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SYMETRA®
FINANCIAL

Life's Easy App

To Apply:

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

- ☐ Complete the attached application and the proper state replacement form(s), if any are required.
- ☐ If the customer has existing coverage in place and the NAIC replacement regulation has been adopted by the state, a replacement form may or may not be required even if the existing coverage is not being replaced. Please contact the Sales Center at 1-800-706-0700 for more information.
- ☐ If the customer is replacing this coverage and the state has not adopted the NAIC replacement regulation, a replacement form may or may not be required. Please contact the Sales Center at 1-800-706-0700 for more information.
- ☐ Verify the amount of premium your client is paying.
- ☐ Witness the signing of the application and verify the identity of the customer using photo identification.
- ☐ Give the client a Temporary Insurance Certificate (if applicable), the Notice of Insurance Information Practices and a copy of the application.
- ☐ For payments by check, mail premium to:

  Symetra Life Insurance Company
  PO Box 84068
  Seattle, WA 98124-9918

- ☐ Fax the signed application and any other required replacement forms to Symetra Life Insurance Company at 1-877-435-5500.

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LIFE INSURANCE APPLICATION — PART I LUC-118 10/07

SYMETRA LIFE INSURANCE COMPANY
777 108th Avenue NE, Suite 1200, Bellevue, WA 98004-5135

Mailing Address:
PO Box 84068
Seattle, WA 98124-9918

PROPOSED INSURED INFORMATION

Life Insurance for First MI Last
☐ **Male** ☐ **Female**

Soc. Sec. No. or Tax I.D. #:

Street/PO Box City State Zip

Phone Number Best Time to call Best Day to call

Occupation | Annual Income | State of Birth

Height | Weight | Driver's License # | Date of Birth

Owner if other than Proposed Insured Soc. Sec./Tax ID:

Owner Address Street/PO Box City State Zip

Insurance Needed For
☐ Debt/Family/Business Protection ☐ Income Replacement ☐ Retirement/Estate Planning ☐ Other _____

BENEFICIARY INFORMATION (P-Primary, C-Contingent)

Name	Relationship	%	P	C
Any living children born of this marriage or legally adopted to share equally.				

Amount of Coverage $ **Quoted Premium $** **Net Credited Interest Rate (SPL Only)** **%**

Plan Choice
☐ **Term Plan** (please select term)
☐ 10-yr ☐ 15-yr ☐ 20-yr ☐ 30-yr ☐ ART

☐ **Universal Life Plan (UL)**_____
Death Benefit Option: ☐ Level ☐ Increasing

☐ **Variable Universal Life (VUL)** _____
Death Benefit Option: ☐ Level ☐ Increasing

☐ **Single Premium Life (SPL)**_____

☐ Other_____

Riders (not applicable for Single Premium Life)
☐ On Self? (UL & VUL Only) $_____
☐ On others?
How many?____ (please complete Part I for each rider)
☐ Include my children? (please complete the Part III ICB form)
☐ Waiver of Premium (Term and VUL Only)
☐ Waiver of Monthly Ded. (VUL Only)
☐ Waiver Benefit (UL Only)
☐ Other_____

RATE CLASS

Rate class applied for (Check one only)

	Juvenile	Standard (Nicotine)	Non-Nicotine (Standard)	Standard Plus (Nicotine)	Preferred (Non-Nicotine)	Preferred Plus (Non-Nicotine)	Preferred Best (Non-Nicotine)
Term Plan	N/A	☐	☐	☐	☐	☐	☐
UL	☐	☐	☐	☐	☐	☐	☐
SPL	N/A	☐	☐	☐	☐	N/A	N/A
		Standard Cigarette Smoker	Standard Nonsmoker	Preferred Cigarette Smoker	Preferred Non-Nicotine	Preferred Plus (Non-Nicotine)	Preferred Best (Non-Nicotine)
VUL/ART	N/A	☐	☐	☐	☐	N/A	N/A

PAYMENT & TEMPORARY INSURANCE

Temporary Life Insurance Agreement (TIA) questions:	Yes	No
1. Within the past 90 days, has the Proposed Insured been admitted to, or been advised to be admitted to, a hospital?	☐	☐
2. In the past two years has the Proposed Insured been treated for: heart disease, stroke, tumor, mass, cancer, alcohol, drugs, or Acquired Immunodeficiency Syndrome (AIDS)/Aids Related Complex (ARC) by a medical professional?	☐	☐

Payment Method:
Check ☐ Automatic EFT* ☐ Wire transfer to Symetra (SPL Only) ☐

Payment Frequency:
Annual ☐ Semiannual ☐ Qtr ☐ Monthly EFT* ☐ Single Payment ☐
For all payments (initial and future) to be taken by EFT, please complete the following:
Name On Account _____ Checking ☐ Savings ☐ Bank Name _____
Routing Number _____ Account Number _____ Draft date (not the 29th, 30th, 31st) _____
*Marking this box authorizes us to automatically deduct from your checking or savings account by electronic funds transfer (EFT).

If your face amount is $1,000,000 or less and you answered NO to the TIA questions above, you will be covered under the temporary insurance agreement if a check is collected for the initial payment or you sign up for the initial payment by EFT or wire transfer (maximum coverage is $250,000).

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REMARKS

Remarks: Please explain any yes answer to questions 1 and 2 under Temporary Insurance, including doctor names, addresses, dates and treatments.

REPLACEMENT

Do you have any other existing insurance policies or annuity contracts with this or any other company? (in force or applied for)	Yes ☐	No ☐

Company	Face Amount	Policy Type	Annual Premium

To the best of the Applicant's knowledge, will the policy applied for replace any existing life insurance policy or annuity, or is any part of the premium to be paid by policy loan, or cash value on insurance presently in force? (If yes, attach state replacement disclosure.)	Yes ☐	No ☐
Existing Policy Cash Value $ _____	Amount of Surrender Charge $ _____	
Will new policy have surrender charges?	Yes ☐	No ☐

AGENT

Does the Applicant have any existing life insurance policies or annuity contracts with this or any other company?	Yes ☐	No ☐
To the best of your knowledge, will this insurance replace or change any existing life insurance or annuity?	Yes ☐	No ☐

If replacing, how does this policy better serve the Applicant's needs?

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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, the Owner, certify under the penalties of perjury that (1) the number shown in Proposed Insured Information section is my correct taxpayer identification number, and (2) I am not subject to backup withholding.

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 Coverage is $250,000.)

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.

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.

Signed this _____, at _____, State of _____
Date City State

_____ _____
Printed Name of Proposed Insured Print Name of Writing or Authorized Agent

_____ _____
Signature of Proposed Insured (Age 15 or older) Signature of Writing or Authorized Agent

_____ _____ _____
Signature of Applicant/Owner* if other than Proposed Insured Agent Phone Agent Email

_____
Agent Stat Number

Branch Name _____ Branch # _____ 7-Digit Cost Center# _____ Rep ID # _____

* If Applicant is corporation/partnership, a corporate officer/partner other than Proposed Insured must sign.

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. Please contact MIB at 1-866-692-6901 (TTY 1-866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112.

Symetra Life or its reinsurers may also release information in its file to others 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 on the reverse side 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 this Notice.

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 the Medical Information Bureau.
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 Individual New Business Department of Symetra Life, PO Box 84068, Seattle, Washington 98124-9918. Your comments will be carefully considered and corrections made where justified.

TEMPORARY LIFE INSURANCE AGREEMENT

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 the Proposed Insured 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 the Proposed Insured is less than 15 days old or more than 80 years old, the Company's liability under this Agreement is limited to a refund of the payment made.
(d) If the Proposed Insured commits suicide, the Company's liability under this Agreement is limited to a refund of the payment made. (For citizens of Missouri, suicide is no defense unless we can show that the Proposed Insured intended suicide when the application was completed.)
(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.

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What Happens Next?

Thank you for applying for Life Insurance coverage with Symetra! The back of this form contains the Notice of Insurance Information Practices and, if applicable, the Temporary Insurance Agreement. Now that the application is complete, we would like you to know what happens next.

There are essentially ***five steps*** to applying for life insurance:

Phone Call

An interviewer will contact you in the next few days to obtain more information about your health & medical history and to schedule your medical exam, if necessary. To assist us with the interview, please have your Driver's License number and your physician's name and address available.

Physical Exam (if required) — at no cost to you!

Typically, the exam will take place within a week of the phone interview in a medical center or in your home or place of business. If you are unable to keep your appointment, please notify the examiner to reschedule.

Process

Upon the completion of your interview and receiving your exam, we will review your application for approval.

Policy

Once your application has been approved, the policy will be mailed to your agent for your final review.

Payment

Payment is required to place the policy in force. If the initial payment is made by Automatic EFT, the initial premium will be drafted from your bank account the next business day after your policy has been put in force. Otherwise, your premium will be billed through the mail. Note: Monthly Automatic EFT will continue until Symetra receives written notification to cancel or change billing.

That's it! Applying for life insurance could not be easier. The entire process should take 30-45 days. If you have any questions about your application or this process, please contact your agent.

LIFE INSURANCE PAYMENT RECEIPT

Date: _____

Symetra Life Insurance Company
PO Box 84068
Seattle, WA 98124-9918
Fax: 1-877-435-5500

Payment Amount: $ _____

Proposed Insured: _____

Owner's Name (If other than Proposed Insured): _____

Agent Name: _____

Agent Address: _____

Agent Phone Number: _____

Thank you for your business!