History (continued) *(Explain "Yes" answers in section 12 **Remarks**.)*

Question	Yes	No
g. Other than as a fare paying passenger on a scheduled airline, have you flown in the past 5 years, or do you plan to fly within the next 2 years? (If "Yes," complete *Aviation Supplement*.)........	☐	☐
h. Have you in the past 3 years engaged in, or do you plan within the next 2 years to engage in any of the following: .... (Check all that apply) ☐ Underwater diving ☐Sky sports ☐ Mountain, Rock or Ice Climbing ☐ Motor sport events (e.g. scuba diving, sky diving, base or bungee jumping, paraskiing, parakiting, racing on land or water to include auto, cycle, boat, snowmobile, etc) (If "Yes," complete appropriate activities supplements.)	☐	☐
i. In the next 2 years, do you intend to travel or reside outside of the U.S. for more than 4 consecutive weeks other than for vacation? (If "Yes," complete *Foreign Residence/Travel Supplement*.)	☐	☐

12. Remarks.
(Use this section to provide full details to all "Yes" answers from previous sections. Include question number and section/letter number. If beneficiaries are needed beyond those listed in section 3, provide full details here. Use Application Overflow form if additional space is needed.)

13. Authorization to Obtain Information

I authorize any physician, health care professional, medical practitioner, other health care provider, hospital, clinic, laboratory, pharmacy, medical facility, pharmacy benefit manager, information database manager, other medical or medically related facility, insurance company, health plan, MIB, Inc., consumer reporting agency, state motor vehicle agency, or employer to release to **Pacific Life Insurance Company (PLIC)** its subsidiaries, reinsurers, employees and representatives, any protected health information (PHI) they may have in their possession or under their control as to the diagnosis, treatment, prognosis of any physical or mental condition, human immunodeficiency virus (HIV) infection, sexually transmitted diseases, treatment of mental illness, and the use of tobacco; and any non-medical information, including finances, avocations, occupation, foreign travel, and driving record for me and any children who are to be insured. Although Federal Regulation protects information related to drug or alcohol abuse from disclosure, I give permission to collect this information. I authorize PLIC, or its reinsurers, to make a brief report of my PHI to MIB, Inc. This authorization is not affected or limited by any prior agreements I may have made with any of the above persons or entities to restrict the release of such information, and I instruct them to release and disclose all such information without restriction.

I understand that the reason for releasing such information under this authorization is to determine eligibility for insurance, and that such information will not be released to any person or organization except: a reinsurer, MIB, Inc., business associates, or other persons or organizations performing business or legal services in connection with my application; or as may be otherwise required by law, or as I may further authorize. I understand that I may revoke this authorization at any time by sending a written revocation request to Pacific Life Insurance Company at: P.O. Box 42000, Lynchburg, VA 24506. Such a revocation will not affect any action taken or information released prior to the revocation, and will not affect any legal right PLIC has to contest an insurance policy/certificate, or to contest a claim under an insurance policy/certificate. I understand that if I revoke or refuse to sign this authorization, PLIC may not be able to process my application, and may not be able to make any benefit payments due under any existing policy, certificate, or other binding agreement.

This authorization will be valid for the period of time permitted by applicable law in the state where the policy is delivered or issued for delivery, after the date of my signature below, and a copy of this authorization is as valid as the original. I understand that once any such health-related information is released pursuant to this authorization, that information may be redisclosed and will no longer be covered or protected by the HIPAA rules governing privacy and confidentiality of health information, but such information may be covered or protected from such redisclosure under other federal or state privacy laws.

14. Declarations of All Signing Parties

I understand and agree that:

1. Acceptance of a life insurance policy will be ratification of any administrative change with respect to such policy made by Pacific Life Insurance Company (PLIC) as indicated under the title Endorsement, where permitted by state law. All other changes made to the application or policy by PLIC will be indicated on an Amendment to Application form that must be signed by all applicable parties, prior to or at the time of delivery of this policy.
2. (APPLICABLE ONLY IF THE EMPLOYER OR AN EMPLOYER-CONTROLLED TRUST IS TO BE THE POLICYOWNER OF THIS POLICY) If insurance is being applied for on the life of any non-exempt employee, then I represent such insurance is not prohibited by applicable state law.
3. If I am an active duty member of the United States Armed Forces (including active duty military reserve personnel), I confirm that this application was not solicited and/or signed on a military base or installation, and I have received from the Producer, whose name appears in the Signatures section, the disclosure required by Section 10 of the Military Personnel Financial Services Protection Act.
4. Coverage will only take effect when: a) the policy is delivered and the entire first premium is paid; b) each Proposed Insured is alive at the time of delivery; *and* c) all answers in this application that are material to the basis of any policy issued by PLIC are still true and complete at the time of delivery.
5. Exceptions, if any, to the coverage conditions detailed above will apply as provided by the terms of any Temporary Insurance Application and Agreement (TIAA) or 1035 Exchange Agreement that I may have received in connection with this application.
6. The death benefit will not exceed the TIAA coverage limit if: a) I have given money and received a TIAA in connection with this application; b) the coverage amount of the application exceeds the TIAA coverage limits; *and* c) the Proposed Insured(s) die(s) before a policy is delivered.
7. I must inform PLIC of any changes in the health of any Proposed Insured(s) prior to policy issuance. If any of the statements or answers previously provided on the ticket/request (if applicable), applications, and medical forms change prior to delivery of the policy, I am obligated to notify PLIC of the changes immediately.
8. No Producer is authorized to make or change contracts or insurance policies on the behalf of PLIC and no Producer may alter the terms of this application, the TIAA, 1035 Exchange Agreement, or the policy, nor does the Producer have the authority to waive any of PLIC's rights or requirements.
9. No representation is made that, based on information provided in the application, a particular premium rate, risk category or class will be offered to me. I will review my policy and ask the Producer or PLIC about the specific premium and risk class referenced in my policy.
10. The policy as applied for in this application will meet my insurance needs and financial objectives based in part upon my age, income, net worth, tax and family status, and any existing insurance policies I own.
11. PLIC is not authorized to engage in any activity in non-US jurisdictions, and I will perform all parts of the application, underwriting and delivery associated with this policy in a U.S. jurisdiction.
12. The statements and answers in the application, in addition to any information we are authorized to collect, are the basis for any policy issued by PLIC, and no information about the applicant will be considered to have been given to PLIC unless it is stated in the application or provided to us as part of our underwriting process.
13. I represent that all parties have an insurable interest in the life of the Proposed Insured.

14. Declarations of All Signing Parties (continued)

14. I understand that only the Producer signing this application is responsible for ensuring that the policy meets my insurance needs and financial objectives, regardless of whether a PLIC employee attended any meetings to discuss the policy.
15. This application will be attached to and made part of the policy.
16. I HAVE READ the completed Application and all related forms before signing below. All statements and answers on this application are correctly recorded, and are full, complete and true to the best of my knowledge and belief.

15. Signatures

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.

If you are signing on behalf of an entity, you represent that you are authorized to execute this document and make the statements that may be shown. You further represent that all requirements of those entities, including the use of any seal (in the case of a Corporation) and any authorized signatures (in the case of a Corporation and/or Trust), have been met.

If Proposed Insured or Policyowner is under age 18, a signature of parent/guardian is required in place of the minor's signature.

Date Signed (mm/dd/yyyy)	State in which owner signed application	State in which policy will be delivered

X______________________________
Proposed Insured's Signature

Proposed Insured Name (Print)

X______________________________
Policyowner's Signature

Policyowner Name (Print)

X______________________________
Producer's Signature

Producer Name (Print)

License No.:____________________

Managing Agency/Brokerage No.:________________

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PRODUCER'S REPORT

1. Life Insurance Producers to Receive Commission (Complete for each producer to receive commission.) Total Commission Share(s) to equal 100%, including a Producer Report Overflow page, if applicable. Each producer will share equally unless otherwise indicated.

A. Producer's Name: First	MI	Last		B. Last four of SSN/TIN
C. Address: Street	City	State		Zip
D. Email Address	E. Telephone # (include area code)	F. Commission Share		G. Company Code #

A. Producer's Name: First	MI	Last		B. Last four of SSN/TIN
C. Address: Street	City	State		Zip
D. Email Address	E. Telephone # (include area code)	F. Commission Share		G. Company Code #

2. Managing Agency/Brokerage Report

A. Managing Agency/Brokerage Name	B. Managing Agency/Brokerage #
C. Email Address	D. Date

3. Modified Underwriting Pre-Screen

The Proposed Insured may be eligible for Pacific Life Modified Underwriting without the need for a paramed exam with lab testing. If you and the Proposed Insured believe he/she meets the following criteria, please check "Yes" below indicating your client meets the pre-screen:

- Applicant is age nearest birthday 18-70, any risk class including Substandard
- Amount of coverage is <= $3 million for term insurance or is <=2 million for GUL insurance, pending and inforce with Pacific Life Insurance Company
- Has Attending Physician Statement (APS) with physical and blood work within the last 12 months

☐ **Yes, the applicant qualifies for Pacific Life Modified Underwriting** (If the box is **NOT** selected, you will be required to order the paramed exam with lab testing.)

4. General Information

A. Indicate which language(s) the Proposed Insured speaks and understands.
☐ English ☐ Spanish ☐ Other: Provide Details ____________________

B. If the Proposed Insured is married, provide the amount of insurance on the spouse. $____________________
If the spouse is not insured provide reason:____________________

C. If the Proposed Insured is a minor, provide the amount of insurance on parents and siblings, include sibling's name, below:
Father: $__________ Mother: $__________ Sibling:__________ $__________
Sibling: __________ $__________ Sibling:__________ $__________
If parents and siblings are not insured provide reason:____________________

5. Signature

I represent to the best of my knowledge and belief: (1) the insurance being applied for is suitable for the Owner's insurance needs and financial objectives, and I have discussed the appropriateness of replacement, if any, and followed applicable state laws; (2) the information provided in this report and by the Owner and Proposed Insured in the application is complete, accurate and correctly recorded; (3) there is nothing adversely affecting the insurability of the Proposed Insured other than as indicated in the application. I also represent that I gave all required form(s) on or before the date the application was taken.

X____________________
Producer's Signature

Date (mm/dd/yyyy)

PACIFIC LIFE INSURANCE COMPANY

Lynchburg Operations | 6750 Mercy Rd., Ste. B, Omaha, NE 68106
P.O. Box 2869, Omaha, NE 68103
(844) 276-5759 • Fax (844) 520-1618 • www.PacificLife.com

PRODUCER'S REPORT OVERFLOW

1. Life Insurance Producers to Receive Commission (Complete for each producer to receive commission.) Total Commission Share(s) to equal100%, including Producer listed on Producer Report form. Each producer will share equally unless otherwise indicated.

A. Producer's Name: First	MI	Last	B. Last four of SSN/TIN
C. Address: Street	City	State	Zip
D. Email Address		E. Commission Share	F. Company Code #

A. Producer's Name: First	MI	Last	B. Last four of SSN/TIN
C. Address: Street	City	State	Zip
D. Email Address		E. Commission Share	F. Company Code #

A. Producer's Name: First	MI	Last	B. Last four of SSN/TIN
C. Address: Street	City	State	Zip
D. Email Address		E. Commission Share	F. Company Code #

2. Signature

I represent to the best of my knowledge and belief: (1) the insurance being applied for is suitable for the Owner's insurance needs and financial objectives; (2) the information provided in this report and by the Owner and Proposed Insured in the application is complete, accurate and correctly recorded; (3) there is nothing adversely affecting the insurability of the Proposed Insured other than as indicated in the application. I also represent that I gave all required form(s) on or before the date the application was taken.

X

Producer's Signature

Date (mm/dd/yyyy)

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APPLICATION FOR INDIVIDUAL LIFE INSURANCE - OVERFLOW FORM

Proposed Insured

a. Full Name (First)	(Middle)	(Last)	b. Date of Birth (Mo./Day/Yr.)	c. Social Security Number

Remarks *(Provide explanations and requested information. Identify applicable item number and letter.)*

I represent that the statements and answers given in the application are true, complete and correctly recorded to the best of my knowledge and belief. I agree that: (1) I will notify the Insurer if any statement or answer given in the application changes prior to policy delivery; and (2) **except as provided in the Temporary Insurance Application and Agreement, if any, insurance will not begin unless all persons proposed for insurance are living and insurable as set forth in the application at the time a policy is delivered to the Owner and the first premium is paid.**

Signature of Proposed Insured

Date signed

Signature of Owner (if other than Proposed Insured)

Signature of Licensed Insurance Producer or Examiner

PACIFIC LIFE

PACIFIC LIFE INSURANCE COMPANY

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RIGHT TO NAME A SECONDARY ADDRESSEE TO RECEIVE POLICY NOTIFICATIONS

The law in your state permits you to designate a secondary party to receive duplicate copies of your policy billing correspondence, including a notice of lapse or cancellation due to nonpayment of premium. You may designate this party at time of application, policy delivery or any time the policy is in force by written notice to Pacific Life. In addition, a Secondary Addressee Designation form will be provided at the time of policy delivery. You may revoke your designated secondary party at any time also by written notice to Pacific Life.

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NOTICE TO PROPOSED INSURED AND OWNER

DETACH AND LEAVE WITH PROPOSED INSURED(S)

In this disclosure, "we", "us", "our", and "PLIC" refer to Pacific Life Insurance Company, its affiliates, and its subsidiaries. This brief description of our underwriting process is designed to help you understand how an application for life insurance, which may contain long-term care benefits, is handled, the types and sources of information we may collect about you, the circumstances under which we may disclose that information to others and your right, or that of your authorized representative, to learn the nature and substance of that information upon written request. The purpose of the underwriting process is to make sure you qualify for insurance under our rules, and assuming you do, establish the proper premium charge for that insurance. The goal of the underwriting process is to have the cost of insurance distributed equitably among all policyowners, so that each individual pays his or her fair share. To determine your insurability, we must consider such factors as your medical history, physical condition, occupation, and hazardous avocations. We get this information from various sources.

Application and Medical Records – Your application, including the medical history, is the primary source of information in the evaluation process. In addition, we may ask you to take a physical examination or other special test such as an electrocardiogram. We may also ask for a report from your doctor or hospital, another insurance company, or MIB, Inc. ("MIB", see below). When we do so, we will use the Authorization To Obtain Information that you signed. The purpose of MIB is to protect member companies, their policyowners, and insureds from those who would conceal significant facts relevant to their insurability.

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

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

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

Federal Fair Credit Reporting Act – As part of our underwriting, we may ask that an investigative consumer report be prepared. An independent source known as a consumer reporting agency will prepare the report. The report will typically include information as to your character, general reputation, mode of living and personal characteristics, as well as information obtained from other data sources. ("Mode of living" does not include information related directly or indirectly to your sexual orientation.) The agency may conduct personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted in order to get this information. If you write to us within a reasonable time after you receive this notice, we will tell you whether or not a report was requested. If a report was requested, we will tell you the name, address and telephone number of the agency to whom the request was made. Upon request, the agency will furnish information as to the nature and scope of its investigation. If you would like to inspect and to receive a copy of the report, you may do so by contacting the agency directly.

DISCLOSURE TO OTHERS

Personal information obtained about you during the underwriting process and at other times is confidential and will not be disclosed to other persons or organizations without your written authorization except to the extent necessary for the conduct of our business and only to the extent permitted by applicable state law. Examples of situations where we may share information about you are as follows:

- The Producer may retain a copy of your application, and if a policy is issued will have access to ongoing policy information to better serve your needs.
- If reinsurance is required, the reinsurance company would have access to our application file.
- We may release information to another insurance company to whom you have applied for life, long-term care, or health insurance or to whom you have submitted a claim for benefits, if you have authorized it to obtain such information.
- As stated earlier, we may report information to MIB.
- We will disclose information to government regulatory officials, law enforcement authorities, and others where required by law.

DISCLOSURE TO YOU

In general, you have a right to learn the nature and substance of any personal information about you in our file upon written request. Whenever an adverse underwriting decision is made, we will notify you of the reason(s) for the decision and the source of the information upon which our action is based. Medical record information, however, will normally be given only to a licensed physician of your choice. Please refer to the section on MIB for that organization's disclosure procedure. Should you feel that any information we have is inaccurate or incomplete, please write to: Manager, New Business Services, Pacific Life Insurance Company, P.O. Box 42000, Lynchburg, VA 24506. Your comments will be carefully considered and corrections made where justified. We hope this Notice will help you to understand how we obtain and use personal information in the underwriting process, and the ways you can learn about this information. We are concerned with ensuring privacy as well as lives, and the collection, use, and disclosure of personal information is limited as specified in this Notice.

Our Privacy Promise

- **We do not sell information about you.**
- **We do not share your information with anyone for their marketing purposes.**
- **We only use your personal information to help maintain and grow the relationship you have with us.**

Privacy Notice to All

Whether you are a customer, prospective customer, or have another relationship with Pacific Life, you have entrusted us to safeguard your personal information. We are providing this privacy notice to assist you in understanding the types of personal information we collect, where we receive it, how we use it, and how we protect the privacy of the personal information shared with us.

Where Do We Get Personal Information, Why Do We Collect It, and What Do We Collect?

Most of the personal information we collect is obtained with consent directly from you, from one of our customers, from an organization with whom we do business that has authority to share such information, or through other authorized sources. We primarily collect personal information to confirm your identity and manage your relationship with us. The type of information that we collect depends on our relationship with you. This includes:

- Information you or a person on your behalf provides on an application or other form (for example, name, address, social security number, or income);
- Information we get with your consent from other third-party sources such as credit reporting agencies, information to verify employment or income;
- Information about your relationship and history with us;
- Medical or health information you permit us to receive from doctors or other health care providers;
- Information on your interactions with our websites

Pacific Life will provide you with an updated notice if the types of personal information we collect, or use, is materially different, unrelated, or incompatible with this notice.

How Do We Use and Disclose Your Information?

We use and disclose information to provide you with customer service, to assist with the selection of the products or services we offer, to provide you our products or services, to develop or improve our products or services, for legal or compliance purposes, or as required or permitted by applicable law.

We may share information within our corporate family to service and grow the relationship we have with you. Additionally, we may provide information to individuals and entities with whom you authorize us to share such information. If necessary, we disclose information when it is required by law, for example, a filing to the Internal Revenue Service (such as Form 1099). We may also disclose certain information to other entities to help us report or prevent fraud, including reports to regulatory or law enforcement agencies. We do not share medical or health information among our family of companies or with unrelated companies, except as needed to maintain and process your transactions.

Pacific Life may disclose your personal information to a third party for a business purpose. When we disclose personal information for a business purpose or as you authorize, we require the recipient to keep that personal information confidential and not use it for any purpose except performing the service. Categories of third parties that may be given access to your personal information will depend upon your unique relationship with us. Examples of these categories include:

- Consultants and contractors (e.g., external auditors)
- Financial services professionals
- Software service providers
- Attorneys and other legal professionals
- Cloud service providers
- Regulatory agencies
- Third-party administrators
- Providers of Accommodations
- Providers of Transportation
- Event Facilitators
- Event Coordinators
- Members of Concierge Services

How Do We Protect the Security of Your Information?

We have policies that maintain the physical, electronic, and procedural safeguards to protect the confidentiality of your personal information. Access to your personal information is limited to those who need to know it to help service our relationship with you. Should your relationship with us end, we will continue to follow the privacy policies described in this notice to the extent that we retain information about you. We will store your personal data in accordance with applicable laws or regulatory requirements and retain data for as long as necessary to fulfill those purposes for which the personal data was collected. If we no longer need to retain that information, we will dispose of it in a secure manner.

Do You Need to Do Anything?

It is not necessary for you to take any action. This is because we do not share your information except to service and grow the business relationship you have with us. You do not need to "opt-out" or "opt-in" as you may have done with other financial companies because we do not sell your information.

How Do You Correct Your Information?

If you'd like to correct information that you provided to us, contact the appropriate customer service department as indicated on our **Contact Us** page. Our representative will make the appropriate adjustments to our records. If you wish to correct personal information provided to us by a third party (such as a consumer reporting agency) the representative will provide you with the applicable third-party's contact information.

You May Request Your Information

You may request what information Pacific Life has collected about you and its purpose. We will provide a response once we receive and confirm your request.

All requests must provide sufficient information to allow us to reasonably verify your identity. We require a signed authorization form providing specific personal information that we should have on file for you. To verify your identity, we will compare the information provided to the information we have on file. Your name, address, and relationship with Pacific Life are mandatory data elements and will be used in combination with other information such as your policy/contract/account number, date of birth, social security number and email address. You do not need to create an account to request your information; request forms are available for download on www.pacificlife.com.

You may choose to authorize an agent to make a request on your behalf. In addition to submitting a request form, an agent must also supply one of the following documents:

- Court document showing authority to act on your behalf; or
- Copy of agreement/other document granting them authority to make requests on your behalf. (Subject to additional verification by Pacific Life Insurance Company)

For more information about submitting a request, please use one of the following methods:

- Call us at 877-722-7848, or
- Visit https://www.pacificlife.com/home/privacy-and-other-policies/your-personal-information.html

Confidentiality Practices for Victims of Domestic Violence or Abuse

Pacific Life understands that certain personal information may require special handling. This may be especially true in instances where an individual is, or has been, a victim of domestic violence or abuse. This information may include the individual's address, telephone number, name and place of employment, and other contact or location information.

If you are a Pacific Life applicant, policyowner, insured or beneficiary, who is a victim of domestic violence or other abuse, and would like Pacific Life to take steps to further safeguard your information from others or need to remove a previously submitted request, our Customer Service Representatives are available to assist you.

- For Life Insurance policies that have policy numbers beginning with "2L", please call 844-276-0193 from 9:00AM-8:00PM ET
- For all other Life Insurance policies, please call 800-347-7787 from 5:00AM-5:00PM PT
- For Annuity Contracts, please call 800-722-4448, from 6:00AM-5:00PM PT
- For Pensions or Institutional Clients, please call 800-800-9534 from 5:30AM-2:00PM PT

Pacific Life, as referred to in this notice, means Pacific Life Insurance Company and its affiliates and subsidiaries, including, but not limited to, Pacific Life & Annuity Company, and Pacific Select Distributors, LLC.

Residents of California

The information below supplements Our Privacy Promise and applies to residents of the State of California. The California Consumer Privacy Act of 2018 (CCPA) defines categories of personal information as the following:

<table>
<tr><th colspan="2">Information Categories and Examples</th></tr>
<tr><td><u>Personal Identity, Financial, and Personal Health</u>
• Name
• Alias
• Address
• Signature
• Driver's license
• Email address
• Social Security number
• Medical information
• Health insurance information

<u>Protected Classification Characteristics</u>
• Race
• Ancestry
• Citizenship
• Marital status
• Medical condition
• Physical or mental disability
• Sex (including gender, gender identity)</td><td><u>Commercial Information</u>
• Personal property
• Products or service purchased

<u>Biometric Information</u>
• Genetic characteristics
• Physiological characteristics
• Biological characteristics

<u>Internet or Other Similar Network Activity</u>
• Information on your interaction with our websites

<u>Sensory Data - Audio, Electronic, Visual, Thermal, Olfactory or similar information</u>
• Voice & Video Recordings
• Photographs

<u>Professional or Employment-Related Information</u>
• Current or past job history

<u>Inferences Drawn from Personal Information</u>
• Profile created by analyzing information provided (for example, underwriting analysis)</td></tr>
</table>

Pacific Life obtains the categories of personal information listed above from the following categories of sources:

- Directly from you or someone on your behalf
- Healthcare professional or firm
- Financial service professional or firm
- Publicly available records
- Family member, dependent or beneficiary
- Other third parties (e.g., consumer reporting agency, credit reporting agency, staffing agency, companies that provide services to us)
- Analytical technology (e.g., internet usage, cookies, or automated underwriting technology)

Pacific Life may disclose all categories of personal information as necessary or appropriate with the following categories of third parties:

- Consultants and contractors (e.g., external auditors)
- Financial services professionals
- Software service providers
- Attorneys and other legal professionals
- Cloud service providers
- Regulatory agencies
- Third-party administrators

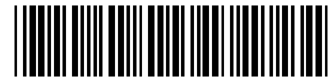
Pacific Life may disclose Personal Identity, Financial, and Personal Health and Protected Classification Characteristics information as necessary or appropriate with the following categories of third parties

- Providers of Accommodations
- Providers of Transportation
- Event Facilitators
- Event Coordinators
- Members of Concierge Services

You may request Pacific Life to delete personal information that we have collected and retained. Once we receive and confirm the request, we will delete (and direct our service providers to delete) your personal information from our records, unless an exception applies. We will not discriminate against you for exercising any of your rights. Please see **You May Request Your Information** section above for more information on how to submit a deletion request.

Please be aware that certain legal and regulatory requirements require us to retain your personal information for a specific period of time which may impact our ability to process your deletion request. If your policy/contract is currently in force, we are unable to process a deletion request as the information is required to service our relationship with you. If your policy/contract is not in force, we must retain the information for a period of time after the termination or application denial date of the policy/contract.

Updated 12/05/2022



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DISCLOSURE & CONSENT TO ELECTRONIC DELIVERY OF DOCUMENTS

Proposed Insured's Name: First MI Last	Date of Birth: (mm/dd/yyyy)
Email Address	Cell Phone/Mobile Number

Proposed Owner's Name (if different than Proposed Insured)	Date of Birth: (mm/dd/yyyy)
Email Address	Cell Phone/Mobile Number

The Producer must present this statement of disclosure and consent to the Applicant(s):

If you consent, Pacific Life Insurance Company (PLIC) will use email and the internet to deliver documents and notices applicable to your life insurance application, or policy contract, including prospectuses, prospectus supplements, reports, statements, confirmations, tax forms, proxy solicitations, privacy notice, and other policy-related correspondence in an electronic format as permitted by law ("Electronic Delivery of Documents"). Your consent is voluntary, PLIC will send paper copies of documents if paper copies are required by state or federal law. Not all policy servicing documentation and notifications may be currently available in electronic format.

By signing below, you understand and expressly, affirmatively, and voluntarily consent to the following:

- You are authorizing PLIC to use Electronic Delivery of Documents for purposes of completing the application process or purchasing insurance from PLIC;
- You are agreeing to set-up a My Life Insurance Account at Life.MyAccount.Pacificlife.com for the purpose of receiving policy servicing documents such as policy statements from PLIC;
- To receive documents electronically from PLIC, you must have a device with ready internet access, an active email account, as well as the ability to read and retain online documents;
- You must provide PLIC current email addresses, current phone numbers, and update PLIC promptly when those changes occur either through online updates at Life.MyAccount.Pacificlife.com or by calling PLIC at (844) 276-5759;
- There is no charge to you from PLIC for the use of paper delivery, or the use of Electronic Delivery of Documents;
- Once you have agreed to receive your documents electronically, PLIC will provide, at no charge to you, one paper copy per year of any document upon your request;
- If PLIC seeks your voluntary consent prior to completion of the application, your voluntary consent must be obtained before the application is completed. However, if you have not consented at the time of the application, then you are still permitted to consent at any time thereafter;
- You are not required to provide consent to PLIC to use Electronic Delivery of Documents as a condition of completing the application process or purchasing insurance, or receiving policy servicing documents from PLIC;
- Signing this agreement is not required as a condition to buy any goods, services or property;
- If emails are returned as undeliverable, we will contact you to obtain an updated email address or we will mail you the undelivered documents; and
- This consent will remain in effect until you revoke it. You may revoke this consent, opt-out of Electronic Delivery of Documents, or request paper copies of information at any time by contacting PLIC at (844) 276-5759. Revoking this consent will not impact your ability to apply for or purchase insurance from PLIC.

Signatures

All signing parties expressly, affirmatively, and voluntarily consent to the use of Electronic Delivery of Documents by PLIC.

Signed and Dated On:

Date (mm/dd/yyyy)

X ______________________________

Proposed Insured Signature

X ______________________________

Proposed Owner Signature, if other than Proposed Insured

Policyowner's Name: First, MI, Last

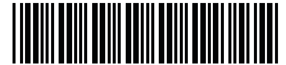
Producer's Signature

I certify and attest that: (a) the statement above was presented to the Applicant(s); (b) the Applicant(s) expressly, affirmatively, and voluntarily consented to the use to Electronic Delivery of Documents by PLIC.

X ______________________________

Producer Signature

Producer's Name: First, MI, Last



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NOTICE AND CONSENT FOR HIV-RELATED TESTING

To evaluate your insurability, the Insurer indicated on this form (the Insurer) has requested that you provide a sample of your blood, oral fluid extracted from cheek and gum tissue, or urine for testing and analysis to determine the presence of human immunodeficiency virus (HIV) antibodies. By signing and dating this form you agree that this test may be done and that underwriting decisions will be based on the test result. A series of three tests will be performed by a licensed laboratory through a medically accepted procedure.

Pre-Testing Considerations

Many public health organizations have recommended that before taking an HIV-related test a person seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, prior to being tested.

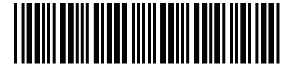
Meaning of Positive Test Result

The test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus. A positive test result does not mean that you have AIDS but that you are at significantly increased risk of developing problems with your immune system. The test for HIV antibodies is very sensitive Errors are rare, but they do occur. Your private physician, a public health clinic, or an AIDS information organization in your city might provide you with further information on the medical implications of a positive test.

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

Confidentiality of Test Results

All test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed as required by law or may be disclosed to employees of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer or to outside legal counsel who needs such information to effectively represent the Insurer in regard to your application. The results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover results of tests for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular person.



Notification of Test Results

If your test results are negative, no routine notification will be sent to you. If your test results are reported by the laboratory to the Insurer as being positive, you will receive written notification of such results from a physician you have designated or, in the absence of such designation, from the Texas Department of Health. Because a trained person should deliver that information so that you can understand clearly what the test result means, please list your private physician so that the Insurer can have him or her tell you the test result and explain its meaning.

Name of physician for reporting a possible positive test result:____

Address:____

In the event the test is positive and you are denied coverage because of that fact and you request the reason for the denial, the Insurer may require you to name a physician at that time in order to receive the information.

If the test indicates a positive result, but you do not designate a private physician, the test results will be provided to you by a representative of the Texas Department of Health.

Consent

I have read and I understand this Notice and Consent for HIV-Related Testing. I voluntarily consent to the collection of a sample of blood, oral fluid extracted from cheek and gum tissue, or urine from me, the testing of that sample, and the disclosure of the test results as described above. I have read the information on this form about what a test result means.

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

______________________________________ ____

Name of Proposed Insured Signature of Proposed Insured or Parent/ Guardian

____ ________________________________

Address Date Signed

Life Insurance

Buyer's Guide

Life Insurance *Buyer's Guide*

Prepared by the National Association of Insurance Commissioners

The National Association of Insurance Commissioners is an association of state insurance regulatory officials. This association helps the various insurance departments to coordinate insurance laws for the benefit of all consumers.

This guide does not endorse any company or policy

© 2018 National Association of Insurance Commissioners

Before You Buy Life Insurance

Understand What Life Insurance Is

Life insurance pays a death benefit if you die while the policy is in effect, in exchange for premiums you pay before your death. You can use the death benefit to protect against financial hardships such as loss of your income, funeral expenses, medical or nursing care expenses, debt repayments, and child care costs after your death. You can get information from the NAIC InsureU Life Insurance website -- *www.insureuonline.org/insureu_type_life.htm*

If You Need Life Insurance, Decide How Much Coverage to Buy

How much life insurance to buy depends on the financial needs that will continue after your death. Examples include supporting your family, paying for child(ren)'s education, and paying off a mortgage. Some questions you may want to ask about your own needs include:

- Does anyone depend on me financially?
- How much of the family income do I provide?
- How will my family pay my final expenses and repay debts after my death?
- Do I want to leave money to charity or family?
- If I have life insurance through my employer, is it enough to meet my financial obligations?

The answers to these questions can help you decide how much coverage you need. An insurance agent, financial advisor, or insurance company representative can help you evaluate your insurance needs and give you information about available policies.

If You Already Have Life Insurance, Assess Your Current Life Insurance Policy

It's important to compare your current policy with any new policy you might buy. Keep in mind that you may be able to change your current policy to get benefits you want. Also, know that any changes in your health may impact your ability to get a new policy or the premium you'll pay. Don't cancel your current policy until you get the new one.

Also, while you may have free or low-cost life insurance through your employer, the death benefit usually is less than you need. And if you leave the employer, you may not be able to take this coverage with you.

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Compare the Different Types of Insurance Policies

There are many types of life insurance policies. You should choose a policy with features that fit your individual needs. Some things to consider are:

- ***Term Insurance vs. Cash Value Insurance.*** Term insurance is intended to provide lower-cost coverage for a specific period of time ("a term"). If you want coverage for a longer period of time, such as for your lifetime, cash value insurance may be more cost effective. Most term policies don't build up cash values that you can use in the future.

- ***Renewable Term vs. Non-renewable Term.*** Most term life insurance coverage can be continued ("renewed") at the end of the term, even if your health has changed. If you renew a term policy, the new premiums are higher. Ask what the premiums will be before you renew the policy. Also ask if you'll lose the right to renew the policy at a certain age. A Non-renewable term policy can't be continued. You'll have to apply for a new policy if you still want coverage.

- ***Whole Life vs. Universal Life.*** Whole life and universal life insurance are two types of cash value insurance. A key difference between the two is how you pay for the coverage. You typically pay premiums for whole life insurance according to a set schedule. In a universal life policy, you can choose a flexible premium payment pattern as long as you pay enough to keep your policy in force.

- ***Variable Life vs. Non-variable Life.*** The investments you will choose (such as stock and bond funds) in a variable life policy directly impact your cash value. These policies have the greatest potential to build cash value but also the greatest risk of losing cash value. Non-variable life policies often have guaranteed minimums for some features (interest or cash value, for example) but not all. Non-variable life policies also have less potential to build cash value than variable life policies.

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Be Sure You Can Afford the Premium

Before you buy a life insurance policy, be sure you can pay the premiums. Can you afford the initial premium? If the premium increases later, will you still be able to afford it? The premiums for many life insurance policies are sensitive to changes in the company's investment earnings, claims costs, and other expenses. If those are worse than expected, you may have to pay a much higher premium. Ask what might be the highest premium you'd have to pay to keep your coverage.

Understand the Application Process

You can apply for life insurance through life insurance agents, the mail, and online. In addition to basic information, such as your name, address, employer, job title, and date of birth, you'll be asked for more personal information. Depending on the type of policy, the insurer may require you to see a doctor, answer health-related questions, or have a medical professional come to your home or office to assess your health. Usually a policy that doesn't require detailed health information will cost more and provide less coverage than one that does.

It's important to tell the truth on the application. The insurance company will check your answers so review the application before you sign. If the insurance company discovers false statements on your application after it issues your policy, it could reduce or cancel your coverage.

Choose a Beneficiary

A beneficiary is the person(s) or organization(s) you name to receive your life insurance policy's death benefit. You'll need to know the Social Security or tax identification number for all beneficiaries. Experts advise you not to name a minor child as a beneficiary. Insurance companies won't pay a minor. Instead, consider leaving the money to your estate or trust.

Evaluate the Future of Your Policy

Does your policy have a cash value? In some cash value policies, the values are low in the early years but build later on. In other policies the values build up gradually over the years. Most term policies have no cash value. Ask your insurance agent, financial advisor, or an insurance company representative for an illustration showing future values and benefits.

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After You Buy Life Insurance

Read Your Policy Carefully

After you carefully read your policy, you should be able to answer the following important questions:

- Is your personal information correct?
- Do premiums or policy values vary from year to year?
- What part of the premium or policy value isn't guaranteed?
- How will the timing of money paid and received affect any interest the policy might earn?

Your insurance agent, financial advisor, or an insurance company representative can help you understand anything that isn't clear.

If you're not satisfied with your new policy, you can return it for a full refund within a certain period, usually 10 days after you receive it. The review period usually is stated on the first page of the policy.

Review Your Life Insurance Program Every Few Years

Review your policy with your insurance agent, financial advisor, or an insurance company representative every few years to keep up with changes in your policy and your needs.

- Have the premiums or benefits changed since your policy was issued?
- Do the death benefits still meet your needs?
- Do you need more or less coverage after life events, such as birth, adoption, marriage, job change, death, or divorce?

The insurance company can provide policy statements and illustrations to help with this review. As the policy owner, you can change beneficiaries at no cost. Be sure to review your beneficiaries every few years, especially after major life events that affect your life insurance needs.

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Notes

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(816) 842-3600

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This notice only applies if in the Armed Forces.

IMPORTANT NOTICE FOR ACTIVE DUTY MEMBERS OF THE UNITED STATES ARMED FORCES

In connection with your proposed purchase of a life insurance policy or annuity contract with Pacific Life Insurance Company, you have indicated to your life insurance producer that you are an active duty member of the United States Armed Forces.

Please be aware that subsidized life insurance is available to members of the Armed Forces from the Federal Government under the Service members' Group Life Insurance program (also referred to as "SGLI"), under subchapter III of chapter 19 of title 38, United States Code. Effective July 1, 2008, the premium rate for basic SGLI is $0.065 per $1,000 per month (regardless of age). SGLI may be purchased in $50,000 increments up to a maximum of $400,000. For more information about SGLI, visit http://www.insurance.va.gov.

The proposed life insurance policy or annuity contract that your insurance producer is currently discussing with you is not offered or provided by the Federal Government. The sale of the life insurance policy or annuity contract being offered to you has not been sanctioned, recommended, or encouraged by the Federal Government.

No person has received any referral fee or incentive compensation in connection with the offer or sale of the proposed life insurance policy or annuity contract, unless such person is a licensed insurance producer of the issuing life insurance company.

If you have a complaint you have been unable to resolve with your insurance company, you may contact your state insurance commissioner for the state having primary jurisdiction. Contact information may be obtained on the Web site for the National Association of Insurance Commissioners at http://eapps.naic.org/cis.

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AUTHORIZATION TO COLLECT AND DISCLOSE INFORMATION

This authorization complies with HIPAA.
Original to Insurer

Proposed Insured *Print* ▪

Birthdate *mm/dd/yyyy* ▪

Terms

Information

Facts about the Proposed Insured. It includes the Insured's entire medical record, including facts about mental and physical health; prescription drugs; and facts about communicable diseases such as HIV infection, AIDS, tuberculosis, and sexually transmitted diseases. Information also includes facts about other insurance coverage; hazardous activities; character; finances; vocation; and other personal traits. It does not include facts about sexual orientation. Information does not include a mental health professional's Psychotherapy Notes (actual recorded notes of a counseling session that are separate from the rest of a medical record), but Information does include medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress. For New Jersey and Maine, Information does not include facts about previously administered tests for HIV Antibodies, T-Cell Counts, or AIDS.

Source

Medical Physicians; chiropractors; physical therapists; psychologists; drug, alcohol, or mental health counselors; care providers or evaluators; hospitals; clinics; drug or alcohol treatment or consultation facilities; nursing homes; mental health facilities; ambulatory care centers; the Department of Veterans Affairs; facilities or offices staffed or run by care providers; other medical or medically related facilities; medical prescription drug databases; pharmacy or pharmacy benefit manager; insurers; reinsurers; health plans; MIB; consumer reporting agencies; laboratories; financial sources; employers; the Social Security Administration; neighbors; friends; and relatives.

Insurer Pacific Life Insurance Company

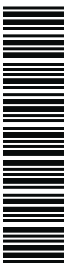
Proposed Insured The Proposed Insured is the person whose life is proposed to be insured.

Authorization The Authorization is this Authorization to Collect and Disclose Information.

MIB MIB is the medical information bureau known as MIB, Inc.

Understanding

1. The following parties may need to collect Information in connection with proposed insurance coverage: the Insurer and its reinsurers; MIB; consumer reporting agencies; and these parties' representatives.
2. These parties may disclose collected Information to the following recipient parties: other insurers to which the Proposed Insured has applied or may apply; reinsurers; MIB; or persons or organizations that perform business, professional, or insurance tasks for them.
3. All parties may disclose Information as allowed or required by law. MIB and consumer reporting agencies may disclose Information only as set forth in an agreement with a member company or organization.
4. Some Information may be disclosed to persons or organizations that are not subject to federal health information privacy laws, which means that the information may no longer be protected under such laws. But even if information is disclosed to persons or organizations that are not subject to federal health information privacy laws, those persons or organizations must comply with all other applicable legal requirements governing the protection and redisclosure of information.
5. The Insurer and its reinsurers will use Information to evaluate the application, obtain reinsurance, administer claims, administer coverage, and conduct other activities that are allowed or required by law and that relate to any insurance coverage or proposed insurance coverage with the Insurer.
6. Failing to sign, changing, or revoking the Authorization will impair processing of the application; as a result, the application may be denied.
7. This Authorization will be valid for twenty-four (24) months after the date signed.
8. The Proposed Insured or person authorized to act on the Proposed Insured's behalf; (a) may revoke this Authorization by sending written notice to the Insurer at P.O. Box 42000, Lynchburg, VA 24506, Attention: Privacy Official, and (b) may ask to receive a copy of this Authorization.



Authorization and Acknowledgement

By signing below, the Proposed Insured or the person authorized to act on the Proposed Insured's behalf: (1) authorizes each Source to give Information when this Authorization is presented; and (2) acknowledges receipt of a copy of the Authorization.

Signature of Proposed Insured or Personal Representative
X

Date *mm/dd/yyyy* ▪

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

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AUTHORIZATION TO COLLECT AND DISCLOSE INFORMATION

This authorization complies with HIPAA.
Copy to Applicant

Proposed Insured *Print* ____________________ Birthdate *mm/dd/yyyy* ____________

Terms

Information

Facts about the Proposed Insured. It includes the Insured's entire medical record, including facts about mental and physical health; prescription drugs; and facts about communicable diseases such as HIV infection, AIDS, tuberculosis, and sexually transmitted diseases. Information also includes facts about other insurance coverage; hazardous activities; character; finances; vocation; and other personal traits. It does not include facts about sexual orientation. Information does not include a mental health professional's Psychotherapy Notes (actual recorded notes of a counseling session that are separate from the rest of a medical record), but Information does include medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress. For New Jersey and Maine, Information does not include facts about previously administered tests for HIV Antibodies, T-Cell Counts, or AIDS.

Source

Medical Physicians; chiropractors; physical therapists; psychologists; drug, alcohol, or mental health counselors; care providers or evaluators; hospitals; clinics; drug or alcohol treatment or consultation facilities; nursing homes; mental health facilities; ambulatory care centers; the Department of Veterans Affairs; facilities or offices staffed or run by care providers; other medical or medically related facilities; medical prescription drug databases; pharmacy or pharmacy benefit manager; insurers; reinsurers; health plans; MIB; consumer reporting agencies; laboratories; financial sources; employers; the Social Security Administration; neighbors; friends; and relatives.

Insurer Pacific Life Insurance Company

Proposed Insured The Proposed Insured is the person whose life is proposed to be insured.

Authorization The Authorization is this Authorization to Collect and Disclose Information.

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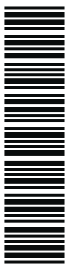
Understanding



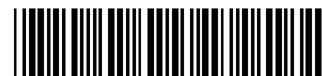
1. The following parties may need to collect Information in connection with proposed insurance coverage: the Insurer and its reinsurers; MIB; consumer reporting agencies; and these parties' representatives.
2. These parties may disclose collected Information to the following recipient parties: other insurers to which the Proposed Insured has applied or may apply; reinsurers; MIB; or persons or organizations that perform business, professional, or insurance tasks for them.
3. All parties may disclose Information as allowed or required by law. MIB and consumer reporting agencies may disclose Information only as set forth in an agreement with a member company or organization.
4. Some Information may be disclosed to persons or organizations that are not subject to federal health information privacy laws, which means that the information may no longer be protected under such laws. But even if information is disclosed to persons or organizations that are not subject to federal health information privacy laws, those persons or organizations must comply with all other applicable legal requirements governing the protection and redisclosure of information.
5. The Insurer and its reinsurers will use Information to evaluate the application, obtain reinsurance, administer claims, administer coverage, and conduct other activities that are allowed or required by law and that relate to any insurance coverage or proposed insurance coverage with the Insurer.
6. Failing to sign, changing, or revoking the Authorization will impair processing of the application; as a result, the application may be denied.
7. This Authorization will be valid for twenty-four (24) months after the date signed.
8. The Proposed Insured or person authorized to act on the Proposed Insured's behalf; (a) may revoke this Authorization by sending written notice to the Insurer at P.O. Box 42000, Lynchburg, VA 24506, Attention: Privacy Official, and (b) may ask to receive a copy of this Authorization.

Authorization and Acknowledgement

By signing below, the Proposed Insured or the person authorized to act on the Proposed Insured's behalf: (1) authorizes each Source to give Information when this Authorization is presented; and (2) acknowledges receipt of a copy of the Authorization.

Signature of Proposed Insured or Personal Representative
X ____________________ Date *mm/dd/yyyy* ____________

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



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IMPORTANT NOTICE: REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

Replacement Information – The Pacific Life Insurance Company listed above is referred to as “we” in this document. The applicant is referred to as “you” and “your.”

This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant.

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases, this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interests. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the last page of this form.

Questions 1 and 2 must be answered. If either answer is “Yes” question 3 must be answered.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? ☐ Yes ☐ No
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ☐ Yes ☐ No
3. The existing policy or contract is being replaced because:

____

If you answered “Yes” to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing.

Insurer’s Name	Contract/Policy #	Insured/Annuitant’s Name	Replaced	Financed Purchase
			☐	☐
			☐	☐
			☐	☐

Make sure you know the facts. Contact your existing company or your producer for information about the old policy or contract. If you request one, an in-force illustration, policy summary, or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the producer in the sales presentation. Be sure that you are making an informed decision.

Signatures

I do not want this notice read aloud to me. _______ (Applicants must initial only if they do not want the notice read aloud.)

I certify that the responses herein are, to the best of my knowledge, accurate:

Signed and Dated on:

Date (mm/dd/yyyy)

X ______________________________

Applicant's Signature

Applicant's Name: First MI Last (print)

I, the producer, certify that: (a) only company-approved sales materials were used in this transaction, they are appropriate for the policy or contract applied for, and copies of all sales materials were left with the applicant; (b) if used, any company-approved electronic sales materials will be printed and provided to the applicant or contract owner prior to or at policy or contract delivery; (c) this sale conforms with the company's replacement policy (set forth below).

I further certify that the responses herein are, to the best of my knowledge, accurate.

X ______________________________

Producer's Signature

Producer's Name: First MI Last (print)

IMPORTANT NOTICE: REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

Life Insurance and Annuities Replacement Model Regulation: A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or producer that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts.

You should discuss the following with your producer to determine whether replacement or financing your purchase makes sense:

Premiums:
Are they affordable? Could they change? You're older - are premiums higher for the proposed new policy?
How long will you have to pay premiums on the new policy? On the old policy?

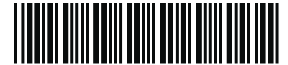
Policy Values:
New policies usually take longer to build cash values and to pay dividends. Acquisition costs for the old policy may have been paid, you will incur costs for the new one. What surrender charges do the policies have? What expense and sales charges will you pay on the new policy? Does the new policy provide more insurance coverage?

Insurability:
If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down. You may need a medical exam for a new policy. Claims on most new policies for up to the first two years can be denied based on inaccurate statements. Suicide limitations may begin anew on the new coverage.

If you are keeping the old policy as well as the new policy:
How are premiums for both policies being paid? How will the premiums on your existing policy be affected?
Will a loan be deducted from death benefits? What values from the old policy are being used to pay premiums?

If you are surrendering an annuity or interest-sensitive life product:
Will you pay surrender charges on your old contract? What are the interest rate guarantees for the new contract?
Have you compared the contract charges or other policy expenses?

Other issues to consider for all transactions:
What are the tax consequences of buying the new policy? Is this a tax-free exchange? (See your tax advisor.)
Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?
Will the existing insurer be willing to modify the old policy? How does the quality and financial stability of the new company compare with your existing company?



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TEMPORARY INDIVIDUAL LIFE INSURANCE APPLICATION AGREEMENT (TIAA)

ORIGINAL – Return with the application and the payment. COPY – Give to the Policyowner only if payment is made at the time the Application – Part I is signed.

1. Notice to Proposed Insured and Policyowner

Payment of the Amount Remitted may only be made at the same time that both the Application - Part I and this TIAA are completed. If the Insurer does not respond to you within 90 days, notify the Insurer at the above address. **Make the Amount Remitted payable to the Insurer. Do not make it payable to the life insurance producer or leave the payee blank. Do not pay cash.**

2. Temporary Insurance Application *Answer all questions*

Temporary insurance cannot begin and you should make no payment if any question is answered "Yes" or left blank.

1. Is the Proposed Insured less than 15 days old or more than 70 years old (age nearest birthday) on the date of this TIAA? ☐ Yes ☐ No
2. Is the Policy applied for a joint life insurance policy? ☐ Yes ☐ No
3. Does the total amount of insurance on the Proposed Insured's life in force with the Insurer under any policies, conditional receipts, or temporary insurance agreements exceed $1,000,000? ☐ Yes ☐ No
4. In the past 90 days, has the Proposed Insured been admitted, or medically advised to be admitted, to a hospital or other licensed health care facility, had surgery performed or recommended, or been medically advised to have any diagnostic test (excluding an AIDS-related test) that was not completed? ☐ Yes ☐ No
5. In the past 5 years, has the Proposed Insured been diagnosed, treated, tested positive for, or been given medical advice by a professional health care provider for, heart disease, stroke, cancer, or alcohol or drug dependence or abuse? ☐ Yes ☐ No
6. Has a medical physician diagnosed the Proposed Insured as having Hepatitis C or Acquired Immunodeficiency Syndrome (AIDS)? ☐ Yes ☐ No
7. In the past year, has the Proposed Insured been convicted of a misdemeanor or felony or have such charge pending? ☐ Yes ☐ No

I represent that: (1) I have read and received a copy of this TIAA and agree to all of its terms and conditions; (2) I understand and agree that temporary insurance will not begin if any question above is answered "Yes" or left blank; (3) the answers given above are true to the best of my knowledge and belief, and I understand that, if they are false, temporary insurance may be denied or declined; (4) I understand that completing this TIAA does not guarantee that the Insurer will issue a policy on the Proposed Insured's life; and (5) I understand that the licensed insurance producer is not authorized to change or waive the terms of this TIAA.

Signature of Proposed Insured	Date of this TIAA	Signature of Policyowner *(If other than Proposed Insured)*
X		X

3. Temporary Insurance Agreement

Agreement - Subject to the terms of the policy applied for and this TIAA, the Insurer agrees to pay the Limited Amount to the beneficiaries listed in the Application - Part I upon receipt of due proof that the Proposed Insured died while temporary insurance was in effect. The consideration for temporary insurance is the Temporary Insurance Application and payment of an amount equal to the first modal premium for the plan applied for.

Limited Amount - The Limited Amount is the lesser of: (1) the Amount of Insurance applied for in the Application - Part I; and (2) $1,000,000 minus the amount of any insurance on the Proposed Insured's life in force with the Insurer under any policies, conditional receipts, or temporary insurance agreements.

Start Date -Temporary insurance equal to the Limited Amount will begin on the Start Date subject to the terms of this TIAA. The Start Date is the Date of this TIAA.

Stop Date - 90 Day Maximum - Temporary insurance automatically ends on the Stop Date and the entire amount remitted will be returned without interest to or for the benefit of the Policyowner. The Stop Date is the earliest of the following: (1) the date the Policyowner withdraws the application; (2) 45 days after the Start Date if the Insurer has not received a properly completed and signed Application Part II – Health History and all medical examinations and tests required by the Insurer as set forth in its Initial Submission Guidelines; (3) the date the Policyowner refuses to accept any policy issued or offered; (4) the date the Insurer sends notice to the Policyowner at the address shown in the Application - Part I that the Insurer has declined to issue insurance; and (5) 90 days after the Start Date.

Other Limitations - The Insurer's liability will be limited to a return of the Amount Remitted if: (1) any part of the life insurance application or this TIAA contains a misrepresentation material to the Insurer; or (2) the Proposed Insured dies by suicide.

Notice: When you provide a check as payment, you authorize us either to use the information from your check to make a one-time electronic fund transfer from your account or to process the payment as a check transaction.

4. Life Insurance Producer's Statement

Amount remitted $__________ *Person from whom received* __________

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

Signature of Life Insurance Producer	*Life Insurance Producer Number(s)*
X	

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DISCLOSURE STATEMENT FOR ACCELERATED DEATH BENEFIT FOR TERMINAL ILLNESS

Rider Benefit

This Rider provides for the early payment of part of the Policy's Death Proceeds. The Accelerated Death Benefit does not qualify as long term care insurance nor is it intended to qualify as such. We will make this Accelerated Death Benefit payment to the Owner of the Policy upon receiving proof that the Insured's life expectancy does not exceed twelve months.

The Owner may make only one request for an accelerated payment. We must receive, in writing, acknowledgement of and Consent for payment under this Rider from any irrevocable beneficiary and any collateral assignee of the Policy before making any payment.

There is no premium or cost of insurance charge for this Rider; however, an administrative fee is deducted before payment.

Consequences of Receiving Accelerated Death Benefit Payment

This Accelerated Death Benefit was not designed for any specific type of favorable tax treatment; such payment may be considered taxable income. A payment may also adversely affect the recipient's eligibility for Medicaid benefits or other state or federal government benefits or entitlements. The Owner should contact a qualified tax advisor and the appropriate government agencies before electing to receive a payment.

Amount of Benefit Available

The Owner requests the amount of Accelerated Death Benefit. Generally, the largest amount available is the benefit maximum minus any Loan Balance. This benefit maximum is the lesser of (a) and (b) where (a) is the amount equal to any Loan Value as defined in the Policy plus 75% of the difference between the Face Amount of the Policy and any Loan Value and (b) is the Maximum Accelerated Amount as shown in your Policy Specifications, which is the lesser of $500,000 or the Policy's Face Amount. The benefit maximum can vary by state, however, and is defined by the Rider.

We will deduct an administrative fee from the Accelerated Death Benefit prior to payment to the Owner.

Effect of an Accelerated Death Benefit Payment

The Accelerated Death Benefit will be treated as a lien against the Death Proceeds of the Policy. Any Policy Value, if applicable under the Policy, is not impacted. However, this lien will reduce the Policy's Death Proceeds and limit the availability of any applicable surrender benefit, future policy loans and withdrawals under the Policy.

We will charge interest on the lien. We will charge interest at the policy loan interest rate(s), if any, stated in the Policy on the portion of the lien amount equal to any Loan Value. We will charge interest on the portion of the lien amount that exceeds any Loan Value at a rate not exceeding the greater of: (a) the current yield on a 90-day treasury bill; and (b) is the maximum fixed annual rate of 8% or a variable rate determined in accordance with the NAIC Model Policy Loan Interest Rate Bill, model #590.

Policy and rider premiums will not be reduced after an Accelerated Death Benefit payment and will remain payable. Any premiums due and unpaid will be added to the lien.

No matter how long the Insured lives, the Policy will not terminate as a result of a payment under this Rider unless the lien equals or exceeds the Death Proceeds. The Owner may repay all or part of the lien subject to the terms of the Rider.

Sample Illustration

Below is a sample illustration of the effect of an Accelerated Death Benefit payment. This illustration shows the effect on the Death Proceeds immediately after the Accelerated Death Benefit payment has been made and 3 months after payment of the Accelerated Death Benefit.

This sample illustration assumes: (1) $800,000 Face Amount; (2) $0 loan value; (3) no policy loans or Loan Balance; (4) the maximum Accelerated Death Benefit is elected; (5) the policy loan interest rate is 4.50%; (6) the lien interest rate is 8.00%; and (7) the quarterly premiums are $500.

Before Accelerated Death Benefit Payment:

Face Amount	$800,000
less: Loan Value	$0
	$800,000
Maximum Accelerating Percentage	X 75%
(a)	$600,000
(b) plus: Loan Value	$0
Min of (a+b, $500,000)	$500,000
less: Loan Balance	$0
Maximum Accelerated Death Benefit Available	$500,000
less: Administration Fee	$250
Amount of Accelerated Death Benefit Payment	$499,750

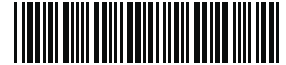
Immediately After Payment of Accelerated Death Benefit:

Amount of Accelerated Death Benefit Payment	$499,750
plus: Administration Fee	$250
Lien Amount	$500,000
Face Amount	$800,000
less: Lien Amount	$500,000
less: Loan Balance	$0
Payment upon Death	$300,000

3 Months After Payment of Accelerated Death Benefit:

Amount of Accelerated Death Benefit Payment	$499,750
plus: Administration Fee	$250
plus Accrued Lien Interest (3 months)	$9,713
plus: Premiums due and unpaid	$500
(c) Lien Amount	$510,213
(d) Loan Balance	$0
(e) Face Amount	$800,000
Payment upon Death (e-d-c)	$289,787

PACIFIC LIFE



PACIFIC LIFE INSURANCE COMPANY

Lynchburg Operations | 6750 Mercy Rd., Ste. B, Omaha, NE 68106
P.O. Box 2869, Omaha, NE 68103
(844) 276-5759 • Fax (844) 520-1618 • www.PacificLife.com

AUTHORIZATION FOR PAYMENT - ELECTRONIC FUNDS TRANSFER (EFT)

For Policy and/or Temporary Insurance Agreement - New Business

Proposed Insured's Name: First MI Last	Policy Number (if known)

1. Electronic Transfer Information Options - More than one option may be selected. If selecting more than one, it is assumed the same bank information will be used for each transfer.

A. For Policy Only - Premium payment frequency: ☐ **Monthly** ☐ **Quarterly** ☐ **Semi-Annual** ☐ **Annual**

B. Check all that apply below:

☐ **For Policy and/or TIA - Initial Payment authorized method**:
The amount authorized from your account will be equivalent to the amount of premium necessary to pay the Policy to current date and/or the TIA. If the Policy was back-dated, or delivery has exceeded standard time frames, this amount may be greater than one standard payment.

☐ **For Policy Only - Recurring Premium authorized payment method** (EFT only)
Recurring drafts will begin on the first available draft date after the Policy is in force.
*Required for Monthly Payment Frequency

2. Payor of Premium (Required to be completed if the payor is other than the insured or policyowner on record of the policy.)

Payor's Name	Relationship to the Policy	Email Address	
Address: Street	City	State	Zip Code

3. Checking Account Information (Complete for EFT only)

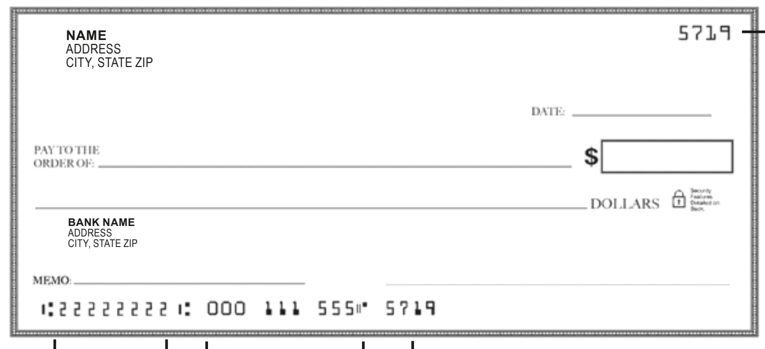
Bank Account Holder Name ______ Additional Bank Account Holder Name (if applicable) ______

Bank Account Holder Address ______ City ______ State ______ Zip Code ______

Financial Institution Name ______

Financial Institution Address ______ City ______ State ______ Zip Code ______

Bank Routing Number (9 digits) ______ Checking Account Number ______



4. Acknowledgments

By signing below, the signer understands and accepts these term and conditions:

Electronic Funds Transfer Payment:

- PLIC is authorized to initiate debit entries from the above account.
- The origination of ACH transactions must comply with the provisions of the U.S. law.
- PLIC will only allow EFT debit requests from authorized U.S. financial institutions.
- If I want to cancel or change this authorization, I must contact PLIC at least three business days before a scheduled payment.
- PLIC has the right to end withdrawals at any time and bill me directly either quarterly or less frequently for premiums due.
- The financial institution's draft date may vary from the policy's draft date and I further understand that PLIC is not responsible for any bank fees incurred as a result of this variance.
- If an EFT request is not honored by the financial institution upon presentation, PLIC will not consider the payment to be made. No insurance will be effective under a Policy and/or TIA. PLIC may, in its sole discretion, resubmit the withdrawal request to the financial institution. PLIC is not responsible for any bank fees incurred by me as a result of insufficient funds or overdraft charges.

5. Signatures

- By signing below, the signer authorizes PLIC to collect the Initial payment and/or Recurring premium stated above by the method I have selected.
- Signing this authorization does not mean that the Policy and/or TIA is in effective.
- This Authorizatoin for Payment does not, in any way modify or change the terms of the Policy and/or TIA.
- If you are signing on behalf of an entity, you represent that you are authoized to execute this document and make the statements that are shown. You further represent that all requirements of those entities, including the use of any seal (in the case of a Corporation) and any authorized signatures (in the case of a Corporation or Trust), have been met.

X ______________________________ Date ______________

Authorized Bank Account Holder's Signature (for EFT authorization)

X ______________________________ Date ______________

Policyowner Signature

____

Print Policyowner Name (if different than proposed insured)

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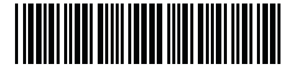

NOTICE AND CONSENT TO EMPLOYER'S APPLICATION FOR LIFE INSURANCE

1. EMPLOYEE (PROPOSED INSURED) INFORMATION

a. Full Name (First, Middle, Last. Include maiden name in parentheses.)	b. Gender ○ F ○ M	c. Date of Birth	d. Social Security Number
e. Street Address	f. City	g. State	h. Zip Code
i. Occupation			

2. EMPLOYER (OWNER) INFORMATION

a. Full Legal Name			
b. Street Address	c. City	d. State	e. Zip Code

3. NOTICE BY EMPLOYER (OWNER)

a. Employer intends to apply for insurance on the life of the Employee (Proposed Insured).

b. The maximum face amount the Employee (Proposed Insured) could be insured for at the time the contract is issued is $ ____________________.

c. The face amount of life insurance, either in dollars or as a multiple of salary, that the Employer reasonably expects to purchase with regard to the employee during the course of the employee's tenure is ______________________.

d. The Employer will be the Owner of any policy issued and a beneficiary of any proceeds payable upon the Employee's (Proposed Insured's) death.

e. State and federal law may limit the right of an Employer to buy life insurance on employees and former employees. Employer certifies that it has independently determined that the purchase of life insurance covered by this form complies with applicable laws and regulations.

4. CONSENT OF EMPLOYEE (PROPOSED INSURED)

a. I consent to being an insured under the life insurance policy for which my Employer intends to apply.

b. I consent to my Employer continuing coverage, after my employment ends, under any policy issued.

c. I understand that my Employer will own the policy. Unless provided in a separate agreement, my Employer will receive all of the death proceeds and my personal representative, next of kin, and heirs at law will have no beneficial interest in the policy or its death proceeds.

AGREEMENT AND AUTHORIZATION

This form is provided as a convenience to the employer and to obtain information that may be needed for information reporting services. By providing this form, the Company makes no representation that completing it will constitute compliance with any law or regulation, tax or otherwise. Federal tax law specifies that the death benefits of certain employer-owned life insurance contracts will not be completely excluded from federal gross income of the employer unless notice-and-consent requirements and other requirements specified in the law are fulfilled.

The Pacific Life Insurance Company and their representatives and distributors do not provide tax or legal advice. We did not create this form for use by any taxpayer to avoid any Internal Revenue Service penalty. You should ask your independent tax and legal advisors for advice based on your particular situation.

A photocopy of this form shall be as valid as the original.

______________________________ ______________
Signature of Employee (Proposed Insured) Date

______________________________ ______________
Signature of Employer (Owner) Date

____
Title

HIPAA AUTHORIZATION RELEASE
TO OBTAIN AND DISCLOSE INFORMATION

Name of Proposed Insured
Please Print

____ ______/_______/_______
First MI Last DOB Month/Day/Year

I authorize any person licensed to provide health care services, hospital, clinic or other medical or medically related facility, insurer, reinsurer, insurance support organization, the Medical Information Bureau, Inc., consumer report agency, state motor vehicle agency, employer, or any other person or institution to release to each of the insurance companies listed below, as well as to their reinsures, any insurance support organizations, those person authorized to represent them; and International Brokerage Agencies, Inc.; any information related to my mental and physical health, lab results, other insurance coverage, hazardous activities, character, general reputations, finances, occupations, other personal traits, drug and/or alcohol use and driving record for me and my minor children who are to be insured. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases.

THIS AUTHORIZATION APPLIES TO THE FOLLOWING:

- Aetna Companies
- American Amicable
- American General
- American National
- APPS
- Bestow
- Brighthouse Life
- EIS
- ExamOne
- Fidelity Life
- Global Atlantic
- Illinois Mutual
- IMG
- J&H
- John Hancock
- Kemper
- Legal & General
- Lincoln Financial Group
- Nationwide
- North American
- OneAmerica
- Pacific Life
- Principal
- Protective
- Prudential
- SBLI
- Securian Financial
- Standard Life
- Symetra
- Transamerica
- United American
- United/Mutual of Omaha
- World Trips

By my signature below, I acknowledge that any agreements I have made with my Providers that restrict disclosure of my medical records and any associated HIPPA protected health information do not apply for purposes of this authorization and I instruct my physician, health care professional, hospital, clinic, medical facility or any other health care provider to release and disclose my entire medical record without restriction to International Brokerage Agencies, Inc. I understand that any information that it is disclosed pursuant to this authorization may be re-disclosed and no longer covered by certain federal rules governing privacy and confidentiality of health information.

International Brokerage Agencies, Inc.
P.O. Box 1345, Joshua, TX 76058
Phone: (817) 752-4980; Fax: (817) 752-4982

The information contained in these medical and financial records will be held in confidence and may be used only for the purpose of the procurement, or the evaluation or underwriting for the possible procurement, of life, health, disability income, long term care, or other insurance products. The contents therein may be reviewed and assessed by a qualified staff consisting of medical directors, underwriters, underwriting assistants, or other related employees involved in the submission, receipt, or evaluation of insurance applications or prospective applications of the insurance companies listed above and their re-insurers as well as International Brokerage Agencies, Inc. and its staff, employees and affiliated companies.

I understand and agree that this form is not an application for life insurance and that no life insurance coverage is provided in connection with this form.

This authorization shall be valid for twenty-four (24) months from the date below. A copy of this authorization shall be as valid as the original. I understand that I am entitled to receive a copy of this authorization. I understand I may revoke this authorization in writing at any time by providing that written notification to International Brokerage Agencies, Inc. at the service address below. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

I agree that a photographic copy or facsimile of this Authorization shall be valid as the original. I agree that this Authorization shall remain valid for the lifetime of the undersigned, absent any provision of any applicable state statute regulation to the contrary, in which event it shall remain valid for the maximum period permitted there under. I understand that if I refuse to sign this authorization, International Brokerage Agencies, Inc. may not be able to provide full and complete information about the insurance coverage and its cost that may be available to me. I also understand and acknowledge that each of the insurers listed on this form or to which I may formally apply, may require me to sign a similar authorization used exclusively by such insurer before they will process my application or offer insurance coverage. I understand that my Providers may not refuse to provide treatment or payment for health services if I refuse to sign this authorization.

________________________________ ________________________________

Signature of Proposed Insured Name of Proposed Insured

_________________________ __________ _____________________

City State Month/Day/Year