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SYMETRA
RETIREMENT | BENEFITS | LIFE

Application/Fax
Cover Sheet

Symetra Life Insurance Company
777 108th Avenue NE, Suite 1200
Bellevue, WA 98004-5135
www.symetra.com

New Application Fax Number: 1-877-435-5500

Date _____ Number of pages (including cover sheet) _____

Agent Name _____ Agent Fax_____

Proposed Insured _____

Agent Notes _____

To Apply:

To help you remember all the steps involved with submitting an application, please follow the checklist below:

- Medical requirements are needed for every application.

  ☐ Agent order medical requirements. If not checked, Symetra will order the medical requirements. Paramed Company used: _____

- Complete and obtain signatures on the attached application, any state specific forms (if applicable) and the HIPAA Authorization.
- If your client has applied for Symetra UL-G or CAUL and they reside in one of the following states: AL, AR, CA, CT, IL, IN, KS, LA, MA, MI, MN, MS, MT, NC, OH, OK, OR, PA, VA, and WA, please provide the m with a copy of the Chronic Illness Rider and, Terminal Illness rider disclosures and, if applied for the Chronic Illness Plus Rider disclosure which are included in this application packet.
- Complete and obtain signatures on any state Replacement forms (if applicable).

  Note: For states requiring the LU-745 replacement form, the form must be completed if any existing coverage is listed on the application in the "Replacement" section, even if this is not a replacement. Exceptions are Arkansas, Oregon and Utah. For Arkansas, Oregon and Utah, complete and obtain the LU-745 only if the client is replacing existing coverage.
- If the customer is replacing existing coverage, a replacement form may or may not be required.
  Please contact the Life Sales Desk at 1-877-737-3611 for more information.
- A signed and dated illustration may be required to accompany this application, depending on the product applied for and the application state. If a signed illustration is required, provide your client with a copy and forward the original, including all pages, along with the application packet to Life New Business.
- Witness the signing of the application and verify the identity of the customer using photo identification.
- Give the "What happens next" form to your client.
- Provide client with the Notice of Insurance Information Practices, Symetra Privacy Notice and any state required disclosures, and copies of all forms completed as part of the application packet.
- Return the signed application and any other required forms to Symetra Life Insurance Company:

  Fax: 1-877-435-5500

  Email: PremierNewBusiness@symetra.com

  Mailing address: Symetra Life Insurance Company
  PO Box 549291
  Waltham, MA 02454-9291

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INDIVIDUAL LIFE INSURANCE APPLICATION
PART 1 – LUC – 199/CA

1. PROPOSED INSURED A INFORMATION

(a) First Name	(b) Middle Initial	(c) Last Name
(d) Residence Address (may not be a P.O. Box) City State Zip		
(e) Mailing Address (may be a P.O. Box)		
(f) Phone Number		
(g) Date of Birth	(h) State of Birth	(i) Gender ☐ Male ☐ Female

(j) Height	(k) Weight	(l) Social Security #/Tax ID	(m) Driver's License # and State of Issue

(n) US Citizen ☐ Yes ☐ No If No, provide Country of Citizenship _____
Type of US Visa _____ Expiration Date_____

(o) Occupation/Duties	(p) Employer & Employer Address

(q) Earned Annual Income	(r) Unearned Annual Income	(s) Net Worth

2. COVERAGES

(a) Amount of Coverage: _____

(b) Universal Life Plans:

Product Selection	Life Insurance Qualification Test (choose one)	Death Benefit Election (choose one)	Optional Riders
☐ Symetra UL-G w/Lapse Protection	☐ Cash Value Accumulation Test (CVAT) ☐ Guideline Premium Test (GPT)	☐ A: Face Amount	☐ Accidental Death Benefit $_____ ☐ Charitable Giving Rider (please complete information section below) ☐ Chronic Illness Plus Rider (please complete CIPR supplemental app) ☐ Insured Children's Benefit (please complete the Part III ICB form) ☐ Return of Premium Rider ☐ Term Rider on Others (please complete Part I for each rider insured)
☐ Symetra SUL-G w/Lapse Protection	☐ Cash Value Accumulation Test (CVAT) ☐ Guideline Premium Test (GPT)	☐ A: Face Amount	☐ Charitable Giving Rider (please complete information section below) ☐ Estate Preservation Rider ☐ Return of Premium Rider
☐ Symetra CAUL	☐ Cash Value Accumulation Test (CVAT) ☐ Guideline Premium Test (GPT)	☐ A: Face Amount ☐ B: Face Amount + Accumulation Fund ☐ C: Face Amount + Return of Premium	☐ Accidental Death Benefit $_____ ☐ Charitable Giving Rider (please complete information section below) ☐ Chronic Illness Plus Rider (please complete CIPR supplemental app) ☐ Insured Children's Benefit (please complete the Part III ICB form) ☐ Term Rider on Others (please complete Part I for each rider insured) ☐ Term Rider on Self $_____

(c) Term Plans:

Product Section	Term Length	Optional Riders	
☐ Symetra Term	☐ 10 Years ☐ 30 Years ☐ 15 Years ☐ 20 Years	☐ Accidental Death Benefit $_____ ☐ Insured Children's Benefit (please complete the Part III ICB form)	☐ Term Rider on Others (please complete Part I for each rider insured) ☐ Waiver of Premium

(d) If you Elected the Charitable Giving Rider Please Complete this Section:

Name of Charitable Giving Beneficiary: _____

Address: _____

501(c) Tax ID Number: _____

Who will provide confirmation to the charitable organization? (choose one)

☐ I will notify the charity of my intent ☐ Permit the Company to notify the charity of my intention upon my death

3. PROPOSED OWNER INFORMATION

(a) Who is the Owner?
- ☐ Proposed Insured A
- ☐ Proposed Insured B (For Symetra SUL-G plans only)
- ☐ Trust (Provide details in the section below and complete the Trust Certification)
- ☐ Other (Provide details in the section below and complete the Entity Certification, if appropriate)

(b) First Name	(c) Middle Initial	(d) Last Name

(e) Residence Address (may not be a P.O. Box) City State Zip

(f) Mailing Address (may be a P.O. Box)

(g) Date of Birth	(h) Social Security/Tax I.D.	(i) Relationship to Insured

(j) US Citizen ☐ Yes ☐ No If No, provide Country of Citizenship _____
Type of US Visa _____ Expiration Date_____

(k) Would you like to designate a Secondary Addressee to receive notice of lapse or termination of the policy for nonpayment of premium? ☐ Yes ☐ No (provide details below)
Name: _____ Address: _____

4. BENEFICIARY INFORMATION

The percentage for each type of beneficiary must total 100%. Do not indicate multiple beneficiaries as a group – e.g., "All Children of Proposed Insured."

P = Primary C = Contingent	Name (first, middle initial, last) or Organization Name, Residence Address and Telephone Number	Date of Birth/Trust	SSN, TIN or 501(c) Tax ID Number	Relationship to Proposed Insureds	%
☐ **P**					
☐ **P** ☐ **C**					
☐ **P** ☐ **C**					
☐ **P** ☐ **C**					
☐ **P** ☐ **C**					
☐ **P** ☐ **C**					

For any "Yes" answers or additional information to Sections 5, 6, 7 & 10, please provide details in Remarks Section 9

5. PROPOSED INSURED A IN FORCE COVERAGE

(a) Does Proposed Insured A have any other existing life insurance policies in force or applied for with this or any other company? If yes, please list below. **Yes** ☐ **No** ☐

Company Name	Face Amount	Policy Type (UL/VUL/Term/Group)	Issue Month/Year	Select if Replacing	1035 Exchange*
			MO/YR ☐ In Force ☐ Applied For	☐	☐
			MO/YR ☐ In Force ☐ Applied For	☐	☐
			MO/YR ☐ In Force ☐ Applied For	☐	☐
			MO/YR ☐ In Force ☐ Applied For	☐	☐

(b) Total in force and applied for with all companies including Symetra $_____

(c) Existing Policy Cash Value $ _____

* If 1035 Exchange complete the 1035 Absolute Assignment form

6. PROPOSED OWNER(S) REPLACEMENT

	Yes	No
(a) Does the Proposed Owner(s) have existing life insurance policies or annuity contracts with this or any other company on the life of Proposed Insured A?	☐	☐
(b) Is the policy applied for expected to replace or change any existing life insurance policy or annuity, or is any part of the premium to be paid by policy loan or cash value from insurance presently in force? (If yes, complete state required replacement form.)	☐	☐
(c) Do you plan to replace an existing long term care policy or Life Insurance Policy with an Accelerated Death Benefit with this Life Insurance Policy that includes an Accelerated Death Benefit? If Yes, please review and sign the Important Notice to Applicant Regarding the Replacement of Long Term Care Insurance or Life Insurance Including Accelerated Death Benefits.	☐	☐

7. PROPOSED INSURED A PERSONAL HISTORY

(a) Has Proposed Insured A:	Yes	No
i) Had any Life or Disability Insurance application declined or rated?	☐	☐
ii) Had any driver's license suspended or revoked, plead guilty to or been convicted of driving while impaired, intoxicated or under the influence of any drug; or plead guilty to or been convicted of two or more moving violations within the past three years?	☐	☐
iii) Ever plead guilty to, or been convicted of, a felony or misdemeanor; or is any such charge pending?	☐	☐
iv) Declared personal or business bankruptcy in the past five years or does Proposed Insured A anticipate declaring bankruptcy within the next two years?	☐	☐
(b) Does Proposed Insured A have any plans to travel or live outside of the U.S or Canada within the next 12 months?	☐	☐
(c) Within the past two years, has Proposed Insured A engaged in, or is he or she currently engaging in, aviation activities as a pilot or crew, scuba diving, parachuting, hang gliding, mountain/rock climbing or racing of any motorized vehicles? (If "Yes", also complete the Aviation/Avocation questionnaire.)	☐	☐
(d) Has Proposed Insured A ever used any form of tobacco or nicotine based products? If yes, make all that apply and complete the details below:	☐	☐

Type	Frequency	MO/YR Last Used	Type	Frequency	MO/YR Last Used
☐ Cigarettes			☐ Nicotine Patches		
☐ Cigars			☐ Nicotine Gum		
☐ Pipes			☐ Snuff		
☐ Chewing Tobacco			☐ Other (list):		

8. PAYMENT METHOD AND FREQUENCY

(a) Payment Method: ☐ Automatic EFT* ☐ Check ☐ Wire Transfer
Payment With Application: $_____ (only if qualified for Temporary Insurance – Refer to Section 10)
Planned Subsequent Premium: $_____

(b) Payment Frequency: ☐ Monthly (EFT only) ☐ Quarterly ☐ Semiannually ☐ Annually

Complete for payments to be taken by EFT*:

(c) Draft the following Premiums: ☐ Initial and Subsequent Premiums ☐ Subsequent Premiums Only

(d) Account Details: Name On Account: _____ Type of Account: ☐ Checking ☐ Savings
Bank Name: _____ Account #: _____
Routing #: _____ Draft date (Not available on 29th, 30th or 31st): _____

(e) If the Premium Payor is someone other than Proposed Insured A or the Proposed Owner (complete information below):

First	MI	Last	☐ Male ☐ Female	Social Security/Tax I.D.	Date of Birth

Residence Address (may not be a P.O. Box)	City	State	Zip

Mailing Address (may be a P.O. Box)

Signature of Premium Payor

SIGNATURE

* By electing EFT you are authorizing Symetra to automatically deduct the premium from the listed checking or savings account by electronic funds transfer (EFT). The required premium amount may differ from the amount indicated above due to any changes that may occur prior to issue.

9. REMARKS

For any "Yes" answers or additional information to Sections 5, 6, 7 & 10, please provide details here:

10. TEMPORARY LIFE INSURANCE AGREEMENT

Temporary Life Insurance Agreement (TIA) questions: For any "Yes" answers to questions (a) – (b) below please provide details in the Remarks Section 9 including doctor names, addresses, dates and treatments.	Yes	No
(a) Within the past 90 days, has Proposed Insured A been admitted to, or been advised by a member of the medical profession, to be admitted to a hospital?	☐	☐
(b) In the past two years, has Proposed Insured A been treated for: heart disease, stroke, tumor, mass, cancer, alcohol, drugs, or Acquired Immunodeficiency Syndrome (AIDS)/Aids Related Complex (ARC) by a member of the medical profession?	☐	☐

For all plans, except Symetra SUL-G, if Proposed Insured A is under age 75 and the face amount is $1,000,000 or less and the TIA questions above are answered NO, Proposed Insured A will be covered for up to $250,000 under the TIA if a check is collected for the initial payment or if initial premium payment by EFT or wire transfer is selected (maximum coverage for all Symetra applications is $250,000). For Symetra SUL-G plans, TIA is offered under the Additional Insured Application.

NOTE TO AGENT/INSURANCE PRODUCER: For any Yes answers to questions (a) – (b) or if the face amount is greater than $1,000,000, do not collect premium. No TIA coverage will be in effect.

AUTHORIZATION TO RELEASE PERSONAL INFORMATION

I hereby authorize and request any medical care provider, pharmacy, pharmacy benefits manager, individual employer, insurance company, reinsuring company, medical examiners, government unit, consumer reporting agency, or other person or organization, and MIB, Inc., to disclose any and all medical information, non-medical information, employment information, and insurance information they hold concerning me, to the employees, agents, or attorneys of Symetra Life Insurance Company. This disclosure Authorization will permit employees, agents or reinsurers of Symetra Life Insurance Company to view, copy, be furnished copies, share, or be given details of all such information described above including, but not limited to, mental and physical condition, evaluation, diagnoses, treatment, prognoses, prescription records, and/or toxicology results; specifically to include drug or alcohol use, mental illness, psychiatric treatment or diagnosis, testing and/or treatment of HIV (AIDS virus) and/or other sexually-transmitted diseases. Symetra Life Insurance Company obtains medical information only in connection with specific products or claims. Symetra Life Insurance Company will not use or share personally identifiable medical information for any purpose other than the underwriting or administration of your policy, claim or account. I understand that the information obtained pursuant to this Authorization will be used for the purpose of verifying, evaluating, negotiating, and other pertinent legal uses, with respect to my application for insurance, or claim under a policy of insurance. This Authorization will expire at the end of the contestability period of any insurance policy issued in reliance on the records obtained through this Authorization or twenty-four (24) months after the date of signing this Authorization. The individual signing this Authorization has the right to revoke Authorization in writing, except to the extent that action has been taken in reliance on the Authorization, or during a contestability period. A written statement revoking this Authorization delivered to Symetra Life Insurance Company at its usual business address will revoke this Authorization. Any copy of this Authorization shall have the same authority as the original. I also understand that I or my representative have a right to receive a copy of this Authorization upon request.

I authorize Symetra Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB.

I (we) agree that all statements and answers recorded on this application are true and complete to the best of my/our knowledge and belief, and shall form a part of any policy issued. I have also read the Temporary Life Insurance Agreement. (Maximum Temporary Insurance Coverage is $250,000.)

Fraud Warning: Any person who, with intent to defraud or knowing he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

☐ Please check here if you would like to receive a copy of an investigative report (if any) obtained during the application process.

I acknowledge this insurance policy was not a prerequisite to receiving credit, property or services from any bank and that the amount of insurance I am applying for may not meet my complete financial needs. I have received information both orally and in writing stating that this insurance product is not a deposit or other obligation of, or guaranteed by, any bank or an affiliate of a bank and that the insurance product is not insured by the Federal Deposit Insurance Corporation (FDIC) or any other agency of the United States, or an affiliate of a bank.

Under penalties of perjury, I certify that the number shown on this form is my correct Social Security or Tax Identification Number, I am a U.S. citizen or other U.S. person, and I am not subject to backup withholding due to failure to report all interest or dividends.

☐ Check this box if you have received a notification from the IRS that you are subject to backup withholding.

☐ Check this box if you are claiming Non-U.S. status and submitting an appropriate withholding certificate (usually a signed IRS Form W-8 or IRS Form 8233) instead of agreeing to this certification.

The IRS does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

The section below must be completed in entirety to ensure your application can be processed.

Signed this _____ **, at** _____ **, State of** _____

Date (mm/dd/yyy) **City** **State**

Printed Name of Proposed Insured A	Printed Name of Proposed Owner* (if other than insured)
Signature Name of Proposed Insured A	Signature of Owner* (if other than Insured)

Printed Name of Writing/Authorized Primary Insurance Producer	Primary Insurance Producer Phone
Signature of Writing/Authorized Primary Insurance Producer	Primary Insurance Producer Email

*If Proposed Owner is a corporation/partnership, a corporate officer/partner or a Trust or Trustee, other than Proposed Insured must sign including title.

1. AGENT REPLACEMENT QUESTIONS	**Yes**	**No**
(a) Does the Proposed Owner(s) have any existing life insurance policies or annuity contracts with this or any other company?	☐	☐
(b) To the best of your knowledge, is this insurance expected to replace or change any existing life insurance or annuity?	☐	☐
(c) If replacing, how does this policy better serve the Proposed Owner's needs?		

2. ADDITIONAL INFORMATION	**Yes**	**No**
(a) Were you in the presence of the Proposed Insured(s) and/or Owner(s) when the application was taken?	☐	☐
(b) Based on your reasonable inquiry about the Proposed Owner(s) financial situation, insurance objectives and needs, do you believe that the coverage, as applied for, is suitable for their insurance needs and anticipated financial objectives?	☐	☐
(c) Is this Policy being funded via a premium financing loan or with funds borrowed, advanced or paid from another person or entity?	☐	☐
(d) Do you have any knowledge as to whether a formal or informal application for life insurance on the Proposed Insured(s) has been submitted to another insurer or reviewed by one or more reinsurance companies on a facultative basis in the past two years?	☐	☐
(e) Does the Proposed Owner(s) intend to assign or sell, or has the Proposed Owner(s) been involved in any discussion about the possible sale or assignment of, the life insurance policy for which the application is being made?	☐	☐
(f) Has the Proposed Owner(s) ever sold a policy to a life settlement, viatical or other secondary market provider, or is the Proposed Owner(s) in process of selling a policy?	☐	☐
(g) How long have you known the Proposed Insured(s) and in what capacity?		

(h) What insurance need is being met with this application?	(i) Source of funds used to pay premiums on this policy? (Check all that apply):
☐ Debt/Family/Business Protection ☐ Income Replacement ☐ Retirement/Estate Planning ☐ Other _____	☐ Current Income ☐ CD's or Savings ☐ Mutual Funds or Brokerage Account ☐ Existing Life Insurance or Annuity Policy(ies) ☐ Other _____

3. AGENT INFORMATION – List all Agents/Producers assisting in the sale:

Agent/Producer Name	Firm	Phone #	STAT #	Commission Share (%)
(1) Primary:				
(2)				
(3)				
(4)				

4. AGENT CERTIFICATION & SIGNATURES:	**Yes**	**No**
1. I/We have reviewed all the questions on this application and certify that the answers have been recorded accurately. I/We know of nothing affecting the insurability of the Proposed Insured(s) which is not fully recorded in this application.	☐	☐
2. I/We declare that if replacement is involved, I/We certify that only company approved sales materials were used in this sale and that copies of all sales materials were left with the Proposed Owner.	☐	☐
3. I/We declare I/We have not been involved in any recommendation regarding the possible sale or assignment of this policy to a life settlement, viatical or other secondary market provider.	☐	☐
4. I/We declare that I/We have verified that all life insurance coverage in force, or in the process of being applied for, on the Proposed Insured has been disclosed on this application, including any coverage that has been sold or is in the process of being sold to a life settlement, viatical or other secondary market provider.	☐	☐
5. I/We declare, to the best of my knowledge that this policy is not being funded via non-recourse premium financing and is not being paid for with funds from any person or entity whose only interest in the policy is the potential for earnings based on the provision of funding for the policy.	☐	☐
6. I/We declare that I/We have accurately answered all questions contained in the Agent's Report in connection with this application.	☐	☐
7. I/We certify that I/We have verified the identity of each owner/insured by reviewing a valid government issued photo identification.	☐	☐

Signature of Producer 1 _____ Date _____

Signature of Producer 2 _____ Date _____

Signature of Producer 3 _____ Date _____

Signature of Producer 4 _____ Date _____

NOTICE OF INSURANCE INFORMATION PRACTICES

MIB, Inc. (Medical Information Bureau, MIB) – Information regarding your insurability will be treated as confidential. Symetra Life or its reinsurers may, however, make a brief report thereon to MIB, 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 in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. 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. Information for consumers about MIB may be obtained on its website at www.mib.com. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734. MIB may also be contacted at 1-866-692-6901 (TTY 1-866-346-3642). Symetra Life or its reinsurers may also release information in 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.

Investigative Consumer Report – As a part of our underwriting procedure, we may request an investigative consumer report from a consumer reporting agency. A consumer report confirms and supplements the information on your application about your employment, residence, finances, smoking habits, marital status, occupation, hazardous avocations and general health. This report may also include information concerning your general reputation, personal characteristics and mode of living except as may be related directly or indirectly to your sexual orientation, including drug and alcohol use, motor vehicle driving record and any criminal activity. This information may be obtained through personal interviews with you, your family, friends, neighbors and business associates. If a report is required, you may request to be personally interviewed. If you wish to be personally interviewed, request this in the remarks section of this application and we will notify the consumer reporting agency.

The information contained in the report may be retained by the consumer reporting agency and later disclosed to other companies to the extent permitted by the Fair Credit Reporting Act. We hold investigative consumer reports in strict confidence, and we use them only to evaluate your application on a fair and equitable basis. You have a right to inspect and obtain a copy of this report from the consumer reporting agency. Such a report rarely has an adverse effect on an individual's eligibility for insurance. If it should, however, we will notify you in writing, and identify the reporting agency. You, or your authorized representative, are entitled to a copy of the Notice of Insurance Information Practices.

Disclosure to Others – Personal information we obtain about you during the underwriting process is confidential, and we will not disclose it to other persons or organizations without your written authorization, except to the extent necessary for the conduct of our business. Examples of situations where we may share information about you follow:

1. The agent may retain a copy of your application. If reinsurance is required, the reinsurance company will have access to our application file. We give the consumer reporting agency enough identity information about you so that it may initiate a consumer report investigation.
2. We may release information to another life insurance company to whom you have applied for life or health insurance, or to whom you have submitted a claim for benefits, if you have authorized that company to obtain such information, and it submits your authorization to us with its request for information.
3. As stated earlier, we may report information to MIB.
4. We may release information to persons or organizations conducting bona fide actuarial or scientific research studies, audits or evaluations, or to our affiliates who may wish to market products or services.
5. We will disclose information to government regulatory officials, law enforcement authorities, and others where required by law.

Access and Correction – In general, you have a right to learn the nature and substance of any personal information about you in our file, upon your written request. Whenever we make an adverse underwriting decision, we will notify you of the reasons for the decision and the source of the information on which we based our decision. Please refer to the section on MIB, Inc., for that organization's disclosure procedure. There are procedures by which you can obtain access to personal information about you appearing in our policy files, including information contained in investigative consumer reports. We have also established procedures by which you may request correction, amendment or deletion of any information in our files which you believe to be inaccurate or irrelevant. A description of these procedures will also be sent to you upon request. If you feel that any information we have is inaccurate or incomplete, please write to the Life New Business Department of Symetra Life, PO Box 549291, Waltham, MA 02454-9291. Your comments will be carefully considered and corrections made where justified.

TEMPORARY LIFE INSURANCE AGREEMENT

For All plans EXCEPT Symetra UL-G. The Temporary Life Insurance Agreement for Symetra UL-G plans is provided for in the Additional Insured Application.

AMOUNT OF COVERAGE: If the Temporary Life Insurance questions have been answered "no" and if money has been accepted as advance payment for life insurance and Proposed Insured A dies while this temporary insurance is in effect, we will pay the beneficiary an amount equal to the lesser of:

(a) the amount of all death benefits applied for with this application, including any accidental death benefits, if applicable; or
(b) a maximum amount under all Temporary Life Insurance Agreements with Symetra Life of $250,000.

COVERAGE BEGINS: Life insurance under this Agreement will begin on the date of this application, if the Temporary Life Insurance questions have been completed and answered "no" and money equal to the first full premium has been accepted as advance payment for life insurance.

COVERAGE ENDS: Life insurance under this Agreement will terminate on the earliest of:

(a) 90 days from the date of this Agreement; or
(b) the date that insurance takes effect under the policy applied for; or
(c) the date a policy, other than as applied for, is offered to the Applicant; or
(d) the date the Company mails notice of termination of coverage and a return of the payment to the Applicant.

LIMITATIONS:

(a) This Agreement does not provide benefits for disability.
(b) Fraud or material misrepresentation in the application or in the answers to the questions of this Agreement invalidate this Agreement and the Company's only liability is for refund of the payment made.
(c) If Proposed Insured A is less than 15 days old or more than 75 years old, the Company's liability under this Agreement is limited to a refund of the payment made.
(d) If Proposed Insured A commits suicide, the Company's liability under this Agreement is limited to a refund of the payment made.
(e) If the check or draft submitted as payment is not honored by the bank, there is no coverage under this Agreement.
(f) No one is authorized to waive or modify the terms of this Agreement.

Symetra Life Insurance Company
777 108th Avenue NE, Suite 1200 | Bellevue, WA 98004-5135
Mail to New Business: PO Box 549291 | Waltham, MA 02454-9291
Fax: 1-877-435-5500

IMPORTANT NOTICE TO APPLICANT/BUYER REGARDING ACCELERATED DEATH BENEFITS

CHRONIC ILLNESS PLUS RIDER - ACCELERATED DEATH BENEFIT

The benefits provided by this accelerated death benefits are not intended to provide, and will never provide long-term care insurance, nursing home insurance, or home care insurance. If you are interested in long-term care or nursing home or home care insurance, you should consult with an insurance agent licensed to sell that insurance, inquire with the insurance company offering the accelerated death benefits, or visit the California Department of Insurance Internet Web site (www.insurance.ca.gov) section regarding long-term care insurance.

The benefits payable under this Rider are intended to qualify as accelerated death benefits under section 101(g) of the Internal Revenue Code of 1986, as amended ("the Code"). These benefits are not intended to qualify as long-term care insurance under section 7702B of the Code.

The receipt of an accelerated death benefit may be taxable to You, if the benefit does not satisfy all qualification requirements under the Code or to the extent it exceeds the maximum per diem limit under section 101(g) of the Code. Additionally, the receipt of this benefit will reduce the amount your beneficiary(ies) will receive upon your death.

Receipt of this benefit will reduce the amount your beneficiary(ies) will receive upon Your death. In addition, Your Policy's Death Benefit, Cash Surrender Value, and available loan value will be reduced. In addition, You may lose Your right to receive certain public funds such as Medi-Cal, Medicaid, Social Security, Supplemental Security Income (SSI), and possibly others. Prior to electing to buy the accelerated death benefit, You should consult with the appropriate social services agency concerning how receipt of accelerated death benefits may affect that eligibility.

YOU SHOULD CONSULT YOUR PERSONAL TAX OR LEGAL ADVISOR BEFORE CLAIMING FOR A BENEFIT UNDER THIS RIDER.

This Disclosure Statement is intended to help You understand the Chronic Illness Plus Rider. This disclosure does not change any provisions of the Rider or the Policy to which it is attached.

What is the Chronic Illness Plus Rider?

The Chronic Illness Plus Rider provides an Accelerated Death Benefit and must be elected at issue. The Rider allows You to advance or "accelerate" up to 100% of the Policy's Death Benefit prior to the death of the Insured if the Insured is certified as a Chronically Ill Person, as defined by the Internal Revenue Code[1]. The amount of the Accelerated Death Benefit, whether paid in annual lump sum or in monthly payments, will be limited to the per diem amount set by the Internal Revenue Service. See "How is each Acceleration Payment determined" for additional details.

Is there a charge for the Chronic Illness Rider?

[1] Defined as a person who is (a) permanently unable to perform (without substantial assistance from another person) at least two activities of daily living due to loss of functional capacity or (b) requires substantial supervision to protect himself or herself from threats to health and safety due to severe cognitive impairment.

Yes, on each Policy Monthly Anniversary, We will deduct a charge equal to twelve multiplied by the Chronic Illness Plus Rate (based on issue age, gender, risk class, Policy duration, and Death Benefit) divided by the Account Value Net Amount at Risk.

A similar charge will be deducted from Your Lapse Protection Value if You elected the Lapse Protection Benefit Rider.

No surrender charge will apply when You receive an Accelerated Death Benefit.

What triggers the payment of the Accelerated Death Benefit?

While the Insured is alive and the Rider in effect, You can claim an Accelerated Death Benefit if, during the prior 12-month period, the Insured was certified by a Licensed Health Care Practitioner[2] as being a Chronically Ill Person and the Insured has received a written plan of care prescribed by a Licensed Health Care Practitioner setting forth the qualifying services required by the Insured. For this purpose, qualifying services mean the necessary diagnostic, preventative, therapeutic, curing, treating, mitigating and rehabilitative services required because the Insured is a Chronically Ill Person. Qualifying services include personal care services, which consist of any care with the primary purpose of providing needed assistance with any of the disabilities as a result of which the Insured is a Chronically Ill Person.

We may, at Our expense, require certification by a Licensed Physician of Our choice. If there is a difference of opinion regarding the Insured's eligibility for benefits, We may seek, at Our expense, a third medical opinion of a Licensed Physician that is mutually acceptable to the Insured and Us.

Prior to paying an Accelerated Death Benefit, We will provide You, any irrevocable beneficiary, and any assignee, with a statement demonstrating the effect of acceleration on Your Policy values. All irrevocable beneficiaries and assignees must approve, in writing, to the payment of an Accelerated Death Benefit.

How is each Accelerated Death Benefit Payment Determined?

You may request to receive Accelerated Death Benefit payments monthly or in an annual lump sum. At time of claim We will determine the available Death Benefit and the amount of each Accelerated Death Benefit payment based on the payment frequency requested.

Monthly payment amounts for each Payment Period (defined below) are equal to the lesser of (1) 2% of Your Rider Benefit Balance on the first day of the initial Payment Period and (2) the Per Diem Limit multiplied by 30.

The annual payment amount for a Payment Period is equal to the lesser of (1) 2% of Your Rider Benefit Balance on the first day of the initial Payment Period multiplied by the number of Policy months in the Payment Period and (2) the Per Diem Limit multiplied by 30 multiplied by the number of months in the Payment Period.

If Your Policy has a loan, the amount You receive will be less than the amount You elect because We will reduce each Accelerated Death Benefit payment proportionally by the amount of the outstanding loan.

[2] As defined in the Rider based upon the requirements of the Internal Revenue Service

What is a Payment Period?

This is a period of time, not to exceed 12 months, during which the Insured is eligible to receive Accelerated Death Benefit payments. The initial Payment Period begins on the next Monthly Anniversary following receipt of Your request for acceleration in good order and ends 12-months after the date of the initial Written Certification. Each subsequent period begins following the completion of the previous period provided We have received Your Written Recertification.

What happens to Policy Values, Policy Charges and Policy Actions when an Accelerated Death Benefit is Paid?

Each Accelerated Death Benefit payment will reduce Your Policy's Death Benefit dollar for dollar and will reduce any Policy Accumulation Value, Lapse Protection Value and loans proportionally based on the amount of the payment.

Each Accelerated Death Benefit payment will first be applied to repay any outstanding Policy loan, or interest accrued on a Policy loan.

During each Payment Period, We will waive any Cost of Insurance and Expense Charges, Charges related to any Lapse Protection Benefit Rider and any charges for this Rider. No premiums are required during a payment period and Your policy will not lapse.

An Accelerated Death Benefit payment will not impact any active Policy riders or benefits in effect at the time such payment is made and as such any monthly charges related to such riders will continue to be assessed.

If You never made a claim under this Rider, there will be no effect on Your Policy.

What happens if I pass away while receiving Accelerated Death Benefit payments?

Your beneficiaries will be entitled to the Remaining Death Benefit which is equal to the greater of (1) the amount of Policy Death Benefit not accelerated, net of any Policy loans, liens, or interest thereon and (2) $5,000.

This Disclosure Statement is intended to help You understand the Chronic Illness Plus Rider - Accelerated Death Benefit. This disclosure does not change any provisions of the Rider or the Policy to which it is attached.

I have read, or have had read to me, this Important Notice to Applicant/Buyer Regarding Accelerated Death Benefits and acknowledge receipt of a copy.

Signed in _____, this ____ day of _____, _____
(city, state) (Date) (month) (year)

_____ _____
Signature of Proposed Owner Signature of Writing Agent

Symetra Life Insurance Company
777 108th Avenue NE, Suite 1200 | Bellevue, WA 98004-5135
Mail to New Business: PO Box 549291 | Waltham, MA 02454-9291
Fax: 1-877-435-5500

IMPORTANT NOTICE TO APPLICANT/BUYER REGARDING ACCELERATED DEATH BENEFITS

CHRONIC ILLNESS PLUS RIDER - ACCELERATED DEATH BENEFIT

The benefits provided by this accelerated death benefits are not intended to provide, and will never provide long-term care insurance, nursing home insurance, or home care insurance. If you are interested in long-term care or nursing home or home care insurance, you should consult with an insurance agent licensed to sell that insurance, inquire with the insurance company offering the accelerated death benefits, or visit the California Department of Insurance Internet Web site (www.insurance.ca.gov) section regarding long-term care insurance.

The benefits payable under this Rider are intended to qualify as accelerated death benefits under section 101(g) of the Internal Revenue Code of 1986, as amended ("the Code"). These benefits are not intended to qualify as long-term care insurance under section 7702B of the Code.

The receipt of an accelerated death benefit may be taxable to You, if the benefit does not satisfy all qualification requirements under the Code or to the extent it exceeds the maximum per diem limit under section 101(g) of the Code. Additionally, the receipt of this benefit will reduce the amount your beneficiary(ies) will receive upon your death.

Receipt of this benefit will reduce the amount your beneficiary(ies) will receive upon Your death. In addition, Your Policy's Death Benefit, Cash Surrender Value, and available loan value will be reduced. In addition, You may lose Your right to receive certain public funds such as Medi-Cal, Medicaid, Social Security, Supplemental Security Income (SSI), and possibly others. Prior to electing to buy the accelerated death benefit, You should consult with the appropriate social services agency concerning how receipt of accelerated death benefits may affect that eligibility.

YOU SHOULD CONSULT YOUR PERSONAL TAX OR LEGAL ADVISOR BEFORE CLAIMING FOR A BENEFIT UNDER THIS RIDER.

This Disclosure Statement is intended to help You understand the Chronic Illness Plus Rider. This disclosure does not change any provisions of the Rider or the Policy to which it is attached.

What is the Chronic Illness Plus Rider?

The Chronic Illness Plus Rider provides an Accelerated Death Benefit and must be elected at issue. The Rider allows You to advance or "accelerate" up to 100% of the Policy's Death Benefit prior to the death of the Insured if the Insured is certified as a Chronically Ill Person, as defined by the Internal Revenue Code[1]. The amount of the Accelerated Death Benefit, whether paid in annual lump sum or in monthly payments, will be limited to the per diem amount set by the Internal Revenue Service. See "How is each Acceleration Payment determined" for additional details.

Is there a charge for the Chronic Illness Rider?

[1] Defined as a person who is (a) permanently unable to perform (without substantial assistance from another person) at least two activities of daily living due to loss of functional capacity or (b) requires substantial supervision to protect himself or herself from threats to health and safety due to severe cognitive impairment.

Yes, on each Policy Monthly Anniversary, We will deduct a charge equal to twelve multiplied by the Chronic Illness Plus Rate (based on issue age, gender, risk class, Policy duration, and Death Benefit) divided by the Account Value Net Amount at Risk.

A similar charge will be deducted from Your Lapse Protection Value if You elected the Lapse Protection Benefit Rider.

No surrender charge will apply when You receive an Accelerated Death Benefit.

What triggers the payment of the Accelerated Death Benefit?

While the Insured is alive and the Rider in effect, You can claim an Accelerated Death Benefit if, during the prior 12-month period, the Insured was certified by a Licensed Health Care Practitioner[2] as being a Chronically Ill Person and the Insured has received a written plan of care prescribed by a Licensed Health Care Practitioner setting forth the qualifying services required by the Insured. For this purpose, qualifying services mean the necessary diagnostic, preventative, therapeutic, curing, treating, mitigating and rehabilitative services required because the Insured is a Chronically Ill Person. Qualifying services include personal care services, which consist of any care with the primary purpose of providing needed assistance with any of the disabilities as a result of which the Insured is a Chronically Ill Person.

We may, at Our expense, require certification by a Licensed Physician of Our choice. If there is a difference of opinion regarding the Insured's eligibility for benefits, We may seek, at Our expense, a third medical opinion of a Licensed Physician that is mutually acceptable to the Insured and Us.

Prior to paying an Accelerated Death Benefit, We will provide You, any irrevocable beneficiary, and any assignee, with a statement demonstrating the effect of acceleration on Your Policy values. All irrevocable beneficiaries and assignees must approve, in writing, to the payment of an Accelerated Death Benefit.

How is each Accelerated Death Benefit Payment Determined?

You may request to receive Accelerated Death Benefit payments monthly or in an annual lump sum. At time of claim We will determine the available Death Benefit and the amount of each Accelerated Death Benefit payment based on the payment frequency requested.

Monthly payment amounts for each Payment Period (defined below) are equal to the lesser of (1) 2% of Your Rider Benefit Balance on the first day of the initial Payment Period and (2) the Per Diem Limit multiplied by 30.

The annual payment amount for a Payment Period is equal to the lesser of (1) 2% of Your Rider Benefit Balance on the first day of the initial Payment Period multiplied by the number of Policy months in the Payment Period and (2) the Per Diem Limit multiplied by 30 multiplied by the number of months in the Payment Period.

If Your Policy has a loan, the amount You receive will be less than the amount You elect because We will reduce each Accelerated Death Benefit payment proportionally by the amount of the outstanding loan.

[2] As defined in the Rider based upon the requirements of the Internal Revenue Service

What is a Payment Period?

This is a period of time, not to exceed 12 months, during which the Insured is eligible to receive Accelerated Death Benefit payments. The initial Payment Period begins on the next Monthly Anniversary following receipt of Your request for acceleration in good order and ends 12-months after the date of the initial Written Certification. Each subsequent period begins following the completion of the previous period provided We have received Your Written Recertification.

What happens to Policy Values, Policy Charges and Policy Actions when an Accelerated Death Benefit is Paid?

Each Accelerated Death Benefit payment will reduce Your Policy's Death Benefit dollar for dollar and will reduce any Policy Accumulation Value, Lapse Protection Value and loans proportionally based on the amount of the payment.

Each Accelerated Death Benefit payment will first be applied to repay any outstanding Policy loan, or interest accrued on a Policy loan.

During each Payment Period, We will waive any Cost of Insurance and Expense Charges, Charges related to any Lapse Protection Benefit Rider and any charges for this Rider. No premiums are required during a payment period and Your policy will not lapse.

An Accelerated Death Benefit payment will not impact any active Policy riders or benefits in effect at the time such payment is made and as such any monthly charges related to such riders will continue to be assessed.

If You never made a claim under this Rider, there will be no effect on Your Policy.

What happens if I pass away while receiving Accelerated Death Benefit payments?

Your beneficiaries will be entitled to the Remaining Death Benefit which is equal to the greater of (1) the amount of Policy Death Benefit not accelerated, net of any Policy loans, liens, or interest thereon and (2) $5,000.

This Disclosure Statement is intended to help You understand the Chronic Illness Plus Rider - Accelerated Death Benefit. This disclosure does not change any provisions of the Rider or the Policy to which it is attached.

I have read, or have had read to me, this Important Notice to Applicant/Buyer Regarding Accelerated Death Benefits and acknowledge receipt of a copy.

Signed in _____, this ____ day of _____, _____
(city, state) (Date) (month) (year)

_____ _____
Signature of Proposed Owner Signature of Writing Agent

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Fax: 1-877-435-5500

IMPORTANT NOTICE TO APPLICANT/BUYER REGARDING ACCELERATED DEATH BENEFITS

CHRONIC ILLNESS RIDER – ACCELERATED DEATH BENEFIT

The benefits provided by this accelerated death benefits are not intended to provide, and will never provide, long-term care insurance, nursing home insurance, or home care insurance. If you are interested in long-term care or nursing home or home care insurance, you should consult with an insurance agent licensed to sell that insurance, inquire with the insurance company offering the accelerated death benefits, or visit the California Department of Insurance Internet Web site (www.insurance.ca.gov) section regarding long-term care insurance.

The benefits payable under this Rider are intended to qualify as accelerated death benefits under section 101(g) of the Internal Revenue Code of 1986, as amended ("the Code"). These benefits are not intended to qualify as long-term care insurance under section 7702B of the Code.

The receipt of an accelerated death benefit may be taxable to You, if the benefit does not satisfy all qualification requirements under the Code or to the extent it exceeds the maximum per diem limit under section 101(g) of the Code. Additionally, the receipt of this benefit will reduce the amount your beneficiary(ies) will receive upon your death.

Receipt of this benefit will reduce the amount your beneficiary(ies) will receive upon Your death . In addition, Your Policy's Death Benefit, Cash Surrender Value, and available loan value will be reduced. You may also lose Your right to receive certain public funds such as Medi-Cal, Medicaid, Social Security, Supplemental Security Income (SSI), and possibly others. Prior to electing to buy the accelerated death benefit, you should consult with the appropriate social services agency concerning how receipt of accelerated death benefits may affect that eligibility.

YOU SHOULD CONSULT YOUR PERSONAL TAX OR LEGAL ADVISOR BEFORE CLAIMING FOR A BENEFIT UNDER THIS RIDER.

This Disclosure Statement is intended to help You understand the Chronic Illness Rider. This disclosure does not change any provisions of the Rider or the Policy to which it is attached.

What is the Chronic Illness Rider?

The Chronic Illness Rider provides an Accelerated Death Benefit. That is, the Rider allows You to advance or "accelerate" up to 50% of the Policy's Death Benefit (up to a maximum of $500,000) prior to the death of the Insured if the Insured is certified as a Chronically Ill Person, as defined by the Internal Revenue Code[1]. The amount of the Accelerated Death Benefit, whether paid in a lump sum or in monthly payments, will be limited to the per diem amount set by the Internal Revenue Service.

[1] Defined as a person who is (a) permanently unable to perform (without substantial assistance from another person at least two activities of daily living due to loss of functional capacity or (b) requires substantial supervision to protect himself or herself from threats to health and safety due to severe cognitive impairment.

Is there a charge for the Chronic Illness Rider?

No, there is no charge for the Rider.

What triggers the payment of the Accelerated Death Benefit?

While the Insured is alive and the Rider in effect, You can claim an Accelerated Death Benefit if, during the prior 12-month period, the Insured was certified by a Licensed Health Care Practitioner[2] that the Insured is a Chronically Ill Person and has a written plan of care prescribed by a Licensed Health Care Practitioner setting forth the qualifying services required by the Insured. For this purpose, qualifying services mean the necessary diagnostic, preventative, therapeutic, curing, treating, mitigating and rehabilitative services required because the Insured is a Chronically Ill Person. Qualifying services include personal care services, which consist of any care with the primary purpose of providing needed assistance with any of the disabilities as a result of which the Insured is a Chronically Ill Person.

We may, at Our expense, require certification by a Licensed Physician of Our choice. If there is a difference of opinion regarding the Insured's eligibility for benefits, We may seek, at Our expense, a third medical opinion of a Licensed Physician that is mutually acceptable to the Insured and Us.

All irrevocable beneficiaries and assignees must approve, in writing, to the payment of an Accelerated Death Benefit.

What happens to Policy values if an Accelerated Death Benefit is Paid?

Payment of an Accelerated Death Benefit will reduce Your Policy's Death Benefit, Cash Value, and loan value. Your policy will remain in force but will be encumbered by a lien against the Death Benefit. The lien will accrue interest and the remaining Death Benefit will be reduced by the amount of the lien

The Accelerated Death Benefit will first be applied to repay any outstanding Policy loan and accrued Policy loan interest.

Any Partial Withdrawal, surrender, or Policy loan taken after We pay the Accelerated Death Benefit will be limited to the excess of the Net Cash Surrender Value over the lien.

Future Premiums, Cost of Insurance charges, and Expense Charges on this Policy will not be affected by the payment of an Accelerated Death Benefit.

When Your Remaining Death Benefit is equal to $5,000, no further Accelerated Death Benefit payments will be allowed. At that time,

- Monthly Deductions and Policy loan interest charges will cease;
- no additional Premium payments or loan repayments will be accepted; and
- no new Partial Withdrawals or loans will be available.

Payment of an Accelerated Death Benefit will not impact any active riders or benefits of the Policy in effect at the time such payment is made.

If You never made a claim under this Rider, there will be no effect on Your Policy.

[2] As defined in the Rider based upon the requirements of the Internal Revenue Service

This Disclosure Statement is intended to help You understand the Chronic Illness Rider - Accelerated Death Benefit. This disclosure does not change any provisions of the Rider or the Policy to which it is attached.

I have read, or have had read to me, this Important Notice to Applicant/Buyer Regarding Accelerated Death Benefits and acknowledge receipt of a copy.

Signed in _____, this ____ day of _____, _____
(city, state) (Date) (month) (year)

_____ _____
Signature of Proposed Owner Signature of Writing Agent

Symetra Life Insurance Company
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Fax: 1-877-435-5500

IMPORTANT NOTICE TO APPLICANT/BUYER REGARDING ACCELERATED DEATH BENEFITS

CHRONIC ILLNESS RIDER – ACCELERATED DEATH BENEFIT

The benefits provided by this accelerated death benefits are not intended to provide, and will never provide, long-term care insurance, nursing home insurance, or home care insurance. If you are interested in long-term care or nursing home or home care insurance, you should consult with an insurance agent licensed to sell that insurance, inquire with the insurance company offering the accelerated death benefits, or visit the California Department of Insurance Internet Web site (www.insurance.ca.gov) section regarding long-term care insurance.

The benefits payable under this Rider are intended to qualify as accelerated death benefits under section 101(g) of the Internal Revenue Code of 1986, as amended ("the Code"). These benefits are not intended to qualify as long-term care insurance under section 7702B of the Code.

The receipt of an accelerated death benefit may be taxable to You, if the benefit does not satisfy all qualification requirements under the Code or to the extent it exceeds the maximum per diem limit under section 101(g) of the Code. Additionally, the receipt of this benefit will reduce the amount your beneficiary(ies) will receive upon your death.

Receipt of this benefit will reduce the amount your beneficiary(ies) will receive upon Your death . In addition, Your Policy's Death Benefit, Cash Surrender Value, and available loan value will be reduced. You may also lose Your right to receive certain public funds such as Medi-Cal, Medicaid, Social Security, Supplemental Security Income (SSI), and possibly others. Prior to electing to buy the accelerated death benefit, you should consult with the appropriate social services agency concerning how receipt of accelerated death benefits may affect that eligibility.

YOU SHOULD CONSULT YOUR PERSONAL TAX OR LEGAL ADVISOR BEFORE CLAIMING FOR A BENEFIT UNDER THIS RIDER.

This Disclosure Statement is intended to help You understand the Chronic Illness Rider. This disclosure does not change any provisions of the Rider or the Policy to which it is attached.

What is the Chronic Illness Rider?

The Chronic Illness Rider provides an Accelerated Death Benefit. That is, the Rider allows You to advance or "accelerate" up to 50% of the Policy's Death Benefit (up to a maximum of $500,000) prior to the death of the Insured if the Insured is certified as a Chronically Ill Person, as defined by the Internal Revenue Code[1]. The amount of the Accelerated Death Benefit, whether paid in a lump sum or in monthly payments, will be limited to the per diem amount set by the Internal Revenue Service.

[1] Defined as a person who is (a) permanently unable to perform (without substantial assistance from another person at least two activities of daily living due to loss of functional capacity or (b) requires substantial supervision to protect himself or herself from threats to health and safety due to severe cognitive impairment.

Is there a charge for the Chronic Illness Rider?

No, there is no charge for the Rider.

What triggers the payment of the Accelerated Death Benefit?

While the Insured is alive and the Rider in effect, You can claim an Accelerated Death Benefit if, during the prior 12-month period, the Insured was certified by a Licensed Health Care Practitioner[2] that the Insured is a Chronically Ill Person and has a written plan of care prescribed by a Licensed Health Care Practitioner setting forth the qualifying services required by the Insured. For this purpose, qualifying services mean the necessary diagnostic, preventative, therapeutic, curing, treating, mitigating and rehabilitative services required because the Insured is a Chronically Ill Person. Qualifying services include personal care services, which consist of any care with the primary purpose of providing needed assistance with any of the disabilities as a result of which the Insured is a Chronically Ill Person.

We may, at Our expense, require certification by a Licensed Physician of Our choice. If there is a difference of opinion regarding the Insured's eligibility for benefits, We may seek, at Our expense, a third medical opinion of a Licensed Physician that is mutually acceptable to the Insured and Us.

All irrevocable beneficiaries and assignees must approve, in writing, to the payment of an Accelerated Death Benefit.

What happens to Policy values if an Accelerated Death Benefit is Paid?

Payment of an Accelerated Death Benefit will reduce Your Policy's Death Benefit, Cash Value, and loan value. Your policy will remain in force but will be encumbered by a lien against the Death Benefit. The lien will accrue interest and the remaining Death Benefit will be reduced by the amount of the lien

The Accelerated Death Benefit will first be applied to repay any outstanding Policy loan and accrued Policy loan interest.

Any Partial Withdrawal, surrender, or Policy loan taken after We pay the Accelerated Death Benefit will be limited to the excess of the Net Cash Surrender Value over the lien.

Future Premiums, Cost of Insurance charges, and Expense Charges on this Policy will not be affected by the payment of an Accelerated Death Benefit.

When Your Remaining Death Benefit is equal to $5,000, no further Accelerated Death Benefit payments will be allowed. At that time,

- Monthly Deductions and Policy loan interest charges will cease;
- no additional Premium payments or loan repayments will be accepted; and
- no new Partial Withdrawals or loans will be available.

Payment of an Accelerated Death Benefit will not impact any active riders or benefits of the Policy in effect at the time such payment is made.

If You never made a claim under this Rider, there will be no effect on Your Policy.

[2] As defined in the Rider based upon the requirements of the Internal Revenue Service

This Disclosure Statement is intended to help You understand the Chronic Illness Rider - Accelerated Death Benefit. This disclosure does not change any provisions of the Rider or the Policy to which it is attached.

I have read, or have had read to me, this Important Notice to Applicant/Buyer Regarding Accelerated Death Benefits and acknowledge receipt of a copy.

Signed in _____, this ____ day of _____, _____
(city, state) (Date) (month) (year)

_____ _____
Signature of Proposed Owner Signature of Writing Agent

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IMPORTANT NOTICE TO APPLICANT/BUYER REGARDING ACCELERATED DEATH BENEFITS

TERMINAL ILLNESS RIDER – ACCELERATED DEATH BENEFIT

The benefits provided by this accelerated death benefits are not intended to provide, and will never provide, long-term care insurance, nursing home insurance, or home care insurance. If you are interested in long-term care or nursing home or home care insurance, you should consult with an insurance agent licensed to sell that insurance, inquire with the insurance company offering the accelerated death benefits, or visit the California Department of Insurance Internet Web site (www.insurance.ca.gov) section regarding long-term care insurance.

The benefits payable under this Rider are intended to qualify as accelerated death benefits under section 101(g) of the Internal Revenue Code of 1986, as amended ("the Code"). These benefits are not intended to qualify as long-term care insurance under section 7702B of the Code.

The receipt of an accelerated death benefit may be taxable to You, if the benefit does not satisfy all qualification requirements under section 101(g) of the Code. Additionally, the receipt of this benefit will reduce the amount your beneficiary(ies) will receive upon your death.

Receipt of this benefit will reduce the amount your beneficiary(ies) will receive upon your death,. In addition, Your Policy's Death Benefit, Cash Surrender Value, and available loan value will be reduced. In addition, You may lose Your right to receive certain public funds such as Medi-Cal, Medicaid, Social Security, Supplemental Security Income (SSI), and possibly others. Prior to electing to buy the accelerated death benefit, you should consult with the appropriate social services agency concerning how receipt of accelerated death benefits may affect that eligibility.

YOU SHOULD CONSULT YOUR PERSONAL TAX OR LEGAL ADVISOR BEFORE CLAIMING FOR A BENEFIT UNDER THIS RIDER.

This disclosure is intended to help You understand the Terminal Illness Rider. It does not change any provisions of the Rider or the Policy to which it is attached.

What is the Terminal Illness Rider?

The Terminal Illness Rider provides an Accelerated Death Benefit. That is, the Rider allows You to advance or "accelerate" up to 75% of the Policy's Death Benefit (up to a maximum of $500,000) prior to the death of the Insured if the Insured becomes a Terminally Ill Person, as defined by the Internal Revenue Code.

The Accelerated Death Benefit is paid in a lump sum at least equal to the percentage of the Death Benefit being accelerated multiplied by the difference between the current Accumulation Value and any outstanding Policy loans.
No surrender charge will apply when You receive an Accelerated Death Benefit.

Is there a charge for the Terminal Illess Rider?

No, there is no charge for the Rider.

What triggers the payment of the Accelerated Death Benefit?

While the Insured is alive and the Rider in effect, You can claim an Accelerated Death Benefit, if the Insured was certified by a Licensed Physician[1] as having an illness or a physical condition which can reasonably be expected to result in death within 12 months after the date of certification.

We may, at Our expense, require certification by a Licensed Physician of Our choice. If there is a difference of opinion regarding the Insured's eligibility for benefits, We may seek, at Our expense, a third medical opinion of a Licensed Physician that is mutually acceptable to the Insured and Us.

All irrevocable beneficiaries and assignees must approve, in writing, to the payment of an Accelerated Death Benefit.

What happens to Policy values if an Accelerated Death Benefit is Paid?

Payment of an Accelerated Death Benefit will reduce Your Policy's Death Benefit, Cash Value, and loan value, but the Policy will continue. The Accelerated Death Benefit will first be applied to repay any outstanding Policy loan and accrued Policy loan interest.

After We pay the Accelerated Death Benefit, any withdrawal, surrender, or Policy loan will be limited to the Net Cash Surrender Value.

Future Premuims, Cost of Insurance charges, and Expense Charges on this Policy will be proportionally reduced by the payment of an Accelerated Death Benefit.

Payment of an Accelerated Death Benefit will not impact any active riders or benefits of the Policy in effect at the time such payment is made.

If You never make a claim under this benefit, there will be no effect on the policy.

This Disclosure Statement is intended to help You understand the Terminal Illness Rider - Accelerated Death Benefit. This disclosure does not change any provisions of the Rider or the Policy to which it is attached.

I have read, or have had read to me, this Important Notice to Applicant/Buyer Regarding Accelerated Death Benefits and acknowledge receipt of a copy.

Signed in _____, this ____ day of _____, _____
(city, state) (Date) (month) (year)

_____ _____
Signature of Proposed Owner Signature of Writing Agent

[1] As defined in the Rider based upon the requirements of the Internal Revenue Service.

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IMPORTANT NOTICE TO APPLICANT/BUYER REGARDING ACCELERATED DEATH BENEFITS

TERMINAL ILLNESS RIDER – ACCELERATED DEATH BENEFIT

The benefits provided by this accelerated death benefits are not intended to provide, and will never provide, long-term care insurance, nursing home insurance, or home care insurance. If you are interested in long-term care or nursing home or home care insurance, you should consult with an insurance agent licensed to sell that insurance, inquire with the insurance company offering the accelerated death benefits, or visit the California Department of Insurance Internet Web site (www.insurance.ca.gov) section regarding long-term care insurance.

The benefits payable under this Rider are intended to qualify as accelerated death benefits under section 101(g) of the Internal Revenue Code of 1986, as amended ("the Code"). These benefits are not intended to qualify as long-term care insurance under section 7702B of the Code.

The receipt of an accelerated death benefit may be taxable to You, if the benefit does not satisfy all qualification requirements under section 101(g) of the Code. Additionally, the receipt of this benefit will reduce the amount your beneficiary(ies) will receive upon your death.

Receipt of this benefit will reduce the amount your beneficiary(ies) will receive upon your death,. In addition, Your Policy's Death Benefit, Cash Surrender Value, and available loan value will be reduced. In addition, You may lose Your right to receive certain public funds such as Medi-Cal, Medicaid, Social Security, Supplemental Security Income (SSI), and possibly others. Prior to electing to buy the accelerated death benefit, you should consult with the appropriate social services agency concerning how receipt of accelerated death benefits may affect that eligibility.

YOU SHOULD CONSULT YOUR PERSONAL TAX OR LEGAL ADVISOR BEFORE CLAIMING FOR A BENEFIT UNDER THIS RIDER.

This disclosure is intended to help You understand the Terminal Illness Rider. It does not change any provisions of the Rider or the Policy to which it is attached.

What is the Terminal Illness Rider?

The Terminal Illness Rider provides an Accelerated Death Benefit. That is, the Rider allows You to advance or "accelerate" up to 75% of the Policy's Death Benefit (up to a maximum of $500,000) prior to the death of the Insured if the Insured becomes a Terminally Ill Person, as defined by the Internal Revenue Code.

The Accelerated Death Benefit is paid in a lump sum at least equal to the percentage of the Death Benefit being accelerated multiplied by the difference between the current Accumulation Value and any outstanding Policy loans.
No surrender charge will apply when You receive an Accelerated Death Benefit.

Is there a charge for the Terminal Illess Rider?

No, there is no charge for the Rider.

What triggers the payment of the Accelerated Death Benefit?

While the Insured is alive and the Rider in effect, You can claim an Accelerated Death Benefit, if the Insured was certified by a Licensed Physician[1] as having an illness or a physical condition which can reasonably be expected to result in death within 12 months after the date of certification.

We may, at Our expense, require certification by a Licensed Physician of Our choice. If there is a difference of opinion regarding the Insured's eligibility for benefits, We may seek, at Our expense, a third medical opinion of a Licensed Physician that is mutually acceptable to the Insured and Us.

All irrevocable beneficiaries and assignees must approve, in writing, to the payment of an Accelerated Death Benefit.

What happens to Policy values if an Accelerated Death Benefit is Paid?

Payment of an Accelerated Death Benefit will reduce Your Policy's Death Benefit, Cash Value, and loan value, but the Policy will continue. The Accelerated Death Benefit will first be applied to repay any outstanding Policy loan and accrued Policy loan interest.

After We pay the Accelerated Death Benefit, any withdrawal, surrender, or Policy loan will be limited to the Net Cash Surrender Value.

Future Premuims, Cost of Insurance charges, and Expense Charges on this Policy will be proportionally reduced by the payment of an Accelerated Death Benefit.

Payment of an Accelerated Death Benefit will not impact any active riders or benefits of the Policy in effect at the time such payment is made.

If You never make a claim under this benefit, there will be no effect on the policy.

This Disclosure Statement is intended to help You understand the Terminal Illness Rider - Accelerated Death Benefit. This disclosure does not change any provisions of the Rider or the Policy to which it is attached.

I have read, or have had read to me, this Important Notice to Applicant/Buyer Regarding Accelerated Death Benefits and acknowledge receipt of a copy.

Signed in _____, this ____ day of _____, _____
(city, state) (Date) (month) (year)

_____ _____
Signature of Proposed Owner Signature of Writing Agent

[1] As defined in the Rider based upon the requirements of the Internal Revenue Service.

Symetra Life Insurance Company
777 108th Avenue NE, Suite 1200 | Bellevue, WA 98004-5135
Mailing Address: PO Box 549291 | Waltham, MA 02454-9291
Phone 1-800-796-3872 | TTY/TDD 1-800-833-6388

NOTICE TO APPLICANT REGARDING REPLACEMENT OF LONG TERM CARE INSURANCE OR LIFE INSURANCE INCLUDING ACCELERATED DEATH BENEFITS

According to your application or information you have furnished, you intend to lapse or otherwise terminate your existing life insurance or long-term care insurance and replace it with a life insurance policy with an accelerated death benefit to be issued by Symetra Life Insurance. Your new accelerated death benefit coverage provides 30 days within which you may decide, without cost, whether you desire to keep the coverage. Please note that your underlying life insurance policy may only provide for a 10-day period during which you may decide, without cost, whether you will keep the coverage. For your own information and protection, you should be aware of, and seriously consider, certain factors that may affect the insurance protection available to you under the new coverage.

This accelerated death benefit is NOT Nursing Home, Home Care, or Long-Term Care Insurance, and is not intended or designed to eliminate your need for that coverage. There are no restrictions or limitation on the use of the accelerated death benefit proceeds.

If you want long-term care insurance, you should consult with an insurance agent licensed to sell that insurance, inquire with the insurance company offering the accelerated death benefits, or visit the California Department of Insurance Internet Web site (www.insurance.ca.gov) that provides information regarding long-term care insurance.

If you want to replace existing coverage with life insurance that includes an accelerated death benefit, you should note the following:

1. Receipt of accelerated death benefits may be taxable. Prior to electing to buy the accelerated death benefit, policyholders or certificate holders should seek assistance from a qualified tax advisor.
2. Receipt of accelerated death benefits may affect eligibility for public assistance programs, such as Medi-Cal or Medicaid. Prior to electing to buy the accelerated death benefit, the applicant/buyer should consult with the appropriate social services agency concerning how receipt of accelerated death benefits may affect that eligibility.

You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present coverage. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

If, after due consideration, you still wish to terminate your present coverage and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on the application may provide a basis for the company to deny any future claims and to refund your premium as though your coverage had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all the information has been properly recorded.

The above "Notice to Applicant" was delivered to me on: _____/ ____/ _____
Month Day Year

_____ _____
Name of Applicant Signature of Applicant

COMPARISON TO CURRENT COVERAGE

I have reviewed your current coverage. To the best of my knowledge, the replacement of insurance involved in this transaction materially improves your position for the following reasons:

- ☐ Additional or different benefits. (please specify) _____
- ☐ No change in benefits, but lower premiums
- ☐ Fewer benefits and lower premiums
- ☐ Other - please specify. _____

_____ _____
Name of Writing Agent Signature of Writing Agent

Please give a copy to your client

Click here to clear form

Symetra Life Insurance Company
Home Office: 777 108th Avenue NE, Suite 1200 | Bellevue, WA 98004-5135
Mail to New Business: PO Box 549291 | Waltham, MA 02454-9291
Fax: 1-877-435-5500

NOTICE AND CONSENT FOR BLOOD TESTING WHICH WILL INCLUDE AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING APPLICATION FOR LIFE OR DISABILITY INCOME INSURANCE

To determine your insurability, the Insurer named above has requested that you provide a sample of your blood for testing and analysis. All tests will be performed by a licensed laboratory.

The consent you give by signing this form authorizes the insurer to withdraw blood and order laboratory tests only in regard to your present application for life or disability income insurance.

The test or tests to be performed are used to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. The HIV antibody test that we perform is actually a series of tests done by a medically accepted procedure. The HIV antigen test directly identifies AIDS viral particles. These tests are extremely reliable.

TESTS TO BE PERFORMED

We will use an ELISA test or a Western Blot Assay, or both.

An ELISA test is an enzyme-linked immunosorbent assay serologic test which has been licensed by the Federal Food and Drug Administration to detect antibodies to the human immunodeficiency virus. A positive ELISA test means an ELISA test performed in accordance with the manufacturer's specifications which is reactive on an initial testing and on at least one of two additional tests of the same serum or plasma specimen.

A Western Blot Assay is an assay which uses reagents consisting of HIV antigens separated by polyacrylamide-gel electrophoresis and then transferred to nitro-cellulose paper to detect antibodies to the human immunodeficiency virus. A reactive Western Blot Assay is a Western Blot Assay which is reactive according to the standards of performance and results specified in the manufacturer's Federal Food and Drug Administration approved product circular for the Western Blot Assay reagents and laboratory apparatus.

MEANING OF POSITIVE TEST RESULT

Positive HIV antibody/antigen test results do not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others.

Positive HIV antibody or antigen test/screening results or other significant blood abnormalities 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 will be treated confidentially. They will be reported by the laboratory to the Insurer. When necessary for business reasons in connection with insurance you have or have applied for with the Insurer, the Insurer may disclose test results to others involved solely in the underwriting process such as its affiliates, reinsurers, employees or contractors. If the Insurer is a member of the Medical Information Bureau (MIB, Inc.), and if the test results for HIV antibodies/antigens are other than normal, the Insurer will report to the MIB, Inc., a generic code which signifies only a non-specific blood test abnormality. If your HIV test is normal, no report will be made about it to the MIB, Inc. The organizations described in this paragraph may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or as authorized by you.

COST OF TESTING

The cost of any testing will be borne by the Insurer.

NOTIFICATION OF TEST RESULTS

If your HIV test results are normal, no routine notification will be sent to you. If the HIV test results are other than normal, the Insurer will contact your designated physician or you if you have not designated a physician. The Insurer will ask you for the name of a physician or other health care provider to whom you may authorize disclosure and with whom you may wish to discuss the results.

TIME LIMIT

This Consent shall be valid for a period of 30 months from the date noted below.

CONSENT

I have read and I understand this Notice of Consent for Blood Testing Which Will Include HIV Antibody/Antigen Testing. I voluntarily consent to the withdrawal of blood from me by needle, the testing of that blood, and the disclosure of the test results as described above.

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.

Proposed Insured _____ Date of Birth _____

Name and Address of Designated Physician:

Name _____

Street _____ City _____ State _____ Zip _____

Signature of Proposed Insured or Parent/Guardian _____ Date _____ State of Residence _____

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777 108th Avenue NE, Suite 1200 | Bellevue, WA 98004-5135
Mail to New Business: PO Box 549291 | Waltham, MA 02454-9291
Fax: 1-877-435-5500

COUNSELING RESOURCES LIST

Public health authorities urge that everyone become educated about how to protect themselves from HIV infection. If you have questions or concerns, your own physician or health care provider is your best source of information. Other counseling services may also be available to you.

As required by California law, the following list of counseling resources is being provided to you. It was compiled from publicly available information, which is subject to change without notice to Symetra Life Insurance Company. Therefore, Symetra makes no representations or warranties that this information is accurate as of the date you receive this list. Also, Symetra makes no representations or warranties about the quality or nature of any services these resources may provide.

This is not a complete list of all resources that may be available to you. If you need further information, we suggest you contact your own physician or health care provider, your county health department, or your local chapter of the American Red Cross for further information.

AIDS HOTLINE — U.S. PUBLIC HEALTH SERVICE
(800) 367-AIDS

SPANISH AIDS HOTLINE
(800) 344-7432

TTY INFORMATION
Information and Referral for Hearing Impaired
(213) 464-0029

KERN COUNTY AIDS TEAM — Bakersfield
(661) 868-0366

CENTRAL VALLEY AIDS TEAM — Fresno
(209) 264-2436

AIDS PROJECT — EAST BAY — Oakland
(415) 420-8181

SACRAMENTO AIDS FOUNDATION
Sacramento
(916) 448-2437

SAN FRANCISCO AIDS FOUNDATION
San Francisco
(415) 846-5855

AIDS PROJECT — LOS ANGELES
West Hollywood
(213) 876-8951

INLAND AIDS PROJECT
Riverside/San Bernardino Counties
(760) 391-8828

SANTA CLARA COUNTY ARIS PROJECT
Campbell
(408) 792-3729

SONOMA COUNTY AIDS INFORMATION HOTLINE SOCIAL SERVICES — SOUTHERN CALIFORNIA
(707) 579-AIDS

AIDS HOTLINE — SOUTHERN CALIFORNIA
(800) 367-AIDS

HEMOPHILIA FOUNDATION OF SOUTHERN CALIFORNIA
Social Services — Southern California
Hemophilia AIDS Information
(818) 792-6192
(714) 740-2222

CALIFORNIA DEPT. OF HEALTH SERVICES
Statewide Services —
Office of AIDS — Sacramento
(916) 323-7415

AIDS SERVICES FOUNDATION OF ORANGE COUNTY — Costa Mesa
(714) 646-0411

SAN DIEGO AIDS PROJECT
(619) 296-2120 — City of San Diego
(619) 945-6000 — City of Vista

SANTA BARBARA COUNTY AIDS HOTLINE
(805) 681-5120

SHASTA COUNTY HELPLINE
(916) 225-5298

Click here to clear page

Sales Material Checklist

SYMETRA
RETIREMENT | BENEFITS | LIFE

AGENT AND ADVISOR USE ONLY

LIFE INSURANCE

Your State Replacement Regulation requires you to submit – with the application – all sales material and proposals used in the replacement sale of life insurance or annuities. To reduce paperwork and mailing costs, you may use this list instead of sending actual copies of all materials. Please complete this form by checking the box in front of the marketing piece(s) used.

Applicant Name_____

Only material approved by Symetra's compliance department can be used in conjunction with this form.

The following materials were used in the sale:

Symetra UL-G Universal Life – Fully Underwritten only

- ☐ Client Concept Brochure – LIM-1287
- ☐ Fact Sheet – LIM-1288
- ☐ No Sales Materials Were Used

Symetra CAUL Universal Life – Fully Underwritten only

- ☐ Client Concept Brochure – LIM-1285
- ☐ Fact Sheet – LIM-1288
- ☐ No Sales Materials Were Used

Symetra SUL-G Survivorship Universal Life – Fully Underwritten only

- ☐ Client Concept Brochure – LIM-1225
- ☐ Fact Sheet – LIM-1226
- ☐ No Sales Materials Were Used

Symetra Level Term – Fully Underwritten and Simplified Issue

- ☐ Client Concept Brochure – LIM-1060
- ☐ Fully Underwritten Fact Sheet – LIM-1061
- ☐ Simplified Issue Fact Sheet – LIM-1062
- ☐ No Sales Materials Were Used

Symetra Universal Life – Fully Underwritten and Simplified Issue

- ☐ Client Concept Brochure – LIM-1135
- ☐ Fully Underwritten Fact Sheet – LIM-1136
- ☐ Simplified Issue Fact Sheet – LIM-1137
- ☐ No Sales Materials Were Used

Symetra Successor Single Premium Life – Fully Underwritten and Simplified Issue

- ☐ Client Concept Brochure – LIM-1003
- ☐ Fact Sheet – LIM-1004
- ☐ No Sales Materials Were Used

Agent or Broker Signature _____ Date _____

Stat No. _____

777 108th Avenue NE | Bellevue, WA 98004
Mailing Address
PO Box 84068 | Seattle, WA 98124
www.symetra.com

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SYMETRA
RETIREMENT | BENEFITS | LIFE

Symetra Life Insurance Company
Symetra National Life Insurance Company
First Symetra National Life Insurance Company of New York
Mail to: PO Box 34690 | Seattle, WA 98124-1690
Phone 1-800-796-3872 | TTY/TDD 1-800-833-6388 | www.symetra.com

ENTITY CERTIFICATION

This Entity Certification Form (the "Form") is used in situations in which a non-natural person other than a trust or corporation is the owner, or intends to become the owner, of a life insurance policy issued by one of the following companies: Symetra Life Insurance Company, Symetra National Life Insurance Company or First Symetra National Life Insurance Company of New York (the "Company"). The form identifies the persons who are authorized on behalf of the Entity named in section 2 ("Authorized Persons") to conduct transactions in, and exercise ownership rights with respect to, the Policy named in section 1.

1. Insured and Policy Information

Insured name (first, middle, last) | Policy number(s), if known

Date of Birth | Social Security Number

Relationship to Owner

2. Entity Information

Entity name

Entity address

Entity type:

- ☐ Partnership, including LLP and family partnerships
- ☐ Limited Liability Company
- ☐ Other (subject to Company approval) _____

Date established | State where established

Tax identification number (or Entity identification number)

3. Authorized Persons

Provide the names of all persons authorized to transact business in, and exercise ownership rights, on behalf of the Entity listed in 2, above. If additional space is needed, use a separate piece of paper, provide all required signatures, and attach to this Form.

Authorized Person's name	Title
Authorized Person's name	Title
Authorized Person's name	Title
Authorized Person's name	Title
Authorized Person's name	Title

If there are multiple Authorized Persons:

- ☐ Any one may act alone. ☐ A majority may act for all. ☐ All must act unanimously.
- ☐ The following must act jointly:

_____
_____
_____

Click here to clear page

4. Certification

Each undersigned Authorized Person does hereby represent and certify the following:

- There are no other Authorized Person(s) of the Entity other than those named on this Form.
- The Entity is valid under the laws of the state where established and is currently in full force and effect.
- The Entity has an insurable interest in the life of the insured named in section 1.
- I/we have the authority to make this certification and, acting on behalf of the Entity, to purchase or surrender life insurance policies, to take withdrawals from the policies, and to give the Company instructions regarding the policies. My/our instructions to the Company will be binding on the Entity.
- I/we will promptly notify the Company, in writing, in the event of any amendment to or termination of the Entity, any change in the identity of the Authorized Person(s), or any other event affecting the representations made in this Form while the above-named policy is in force.
- The Entity will not hold the Company responsible for any duties or obligations other than its contractual obligations as issuer of the above-named policy.
- I/we are aware of the tax requirements for entity ownership of the above-named policy; the Entity will not hold the Company responsible for any adverse tax consequences as a result of the actions of the Authorized Person(s).
- The information contained in this Form is correct, and I/we understand and agree that the Company will rely on this information for all purposed related to entity ownership of the identified policy.

5. Signatures

The undersigned declare(s) that the Entity has not been revoked, modified, or amended in any manner which would cause the representations made in this Form to be incorrect. The undersigned, on behalf of the Entity, agree(s) to indemnify and hold harmless the Company from any and all liabilities and expenses, including attorney's fees, for claims, judgments, surcharges, or settlement amounts that the Company may include as a result of relying upon the representations and certifications made in this Form. Each Authorized Person will be jointly and severally liable for performing the obligations stated above. Such obligations and this indemnification will survive termination of the Entity or the above-named policy and will be binding upon all heirs, successors, or assigns.

I/we understand that the Company will rely on this Form until it receives signed written notice of any changes as noted in the Certification, above.

Authorized Person's signature	Print name	Date
Authorized Person's signature	Print name	Date
Authorized Person's signature	Print name	Date
Authorized Person's signature	Print name	Date
Authorized Person's signature	Print name	Date

HIPAA Compliant Authorization for Release of Medical Information to Symetra Life Insurance Company*

_____
Policy Number

_____ _____
Name of proposed insured/patient (please type or print) Date of birth

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf ("My Providers") to disclose my entire medical record, prescription history, medications prescribed and any other protected health information concerning me to Symetra Life Insurance Company, its employees, agents or representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that Symetra Life Insurance Company may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with Symetra Life Insurance Company.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written notification to Symetra Life Insurance Company. I understand that a revocation is not effective to the extent that any of My Providers has already relied on this Authorization to disclose information about me or to the extent that Symetra Life Insurance Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be redisclosed by Symetra Life Insurance Company except as authorized by me or as required by law.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, Symetra Life Insurance Company may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I understand that any authorized representative or I will receive a copy of this authorization upon request.

_____

Signature of Proposed Insured/Patient or Personal Representative Date

_____

Description of Personal Representative's Authority or Relationship to Patient

* Symetra Life Insurance Company
Mailing Address: PO Box 549291
Waltham, MA 02454-9291
777 108th Avenue NE, Suite 1200
Bellevue, WA 98004-5135

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SYMETRA
RETIREMENT | BENEFITS | LIFE

Symetra Life Insurance Company
777 108th Avenue NE, Suite 1200 | Bellevue, WA 98004-5135
Mailing Address: PO Box 549291 | Waltham, MA 02454-9291
Phone 1-800-796-3872 | TTY/TDD 1-800-833-6388

NOTICE TO APPLICANT REGARDING REPLACEMENT OF LONG TERM CARE INSURANCE OR LIFE INSURANCE INCLUDING ACCELERATED DEATH BENEFITS

According to your application or information you have furnished, you intend to lapse or otherwise terminate your existing life insurance or long-term care insurance and replace it with a life insurance policy with an accelerated death benefit to be issued by Symetra Life Insurance. Your new accelerated death benefit coverage provides 30 days within which you may decide, without cost, whether you desire to keep the coverage. Please note that your underlying life insurance policy may only provide for a 10-day period during which you may decide, without cost, whether you will keep the coverage. For your own information and protection, you should be aware of, and seriously consider, certain factors that may affect the insurance protection available to you under the new coverage.

This accelerated death benefit is NOT Nursing Home, Home Care, or Long-Term Care Insurance, and is not intended or designed to eliminate your need for that coverage. There are no restrictions or limitation on the use of the accelerated death benefit proceeds.

If you want long-term care insurance, you should consult with an insurance agent licensed to sell that insurance, inquire with the insurance company offering the accelerated death benefits, or visit the California Department of Insurance Internet Web site (www.insurance.ca.gov) that provides information regarding long-term care insurance.

If you want to replace existing coverage with life insurance that includes an accelerated death benefit, you should note the following:

1. Receipt of accelerated death benefits may be taxable. Prior to electing to buy the accelerated death benefit, policyholders or certificate holders should seek assistance from a qualified tax advisor.
2. Receipt of accelerated death benefits may affect eligibility for public assistance programs, such as Medi-Cal or Medicaid. Prior to electing to buy the accelerated death benefit, the applicant/buyer should consult with the appropriate social services agency concerning how receipt of accelerated death benefits may affect that eligibility.

You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present coverage. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

If, after due consideration, you still wish to terminate your present coverage and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on the application may provide a basis for the company to deny any future claims and to refund your premium as though your coverage had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all the information has been properly recorded.

The above "Notice to Applicant" was delivered to me on: _____/ ____/ _____
Month Day Year

_____ _____
Name of Applicant Signature of Applicant

COMPARISON TO CURRENT COVERAGE

I have reviewed your current coverage. To the best of my knowledge, the replacement of insurance involved in this transaction materially improves your position for the following reasons:

- ☐ Additional or different benefits. (please specify) _____
- ☐ No change in benefits, but lower premiums
- ☐ Fewer benefits and lower premiums
- ☐ Other - please specify. _____

_____ _____
Name of Writing Agent Signature of Writing Agent

Please give a copy to your client

Symetra Life Insurance Company
777 108th Avenue NE, Suite 1200 | Bellevue, WA 98004-5135
Mailing Address: PO Box 34690 | Seattle, WA 98124-1690
Phone 1-800-796-3872 | TTY/TDD 1-800-833-6388

IMPORTANT NOTICE REGARDING REPLACEMENT

REPLACING YOUR LIFE INSURANCE OR ANNUITY?

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

Make sure you understand the facts. You should ask the agent or company that sold you your existing policy to give you information about it.

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

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

The following policies will be replaced:

Company	Policy No.	Insured

I have read this notice and received a copy of it for my records.

Applicant/Co-Applicant signature

Applicant address

Date

Certification by the agent: I hereby certify that only Symetra approved sales materials were presented and left with the applicant.

Agent signature

Date

Please give a copy to your client

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777 108th Avenue NE, Suite 1200 | Bellevue, WA 98004-5135
Mailing Address: PO Box 84068 | Seattle, WA 98124-9918
Phone 1-800-796-3872 | Fax 1-877-435-5500
TTY/TDD 1-800-833-6388

INITIAL PAYMENT BY BANK DRAFT (EFT) – AUTHORIZATION

Please attach a copy of a voided check or complete the information below for the account from which you wish to have your initial and future premiums paid by EFT.

12-345
6789 **0000**

Mr./Mrs. Checkwriter
Address
City, State Zip

Date_____

Pay to the
Order of_____ _____ $ _____

_____ **VOID** _____ DOLLARS

Bank Name

Branch

For _____ _____

00000000000 00000 000 0000

Tape voided check here.

– OR –

Name on Account: Enter exactly as it appears on your check	_____
Account Type:	☐ Checking ☐ Savings
Bank Name:	_____
Routing Number:	_____
Account Number:	_____

Complete this section.

If your face amount is $1,000,000 or less and you answered "no" to the temporary insurance questions, you will be covered under the Temporary Insurance Agreement if a check is collected for the initial premium payment or you sign up for initial payment by EFT (maximum coverage is $250,000). This is subject to change if, during the underwriting of your application, we determine we are unable to offer the temporary coverage. Please refer to the Temporary Insurance Agreement, included with the Notice of Insurance Information Practices.

Bank Draft/EFT Requests	
Draft Date:	_____ **Note: Completion of this section is required for all Bank Draft/EFT requests.** Draft dates cannot include the 29th, 30th, or 31st. The initial bank draft will be taken the next business day after the policy has been put in force. Future drafts will be taken on the draft date selected. To stop future drafts, contact our Customer Service Department at 1-800-SYMETRA.

Policy number_____

_____ _____
Applicant/Payor Signature Date

Agent Instructions for initial payment EFT authorization form:

1) Remind your client to deduct the initial payment from their checking or savings account register, immediately.

   The initial payment will be drafted immediately, when the policy is put in force.
   Subsequent premiums will be deducted each month, on the selected draft date.

2) Attach a voided check from the account to be drafted, **or** complete the account information section on the EFT authorization form.

3) Always indicate the draft date, in the Bank Draft/EFT Requests section on page 1.

4) Have the applicant sign and date the form.

5) Send the completed form with the application, **or** if sending separately, FAX it to 1-877-435-5500.

Please be sure the information on the form is accurate, and that the client understands that their account will be drafted for the initial premium as soon as we issue the policy.

If there are changes to the EFT information, at any time, please have the client contact us. If we are not notified of a change, an EFT draw can be returned unpaid.

The most common causes for returned EFTs are:

The account was closed
Incorrect account number
Insufficient funds

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SYMETRA
RETIREMENT | BENEFITS | LIFE

Symetra Life Insurance Company
Symetra National Life Insurance Company
First Symetra National Life Insurance Company of New York

Mail to: PO Box 34690 | Seattle, WA 98124-1690
Overnight to: 777 108th Avenue NE, Suite 1200 | Bellevue, WA 98004-5135
Phone 1-800-796-3872 | Fax 1-866-532-1361 | www.symetra.com

TRUSTEE CERTIFICATION

Use this form for situations in which a trust is the owner of a policy issued by Symetra Life Insurance Company / Symetra National Life Insurance Company / First Symetra National Life Insurance Company of New York ("Company").

The trustee(s) and the grantor / settlor should complete and execute this form. The grantor / settlor is the creator of the trust. This form supersedes any previously provided certifications.

The Company reserves the right to request a copy of the full trust at any time.

If additional space is needed, use a separate piece of paper, provide all required signatures and attach it to this form.

1. Policy and Trustee Information

If more than two trustees, please attach additional sheet with trustee names, addresses and signatures.

Insured name (first, middle initial, last) | Policy number(s)

Full name of trust

Date of trust | Trust tax ID number

State where trust created

Trustee name | Trustee address

Trustee name | Trustee address

Relationship of the grantor / insured(s) to the trustee(s):

2. Trust Information

If Section 2 is not completed, I authorize the Company to accept and be bound by the instructions for any one trustee.

Symetra does not permit the purchase of life insurance inside a qualified plan. Please select one:
☐ The owner is not a qualified plan ☐ The owner is a qualified plan

Type of trust ☐ Irrevocable ☐ Revocable (if selected, you must list persons with power to revoke)

Name of person with power to revoke | Name of person with power to revoke

Has the trust been fully executed? ☐ Yes ☐ No

If the trust has more than one trustee, select one:
☐ Trustees must act unanimously ☐ Other (please specify)
☐ Majority of trustees must act _____
☐ Any one trustee may act alone _____

Relationship of the grantor / insured(s) to the trust beneficiary(ies):

Click here to clear page

3. Certification

Each undersigned Trustee does hereby represent and certify the following:

- There are no other trustees of the trust other than the ones named in this form.
- The trust is valid under the laws of the applicable state and is currently in full force and effect.
- The trust and its beneficiaries each has an insurable interest in the continued life of the insured(s) named in the application/policy and is authorized to own a life insurance policy.
- I/we have the authority to make this certification and, acting on behalf of the trust, to purchase or surrender policies, to make distributions from the trust, and to give the Company instructions regarding policies. My/our instructions to the Company will be binding on the trust.
- I/we will promptly notify the Company, in writing, in the event of any amendment to or termination of the trust, any change in the identity of the trustee(s), or any other event affecting the representations made in this form while the policy is in force.
- The trust will not hold the Company responsible for any duties or obligations other than its contractual obligations as issuer of the policy.
- I/we are aware of the tax requirements for trust ownership of this policy; the trust will not hold the Company responsible for any adverse tax consequences as a result of the actions of the trustee(s).
- The information contained in this document is correct, and we/I understand and agree that the Company will rely on this information for all purposes related to trust ownership of the identified policy.

4. Signatures

The undersigned declare(s) that the trust has not been revoked, modified or amended in any manner which would cause the representations contained herein to be incorrect. The undersigned, on behalf of the trust, agree(s) to indemnify and hold harmless the Company from any and all liabilities and expenses, including attorneys' fees, for claims, judgments, surcharges, or settlement amounts that the Company may incur as a result of relying upon the representations and certifications made herein. Each trustee will be jointly and severally liable for performing the obligations stated above. Such obligations and this indemnification will survive termination of the trust or the policy and will be binding upon all heirs, successors, or assigns.

I/we understand that the Company will rely on this form until it receives signed written notice of any changes in the certifications above.

Please PRINT clearly.

Trustee name		Trustee name	
Signature	Date (MM/DD/YYYY)	Signature	Date (MM/DD/YYYY)
For corporate trustees, title/capacity of signatory		For corporate trustees, title/capacity of signatory	

(This form is complete for states outside Michigan. Use a separate piece of paper and attach it to this form if there was not enough room above or on the first page to provide all information and required signatures.)

5. Michigan Required Section

In Michigan only, The settlor or the attorney for the settlor / trust may sign section 4 of this form; however, only the trustee(s) may authorize transactions on the policy. If you are signing this form as one of these individuals, please indicate your title here: ☐ Settlor ☐ Attorney ☐ Trustee

Notary signature and seal: The signer(s) named in this certification have appeared before me, have been sworn and have attested that the information contained in this affidavit is true.

Notary seal	Notary signature	
	Notary printed name	
	Date signed (MM/DD/YYYY)	My commission expires (MM/DD/YYYY)

Click here to clear form

SYMETRA
RETIREMENT | BENEFITS | LIFE

Symetra Life Insurance Company
777 108th Avenue NE, Suite 1200 | Bellevue, WA 98004-5135
Mailing Address: PO Box 84068 | Seattle, WA 98124-9918
Phone 1-800-796-3872 | TTY/TDD 1-800-833-6388

FINANCIAL INFORMATION SUPPLEMENT TO PART 1 APPLICATION

Proposed Insured _____ Date of birth_____

SECTION I - PERSONAL INSURANCE
TO BE ANSWERED IF THE INSURANCE APPLIED FOR IS PERSONAL COVERAGE

1. Net Worth

Assets:		Liabilities:	
Cash/Other Liquid Assets $	_____	Mortgages	_____
Personal Property	_____	Other Liabilities	_____
Real Estate	_____	Total Liabilities:	_____
Stocks/Bonds	_____		
Other (describe)	_____		
Total Assets:	_____		
		Total Net Worth:	_____

2. Please give your total income

	Last Year	Year Prior
Annual Salary	$ _____	$ _____
Investment Income, Dividends, etc.	_____	_____
Other Income (describe)	_____	_____
TOTAL	$ _____	$ _____

SECTION II - BUSINESS INSURANCE
TO BE ANSWERED IF THE INSURANCE APPLIED FOR IS BUSINESS COVERAGE:

1. Name of Company _____
2. Length of time in business ☐ Corporation ☐ Partnership ☐ Sole Proprietorship
3. Is the business being reorganized or expanded? ☐ Yes ☐ No

   If yes, provide details.

4. Please attach a copy of your Company's latest audited financial statements (balance sheet and profit & loss). If not available, complete the following:

a. CURRENT COMPANY BOOK VALUE

Assets	$ _____
Liabilities	_____
Net Worth	_____
Insured's % Ownership	_____

b. COMPANY NET PROFIT - Past Two Years (After taxes and bonuses)

20_____	$_____
20_____	$_____
This Year (Est.)	$_____

c. List below Business Insurance on all other key persons or owners of this business:

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

If other stockholders, partners, or key persons are not being similarly insured, why not?

_____

_____

5. (Check at least one box and furnish details)

☐ KEY PERSON

a. What special skills, knowledge, or experience does the proposed insured possess which makes the insurance necessary?

_____

b. What is his/her compensation from the business? $_____

c. If the business is a new venture or was recently reorganized, please describe the key person's business background.

_____

_____

☐ STOCK REDEMPTION/BUY AND SELL

a. Is there a written agreement in effect? ☐ Yes ☐ No (Attach signed copy)

b. Current value of the business? $_____

c. How was the value determined? _____

☐ BUSINESS LOAN

a. Lender _____

b. Amount of loan $ _____ Date of loan _____ Is lender requiring the insurance? ☐ Yes ☐ No

c. The repayment terms are _____

_____

d. The purpose of the loan is _____

_____

I represent that all the statements and answers to the above questions are complete and true, to the best of my knowledge and belief, and I agree that they shall form a part of my application for insurance.

Signed at _____ this _____ day of _____ , _____

Signature of Proposed Insured Date

Signature of Applicant Date

Witnessed by Date