

**A plan that helps
provide peace of
mind to those we love.**

**Final Expense
Individual Whole Life Insurance**



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



Our commitment to you and yours

With so many insurance companies offering different types of insurance plans, we know that your choice comes down to not only benefits but the price that fits your budget, the company's financial strength, service, reputation, reliability, and experience.

Our unwavering commitment is to provide the best personal service possible, quick claims payment, quality products with solid financial backing, and helpful, friendly associates with extensive knowledge and experience.

Our valued policyholders and their family members rely on our company to be there when they need us. We take those obligations very seriously. Everything we do is focused on fulfilling our commitments in a timely, hassle-free manner.

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

Your wishes. Your way.

A Final Expense Whole Life insurance policy can help your loved ones carry out your final wishes.

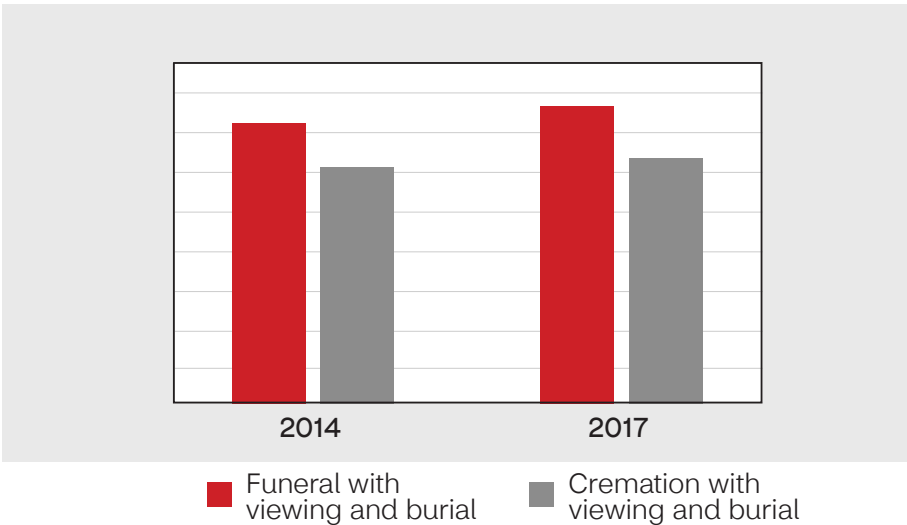
Families could have to make several important decisions soon after the death of a loved one. Along with those decisions, expenses from burial planning, debt balances, and out-of-pocket health care bills can quickly add up.

Planning for tomorrow, today



A funeral can be one of the largest family expenses. On average a funeral can cost \$7,360 or more, not including the cemetery plot, tombstone, and other related fees. While there is a belief that cremation is a far less expensive option, data shows that the cost is only 15% less than the traditional funeral.¹ Social Security benefits pay only \$255 to qualified dependents and the Veteran's Administration benefit offers only \$300.² The majority of U.S. health care costs rise in the final phase of life, and living with fatal chronic illnesses have the highest costs associated with the treatments.³

Burial vs. Cremation⁴



No one likes to think about this now



Early planning can give you peace of mind knowing that you have taken care of your final expenses, so your loved ones don't have to. This is why final expense insurance was created. A Final Expense whole life insurance plan can help minimize the emotional and financial burden a loss could have on your family. It can help fund your final wishes by providing a cash payment made directly to your beneficiaries. There is no medical exam required for this product and premiums will not increase as long as premiums are paid.

Sources:

¹National Funeral Directors Association 2020, nfda.org/news/statistics
²Social Security Rules and Regs, www.ssa.gov/pubs/10008.html

³Rand: Living Well at the End of Life, www.medicaring.org
⁴Rates of Cremation and Burial, www.nfda.org/news/statistics

Financial obligations after passing

Purchasing a Final Expense insurance plan now can help take the strain off those left to cover the costs after a passing. It can allow you to make choices, plans, and decisions on what is appropriate for you. And, it can help provide funding for your family when it's needed the most.

How much coverage should I buy?

To help you decide how much Final Expense insurance coverage is right for you, use the five steps below:

Step 1 Household expenses
Total your average monthly bills (utilities, car expenses, food, insurance, etc.) and multiply it by three. This will give you an idea of how much your family needs for three months.

Example: Household expenses = \$400/month
 $\$400 \times 3 = \mathbf{\$1,200}$

Step 2 Debt
How much debt do you have? Consider these debts: mortgage, credit card balances, auto loans, etc. Total the monthly amount and then multiply it by three.

Example: Total debt payments = \$1,800/month
 $\$1,800 \times 3 = \mathbf{\$5,400}$

Step 3 Funeral costs
The cost of a funeral depends on what kind of services you choose. The average funeral can cost **\$7,360** or more.

Step 4 Subtotal
Add the totals of Steps 1-3 to figure out the minimum amount of coverage you'll need. This would cover your funeral, as well as three months of household expenses and debt payments.

*Example: \$1,200 + \$5,400 + \$7,360 = **\$13,960***

Step 5 Inflation
Multiply the total from Step 4 by the inflation factor¹ listed under the number of years before you reach age 90. This is your final estimated cost.

*Example: \$13,960 x 1.34 (age 80) = **\$18,706***

Number of years before reaching age 90²

10 yrs	20 yrs	30 yrs	40 yrs	50 yrs
1.34	1.81	2.34	3.26	4.38

Other expenses to consider:

- Legal costs
- Health care bills
- Student loans or tuition fees for children and/or grandchildren
- Milestone family commitments
- Cemetery plot and tombstone



Sources:

Flexible coverage options

Both level and modified plans* are available to provide flexible coverage options to meet your unique needs. Specific plan details can be found below.

Level Plans

Full face value from policy issue date regardless if death is due to an accident or natural causes.

Accidental death

Full benefit immediately

Non-accidental death

All policy years = full benefit

Modified Plan

Full face value immediately from policy issue date if death is due to an accident.

Accidental death

Full benefit immediately

Non-accidental death

Policy years 1 and 2 =
110% of earned premium

Policy year 3 = full benefit

Level benefit amounts

Issue age**	Min. death benefit	Max. death benefit***
40-55	\$2,000	\$50,000
56-65	\$2,000	\$40,000
66-75	\$2,000	\$30,000
76-89	\$2,000	\$25,000

Modified benefit amount

Issue age**	Min. death benefit	Max. death benefit***
40-75	\$2,000	\$25,000

*Annual policy fee \$40.

**Age as of last birthday.

***Maximum benefit amount varies according to the age of the applicant at the time of policy issue.

Benefit Riders (available for Level Plan only)

Accelerated Death Benefit Rider

This rider pays up to 50% of the death benefit (less policy loan) if a physician provides written certification that the insured meets the definition for a qualifying event, which is a medical condition that results in a terminal, chronic or critical illness with a life expectancy of 12 months or less.

The minimum benefit is \$1,000 and the maximum benefit is \$15,000. An administrative fee of \$200 will be taken from the benefit amount.

Accidental Death Benefits Rider

This rider pays 100% of the base policy's face amount for accidental death for issue ages 40 through 70.

Children's Term Insurance Rider

This rider provides coverage for a child, stepchild, legally adopted child, grandchild, legally adopted grandchild, or great grandchild.

This benefit is available from \$2,500 up to a maximum of \$10,000 per child, in \$2,500 increments. Coverage amount selected will be the same for all covered children and may not exceed the face amount of the base policy.

Issue ages begin at older than 30 days through less than 18 years old. Policy becomes convertible to a whole life policy between the ages of 22 to 25 after two years in force.

Cash value flexibility

Non-forfeiture options enable full or partial benefits or a partial refund of premiums after a lapse in coverage due to non-payment of premiums. These options allow you to decrease your risk if your policy lapses due to non-payment at the end of your grace period.

Reduced paid-up insurance

This option allows your beneficiary to receive a death benefit reduced to the amount of life insurance that can be purchased for the accrued cash value in the policy, if any.

Extended term insurance

This option provides level term insurance for the full death benefit amount, but for a shorter period of time.

Automatic premium loan

This option may help pay future premiums. It takes the cash value accrued and applies it toward the premium. If there is insufficient cash value to advance the premium as a policy loan, no automatic premium loan will be made. Any remaining value will be applied under the above non-forfeiture options.

You may elect the non-forfeiture option at the time of application and at any time in writing

during your lifetime. The option is triggered when your premium remains unpaid at the end of the grace period and you have sufficient cash value.*

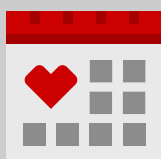
The more cash value you have in your policy at the time the non-forfeiture option is triggered, the more the paid-up benefit or the longer term period you will have.

Build cash value automatically

Over time, you can build up a sum of money that may be available to you if you need it. You can borrow your cash value with policy loans exceeding \$1,000 for any reason. Annual interest rate and fees apply.

For complete details of all provisions or benefits, please read your policy carefully.

*In the early years of your policy, you may have insufficient cash value for reduced paid-up insurance, extended term insurance, or automatic premium loan.



Matches Social Security deposit schedule.

If you're on Social Security, we set up your automatic payments to line up with the Social Security benefit deposit schedule. So it's always easy to pay your premiums when due as you keep your plan current.



Super preferred rate available.

You may qualify for the super preferred rate on this Final Expense plan, which is 10% lower than the preferred rate, if you were issued an Accendo/Aetna Medicare Supplement policy underwritten in the last 180 days.

About CVS Health®

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

CVS Health is the nation's premier health innovation company helping people on their path to better health. Whether in one of its pharmacies or through its health services and plans, CVS Health is pioneering a bold new approach to total health by making quality care more affordable, accessible, simple and seamless. CVS Health is community-based and locally focused, engaging consumers with the care they need when and where they need it.

The Company has more than 9,800 retail locations, approximately 1,100 walk-in medical clinics, a leading pharmacy benefits manager with approximately 93 million plan members, a dedicated senior pharmacy care business serving more than one million patients per year, expanding specialty pharmacy services, and a leading stand-alone Medicare Part D prescription drug plan.

CVS Health also serves an estimated 39 million people through traditional, voluntary and consumer-directed health insurance products and related services. This innovative health care model increases access to quality care, delivers better health outcomes and lowers overall health care costs. Find more information about how CVS Health is shaping the future of health at **www.cvshealth.com**.

Summary of coverage

Presented to: _____

Plan name: _____

Beneficiary: _____

Policy face amount: _____

Policyowner: _____

Riders: _____

Agent name: _____

Total premium: _____

Agent phone: _____

Draft date: _____

Underwritten by

Accendo Insurance Company

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

aetnaseniorproducts.com

Policy administered by Aetna Life Insurance Company and its affiliates

Not connected with or endorsed by the U.S. Government or the Federal Medicare Program.



Final Expense Individual Whole Life Rates

Accendo Insurance Company

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

Effective June 2020

Application form: ICC20-ACCFE05982

- All plans: \$40 annual policy fee
- Plans are Level or Modified
- Rates determined by qualifying plan and rate tier
- Rates are male/female, tobacco/non-tobacco, standard/preferred/super preferred (level plan)
- Use age last birthday on effective date of coverage
- Riders have age varying restrictions
- Rates are guaranteed for life as long as payments are paid on time
- Coverage level is guaranteed as long as payments are paid on time

Refer to the Producer Guide and Drug List for important underwriting information.

Need help?

Contact the Agent Services team at **866-272-6630**, or go to **aetnaseniorproducts.com** (agent side).

Modal premium options

Semi-AnnualAnnual x .51
Quarterly.....Annual x .26
Monthly Electronic Funds Transfer (EFT).....Annual x .0875

Calculating rates

Follow these steps for each applicant.

Calculate modal premium

(Annual premium per \$1,000 [found on agent rate card]

x Number of units + \$40 policy fee)

x Modal Factor

= Modal premium (round to nearest whole cent)

EXAMPLE:

Monthly premium for 50 year old male, nonsmoker, preferred, buying \$15,000 of coverage (15 Units)

$(\$35.30 \times 15 + \$40) \times .0875 = \$49.83$

Mobile rate quote app available

You can get a real-time quote for all of our products by downloading our free mobile app. To get started, just search for “Quotes on the go” on either the Apple App Store or Android Google Play Store.



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Effective June 2020

Child Term Rider (no policy fee)

- \$7.50 annual premium per insured child per unit
- One to four units available

Accidental Death Benefit Rider (annual rates per \$1,000)

Issue Age: 40-64 Rate: \$3.30
Issue Age: 65-70 Rate: \$4.80

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(agent side).

ATTAINED AGE	ANNUAL RATES (per \$1,000)							
	SUPER PREFERRED				PREFERRED			
	MALE		FEMALE		MALE		FEMALE	
	NON SMOKER	SMOKER	NON SMOKER	SMOKER	NON SMOKER	SMOKER	NON SMOKER	SMOKER
40	23.60	31.80	20.90	30.90	26.20	35.30	23.20	34.30
41	24.30	33.00	21.20	31.60	27.00	36.70	23.60	35.10
42	25.00	34.30	21.60	32.30	27.80	38.10	24.00	35.90
43	25.70	35.60	22.00	33.00	28.60	39.50	24.40	36.70
44	26.50	36.80	22.30	33.80	29.40	40.90	24.80	37.50
45	27.20	38.10	22.70	34.50	30.20	42.30	25.20	38.30
46	28.10	39.50	23.00	35.40	31.20	43.90	25.60	39.30
47	29.00	41.00	23.40	36.30	32.20	45.50	26.00	40.30
48	29.90	42.40	23.80	37.20	33.20	47.10	26.40	41.30
49	30.80	43.80	24.10	38.10	34.20	48.70	26.80	42.30
50	31.80	45.40	24.50	39.00	35.30	50.40	27.20	43.30
51	33.80	47.00	25.90	39.70	37.50	52.20	28.80	44.10
52	35.70	48.60	27.40	40.40	39.70	54.00	30.40	44.90
53	37.70	50.20	28.80	41.10	41.90	55.80	32.00	45.70
54	39.70	51.80	30.20	41.90	44.10	57.60	33.60	46.50
55	41.80	53.60	31.80	42.70	46.40	59.50	35.30	47.40
56	43.20	55.70	33.00	43.90	48.00	61.90	36.70	48.80
57	44.60	57.90	34.30	45.20	49.60	64.30	38.10	50.20
58	46.10	60.00	35.60	46.40	51.20	66.70	39.50	51.60
59	47.50	62.20	36.80	47.70	52.80	69.10	40.90	53.00
60	49.00	64.40	38.10	49.00	54.40	71.60	42.30	54.40
61	50.40	67.90	39.50	51.10	56.00	75.40	43.90	56.80
62	51.80	71.30	41.00	53.30	57.60	79.20	45.50	59.20
63	53.30	74.70	42.40	55.40	59.20	83.00	47.10	61.60
64	54.70	78.10	43.80	57.60	60.80	86.80	48.70	64.00
65	56.30	81.60	45.40	59.90	62.50	90.70	50.40	66.50
66	59.30	87.50	47.50	63.50	65.90	97.20	52.80	70.50
67	62.40	93.30	49.70	67.10	69.30	103.70	55.20	74.50
68	65.40	99.20	51.80	70.70	72.70	110.20	57.60	78.50
69	68.50	105.00	54.00	74.30	76.10	116.70	60.00	82.50
70	71.60	110.70	56.30	78.00	79.60	123.00	62.50	86.70
71	77.50	120.20	59.90	83.30	86.10	133.50	66.50	92.50
72	83.30	129.60	63.50	88.50	92.60	144.00	70.50	98.30
73	89.20	139.10	67.10	93.70	99.10	154.50	74.50	104.10
74	95.00	148.50	70.70	98.90	105.60	165.00	78.50	109.90
75	100.70	157.90	74.40	104.30	111.90	175.40	82.70	115.90
76	108.70	172.50	79.70	115.20	120.80	191.70	88.50	128.00
77	116.70	187.20	84.90	126.10	129.70	208.00	94.30	140.10
78	124.70	201.90	90.10	137.00	138.60	224.30	100.10	152.20
79	132.80	216.50	95.30	147.90	147.50	240.60	105.90	164.30
80	140.70	231.40	100.70	158.80	156.30	257.10	111.90	176.40
81	152.10	253.20	108.00	170.40	169.00	281.30	120.00	189.30
82	163.50	275.00	115.30	182.00	181.70	305.50	128.10	202.20
83	175.00	296.70	122.60	193.60	194.40	329.70	136.20	215.10
84	186.40	318.50	129.90	205.20	207.10	353.90	144.30	228.00
85	197.80	340.20	137.00	216.80	219.80	378.00	152.20	240.90
86	239.40	401.40	172.60	260.40	266.00	446.00	191.80	289.30
87	281.00	462.60	208.30	303.90	312.20	514.00	231.40	337.70
88	322.60	523.80	243.90	347.50	358.40	582.00	271.00	386.10
89	364.10	585.00	279.50	391.10	404.60	650.00	310.60	434.50

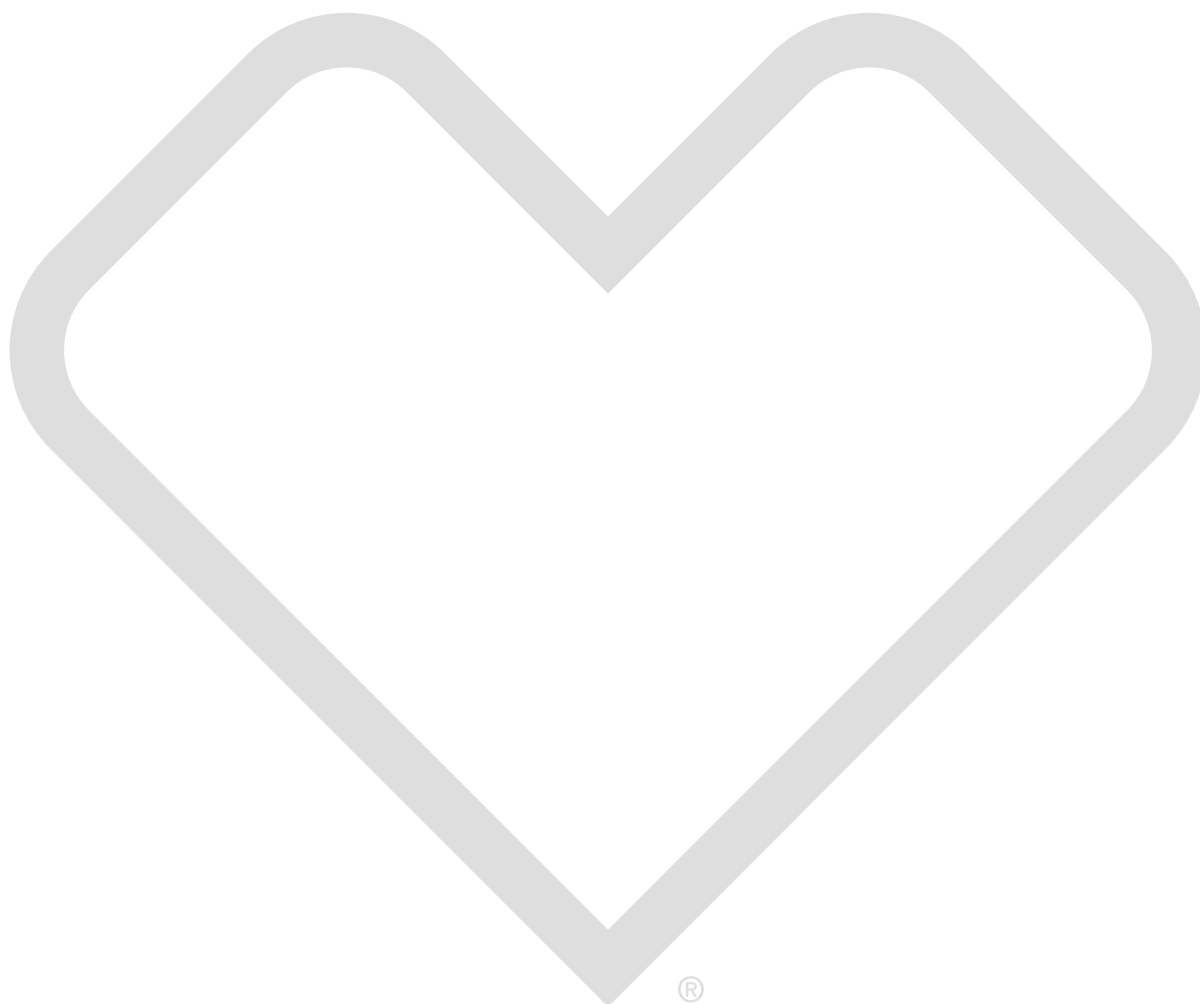
ATTAINED AGE	ANNUAL RATES (per \$1,000)							
	STANDARD				MODIFIED			
	MALE		FEMALE		MALE		FEMALE	
	NON SMOKER	SMOKER	NON SMOKER	SMOKER	NON SMOKER	SMOKER	NON SMOKER	SMOKER
40	29.20	52.40	24.20	34.30	36.30	55.40	32.30	39.30
41	30.40	53.00	25.40	36.10	37.70	56.40	33.10	41.20
42	31.60	53.60	26.60	37.90	39.10	57.40	33.90	43.10
43	32.80	54.20	27.80	39.70	40.50	58.40	34.70	45.00
44	34.00	54.80	29.00	41.50	41.90	59.40	35.50	46.90
45	35.30	55.40	30.20	43.30	43.40	60.20	36.30	48.80
46	36.70	56.00	31.80	45.50	45.20	61.20	37.10	51.30
47	38.10	56.60	33.40	47.70	47.00	62.20	37.90	53.80
48	39.50	57.20	35.00	49.90	48.80	63.20	38.70	56.30
49	40.90	57.80	36.60	52.10	50.60	64.20	39.50	58.80
50	42.30	58.50	38.30	54.40	52.50	65.40	40.50	61.30
51	44.10	61.70	39.90	56.00	54.60	68.50	42.80	63.80
52	45.90	64.90	41.50	57.60	56.70	71.60	45.10	66.30
53	47.70	68.10	43.10	59.20	58.80	74.70	47.40	68.80
54	49.50	71.30	44.70	60.80	60.90	77.80	49.70	71.30
55	51.40	74.60	46.40	62.50	62.80	81.00	51.90	73.70
56	54.40	79.40	48.00	65.10	67.40	87.60	54.40	77.00
57	57.40	84.20	49.60	67.70	72.00	94.20	56.90	80.30
58	60.40	89.00	51.20	70.30	76.60	100.80	59.40	83.60
59	63.40	93.80	52.80	72.90	81.20	107.40	61.90	86.90
60	66.50	98.80	54.40	75.60	85.70	114.20	64.40	90.30
61	70.50	107.90	56.80	80.20	91.20	120.80	66.30	95.90
62	74.50	117.00	59.20	84.80	96.70	127.40	68.20	101.50
63	78.50	126.10	61.60	89.40	102.20	134.00	70.10	107.10
64	82.50	135.20	64.00	94.00	107.70	140.60	72.00	112.70
65	86.70	144.20	66.50	98.80	113.10	147.40	73.70	118.40
66	92.30	156.30	69.90	103.80	117.70	157.60	78.50	125.90
67	97.90	168.40	73.30	108.80	122.30	167.80	83.30	133.40
68	103.50	180.50	76.70	113.80	126.90	178.00	88.10	140.90
69	109.10	192.60	80.10	118.80	131.50	188.20	92.90	148.40
70	114.90	204.60	83.70	124.00	135.90	198.30	97.60	155.80
71	124.00	224.80	88.50	131.10	150.30	213.00	110.30	165.10
72	133.10	245.00	93.30	138.20	164.70	227.70	123.00	174.40
73	142.20	265.20	98.10	145.30	179.10	242.40	135.70	183.70
74	151.30	285.40	102.90	152.40	193.50	257.10	148.40	193.00
75	160.30	305.50	107.90	159.30	207.70	272.00	160.90	202.50
76	173.80	322.20	117.60	176.40				
77	187.30	338.90	127.30	193.50				
78	200.80	355.60	137.00	210.60				
79	214.30	372.30	146.70	227.70				
80	227.80	389.10	156.30	245.00				
81	252.80	424.40	174.50	267.70				
82	277.80	459.70	192.70	290.40				
83	302.80	495.00	210.90	313.10				
84	327.80	530.30	229.10	335.80				
85	352.80	565.80	247.40	358.60				
86	408.50	653.60	295.90	422.10				
87	464.20	741.40	344.40	485.60				
88	519.90	829.20	392.90	549.10				
89	575.60	917.00	441.40	612.60				

Application for **Individual Whole Life Insurance**

Accendo Insurance Company

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

Policy administered by Aetna Life Insurance Company and its affiliates



Application for Individual Whole Life Insurance

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

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

Section 1. Proposed insured information

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

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

Section 2. Health questions

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

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

1. Are you currently:

- A.** confined in or been advised to enter a hospital, nursing home, skilled nursing facility, psychiatric facility, correctional facility? Yes No
- B.** receiving or been advised to receive home health care or hospice care? Yes No

2. Do you use a wheelchair or mobility scooter or do you have any physical or mental impairment requiring assistance from anyone with the following activities of daily living: taking medications, bathing, dressing, eating, toileting, getting in or out of bed or chair, or moving about?

Yes No

3. Within the past year have you:

- A.** used or been advised to use oxygen equipment to assist with breathing (excluding CPAP for sleep apnea) or had or been advised to have kidney dialysis? Yes No
- B.** been advised to have any medical procedure, surgery or a diagnostic test which has not yet been started, completed, or for which results are not known, excluding tests related to the Human Immunodeficiency Virus (HIV)? Yes No

4. Have you ever received, or been advised to receive, an organ or bone marrow transplant or an amputation due to any disease or complications of diabetes?

Yes No

Section 2. Health questions *continued*

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

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

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

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

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

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

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

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

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

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

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

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

C. kidney or liver disease? Yes No

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

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

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

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

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

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

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

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

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

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

Section 3. Benefits and premium information

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

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

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

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

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

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

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

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

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

Which do you prefer?

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

*Unless otherwise requested, the effective date is the application signature date as long as the application is received at the administrative office within 15 days.

**If a nonforfeiture option is not selected, extended term insurance is the default.

Mail policy to: Applicant Agent

Payment modes

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

Section 4. Beneficiary

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

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

Address	Social Security Number
•	•

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

Address	Social Security Number
•	•

Section 4. Beneficiary *continued*

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

Section 5. Replacement information

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

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

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

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

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

Section 7. Remarks

Section 8. Producer compensation

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

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

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

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

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

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

Section 9. Applicant agreement

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

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

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

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

I understand and agree that information regarding my

insurability will be treated as confidential. Accendo Insurance Company or its reinsurers may, however, make a brief report of my protected health information to MIB, Inc., a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. I understand and agree that if I apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from me, MIB will arrange disclosure of any information it may have in my file. I may contact MIB at 866-692-6901. If I question the accuracy of information in MIB's file, I may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400 Braintree, MA 02184- 8734. Information for consumers about MIB may be obtained on its website at www.mib.com.

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

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

Applicant signature

X

Date signed

.

Owner signature* (if not proposed insured)

Date signed

X

.

Owner Social Security Number

Signed in (city and state)

.

.

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

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Section 10. Bank account information

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

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

Account owner relationship to proposed insured

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

Financial institution name

Account type

- Checking Savings

Routing number

Account number

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

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

Section 11. Electronic funds transfer (EFT) authorization

I understand and accept these terms and conditions:

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

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

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

Account owner signature

Date signed

X .

Section 12. Agent information

I certify that:

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

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

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

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

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

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

Agent name *(printed)*

Writing number *(agent or company)*

•

•

Agent signature

X

Phone

Email

•

•

Section 13. Agent request to split commissions

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

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

Writing agent name *(printed)*

Percentage

•

• %

Writing agent signature

X

Secondary agent

Writing number

Percentage

•

•

• %

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

IMPORTANT NOTICE: REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

Accendo Insurance Company part of the CVS Health® family of companies and Aetna affiliate
1021 Reams Fleming Boulevard, Franklin, TN 37064 • 800-264-4000

This document must be signed by the applicant and the producer, 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 back of this form.

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**

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 will be replaced or used as a source of financing:

Insurer name .	Contract/policy number .	Insured or annuitant .	<input type="checkbox"/> Replace <input type="checkbox"/> Financing
Insurer name .	Contract/policy number .	Insured or annuitant .	<input type="checkbox"/> Replace <input type="checkbox"/> Financing
Insurer name .	Contract/policy number .	Insured or annuitant .	<input type="checkbox"/> Replace <input type="checkbox"/> Financing

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

The existing policy or contract is being replaced because _____.

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

Applicant signature **Applicant name (print)** **Date**

Agent signature **Agent name (print)** **Date**

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

Application for Individual Children's Term Insurance Rider

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

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

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

1. Children proposed for insurance

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

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

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

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

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

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

2. Beneficiary

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

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

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

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

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

Percent share must total 100%.

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

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

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

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

3. Health history

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

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

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

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

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

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

.....

.....

4. Acknowledgement

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

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

Agent signature	Writing number	Date
X	.	.

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

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 agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration or 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 agent 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?

Health information authorization

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

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

Applicant / insured declarations

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

Health Information to be Used or Disclosed:

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

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

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

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

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

Applicant / insured complete this section.

Signature of applicant / insured

Date

X

.

Printed name of applicant / insured

X

City

State

Zip

.

.

.

Policy number of insured (if known)

.

Conditional receipt

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

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

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

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

Agent name	Date
.....

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

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

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

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

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

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



Electronic check authorization

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

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

1. Usage guidelines

Requirements:

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

2. Authorization

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

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

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

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

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

Date

Amount to apply

X

.

\$



PRODUCER STATEMENT

Accendo Insurance Company

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

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

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

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

_____	_____
_____	_____
_____	_____

Date

Producer's signature

Producer's name

Replacement policy

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

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

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