

**National Life Insurance Company
 New Business Department
 Fax (802) 229-7592 • Tel (802) 229-3798
 Email: NBApplicationImages@nationallife.com**

INSTRUCTIONS: ONE PRELIMINARY INQUIRY PER TRANSMITTAL

All information pertaining to a specific client should be pre-sorted within this fax transmission. After faxing, retain original signed forms for 30 days.

PLEASE PRINT LEGIBLY

Agent Number:	Agent Name:
Agent Phone:	Agent Fax:
Product Name:	Agent Email:
Insured Name:	Product Type: UL
Companion Name:	Insured Birth Location:
Insured DOB:	Death Benefit:
Insured SSN:	Premium Mode: COM Quarterly Semi-Annual Annual

For use with NLIC Reg60 requests (Check appropriate box to indicate form is accompanying the Preliminary Inquiry)

- | PI | CP | New Business Requirements | PI | CP | Underwriting Requirements |
|--------------------------|--------------------------|---|--------------------------|--------------------------|---------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | HIV Consent Form (1443NY(0594)N) | <input type="checkbox"/> | <input type="checkbox"/> | Blood and HOS |
| <input type="checkbox"/> | <input type="checkbox"/> | HIPAA Compliant Authorization (9567) | <input type="checkbox"/> | <input type="checkbox"/> | EKG |
| <input type="checkbox"/> | <input type="checkbox"/> | Definition of Replacement (7717NY) | <input type="checkbox"/> | <input type="checkbox"/> | Inspection |
| <input type="checkbox"/> | <input type="checkbox"/> | Preliminary Inquiry (8679) | <input type="checkbox"/> | <input type="checkbox"/> | Paramed |
| <input type="checkbox"/> | <input type="checkbox"/> | Authorization to Disclose Policy Information (8678) | <input type="checkbox"/> | <input type="checkbox"/> | MD Exam |
| <input type="checkbox"/> | <input type="checkbox"/> | Full Illustration | <input type="checkbox"/> | <input type="checkbox"/> | Other |

PI = Proposed Insured

CP = Companion Policy

Comments:

Regulation 60 Requirements

If the client has any inforce Annuity Contracts or Life Insurance Policies, to be in compliance with the state of New York Regulation 60 laws, the agent must complete with the client a Definition of Replacement to determine if there will be any replacement or status change of existing coverage. The following outlines the steps to take to be within compliance with NY Reg60 regulations. It is imperative this process be followed in the order as described.

Step 1 - Complete NY Definition of Replacement

Complete the NY Definition of Replacement (Form 7717NY). If the client answers **YES** to any of the questions on this form, go to Step 2 to proceed. If the client answers **NO** to all questions on this form, complete the application and all the accompanying paperwork (Kit 8728K).

Step 2 - Preliminary Inquiry Process (for replacement situations only)

If the client answers **YES** to any question on the Definition of Replacement, please complete:

- Authorization to Disclose Policy Information (Form 8678)
- Preliminary Inquiry (Form 8679)
- Full Policy Illustration
- HIPAA Compliant Authorization (Form 9567)
- HIV Consent (Form 1443NY)
- Preliminary Inquiry Transmittal (Form 8655)

Provide the client with the Prenotifications (Form 6496NY) and make them aware a representative may contact them to complete a Personal History Interview.

Refer to the Underwriting Guide to determine Age & Amount Requirements needed. NLIC has three approved paramedical facilities which you may use to obtain these requirements. **Portamedic** - <http://portamedic.com>, **APPS** - <http://www.appsnational.com>, and **ExamOne** - <http://www.examone.com>. Local Branch Offices may be found on their websites.

Fax the above signed and dated forms along with the 7717NY to NLIC at (802) 229-7592 or email to NBAapplicationimages@nationallife.com.

Retain original signed forms for 30 days

Step 3 - Completion of the NY Disclosure Statement (NLIC's Responsibility)

Once the forms are received, the replacement team at NLIC will:

- Contact the carrier being replaced to obtain the required information on their policy
- Using information received from the carrier being replaced, we will provide you the completed Disclosure Statement, along with a letter of instruction necessary to complete the sale

Step 4 - Application Process

Review with the client completed Disclosure Statement and the Important Notice regarding replacement of the Life Insurance or Annuity contracts.

Complete with the client all paperwork necessary to complete the sale, sign and date all forms.

Fax signed replacement forms with application and all other documents to NLIC at:

(866) 323-3299

(Retain original signed forms during the application process)

Important note: If a 1035 Exchange or Transfer is to occur as part of the sale, the original 9648 Transfer or Exchange form must be forwarded to the NLIC home office replacement department.

Insurance Department of the State Of New York Definition of Replacement

In order to determine whether you are replacing or otherwise changing the status of existing life insurance policies or annuity contracts, and in order to receive the valuable information necessary to make a careful comparison if you are contemplating replacement, the agent is required to ask you the following questions and explain any items that you do not understand.

As part of your purchase of a new life insurance policy or a new annuity contract, has existing coverage been, or is it likely to be:

- (1) Lapsed, surrendered, partially surrendered, forfeited, assigned to the insurer replacing the life insurance policy or annuity contract, or otherwise terminated? Yes No
- (2) Changed or modified into paid-up insurance; continued as extended term insurance or under another form of nonforfeiture benefit; or otherwise reduced in value by the use of nonforfeiture benefits, dividend accumulations, dividend cash values or other cash values? Yes No
- (3) Changed or modified so as to effect a reduction either in the amount of the existing life insurance or annuity benefit or in the period of time the existing life insurance or annuity benefit will continue in force? Yes No
- (4) Reissued with a reduction in amount such that any cash values are released, including all transactions wherein an amount of dividend accumulations or paid-up additions is to be released on one or more of the existing policies? Yes No
- (5) Assigned as collateral for a loan or made subject to borrowing or withdrawal of any portion of the loan value, including all transactions wherein any amount of dividend accumulations or paid-up additions is to be borrowed or withdrawn on one or more existing policies? Yes No
- (6) Continued with a stoppage of premium payments or reduction in the amount of premium paid? Yes No

If you have answered yes to any of the above questions, a replacement as defined by New York Insurance Department Regulation No. 60 has occurred or is likely to occur and your agent is required to provide you with a completed Disclosure Statement and the **IMPORTANT** Notice Regarding Replacement or Change of Life Insurance Policies or Annuity Contracts.

Applicant's Signature: _____

Date: (mm/dd/yyyy)

Applicant's Signature: _____

Date: (mm/dd/yyyy)

To the best of my knowledge, a replacement is involved in this transaction: Yes No

Agent's Signature: _____

Date: (mm/dd/yyyy)

NATIONAL LIFE INSURANCE COMPANY
ONE NATIONAL LIFE DRIVE
MONTPELIER, VERMONT 05604

**Authorization to Disclose
Policy Information**

To: _____

Re: Policyowner: _____
Insured's Name: _____
Policy(s): _____

In accordance with New York State Insurance Department Regulation No. 60, please furnish, directly to the insurance company and agent shown below, the information needed for completing the enclosed alternate New York State Disclosure Statement.

Please forward this information to each of the parties shown below:

Insurer Address:
National Life Insurance Company
One National Life Drive
Montpelier, Vermont 05604
Fax: 802-229-4726

Agent Address:

Agent's E-mail: _____

I authorize the release of the above information. This authorization is valid until revoked by the undersigned in writing.

Policyowner's Name: *(please print)* _____

Policyowner's Signature: _____ Date: *(mm/dd/yyyy)* _____

Street: _____

City: _____ State: _____ Zip: _____

If required, further information may be included on an additional sheet of paper.

A. Personal Information - Proposed Insured (Please Print)

1. Full Name _____ 2. Sex Male Female
3. Date of Birth _____ 3a. Place of Birth _____
4. Social Security Number _____ 5. Drivers License State _____ 5a. Number _____
6. Address (Street, City, State & Zip Code) _____
7. Occupation _____
8. Telephone numbers and best time to call: Home: _____ Best time to call: _____
Work: _____ Best time to call: _____

B. Insurance Information

1. Plan: _____ 1a. Amount: _____
2. Riders: ABR for Covered Chronic and Terminal Illness Waiver of Premiums Other _____
3. Underwriting Classification: Elite Non-Smoker Preferred Non-Smoker Standard Non-Smoker
 Standard Smoker Preferred Smoker
4. Beneficiary _____ 4a. Relationship _____
5. Mode of Premium Payment: Annual Semi-Annual Quarterly COM 6. Planned Periodic Premium \$ _____
7. Owner (If other than Proposed Insured) _____
8. List all insurance, accident & sickness and long term care insurance in force on the life of the Proposed Insured
- | Carrier | Amount | Year Issued | To Be Discontinued? |
|---------|--------|-------------|--|
| _____ | _____ | _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| _____ | _____ | _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |

C. Health and General Information (If Yes to questions 1 & 2, provide details in the space provided)

1. Within the last 3 years, have you participated in or do you intend to participate in any motor powered racing; scuba, skin, or sky diving; rodeos; hang gliding or any other avocation generally considered hazardous? Yes No
2. Do you participate in any aviation activity other than a fare paying passenger? Yes No
3. Have you used any type of product containing nicotine within the last 24 months?
If yes, indicate kinds used, frequency of use and date of last use. Yes No
4. Name, Address & Phone Number of Personal Physician and any Specialist seen in the past 5 years Reason consulted & outcome

D. Authorization

I understand that by signing this form I am requesting that a representative of National Life contact me and take my application for life insurance. I am authorizing the release of information to the Company as explained below. The application when taken and signed by me will form the basis for the policy to be issued by the Company.

I understand that receipt of Accelerated Benefits may affect eligibility for public assistance programs and may be taxable. I understand that there is no separate premium or charge for this rider.

Accelerated Benefits Riders for Terminal Illness and Critical Illness are available on all non-survivorship products (traditional and universal life) offered by the Company. For the Accelerated Benefits Riders for Terminal Illness and Critical Illness, I understand that the amount of the Accelerated Benefit will be the discounted present value of the accelerated face amount, adjusted by future premiums payable and anticipated dividends. I understand that an administrative fee may be assessed upon acceleration.

The Accelerated Benefits Rider for Covered Chronic Illness is available on the AssurePlus Protector product only. For the Accelerated Benefits Rider for Covered Chronic Illness, I understand that the amount of the Accelerated Benefit will be the discounted present value of the accelerated face amount, adjusted by future premiums payable. I understand that an underwriting and administrative fee may be assessed upon acceleration.

I, the Proposed Insured, authorize any physician, medical practitioner, hospital, clinic, or other medically related facility, insurer or reinsurer, the Medical Information Bureau, Inc. (MIB), consumer reporting agency, or employer having information as to:

- diagnosis, treatment and prognosis of any physical or mental condition of me or any of my minor children on whose life I have applied for insurance;
- any non-medical information of me or such minor children;

to give National Life Insurance Company, herein called National Life, or its authorized representative, any and all such information.

I authorize National Life to request a copy of my driving record from the state motor vehicle department.

I authorize National Life Insurance Company to obtain an investigative consumer report. I understand that I am entitled to be interviewed by the consumer reporting agency that prepares any such report, as long as I can reasonably be contacted during normal business hours.

I wish to be interviewed if an investigative consumer report is prepared.

This information may be used to determine eligibility for life or health insurance or claims for benefits, and I authorize National Life to release any of this information to the MIB and/or Reinsurers and other life insurance companies in which I have insurance or from which I seek insurance or benefits.

I authorize National Life to redisclose the information to:

- Any person performing a business or legal function for its benefit;
- An attending physician for diagnostic or treatment purposes;
- Government authorities to prevent insurance related illegal activities;
- Persons conducting medical or statistical studies for National Life;
- Persons having an authorization specifically permitting the redisclosure;

and when required by law. In making this authorization, I waive any right to prohibit redisclosure to an affiliate of National Life where the redisclosure is related to the servicing of my policy.

I understand I have a right to receive a copy of this authorization. A copy of this authorization shall be as valid as the original. I acknowledge receipt of copies of the prenotifications relating to investigative consumer reports and the MIB.

E. Signatures

This Preliminary Inquiry was signed at _____
City State Date

Signature of Proposed Insured

Signature of Parent or Legal Guardian
(If minor child to be proposed insured)

Signature of Owner (Title)

Licensed Agent (Print and Sign)

Agent License Number

General Agent

Agent Code

HIPAA Compliant Authorization
for Release of Health-Related Information to National Life Insurance Company

Proposed Insured/Patient *(Print)*

Date of Birth

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record and any other protected health information concerning me to National Life Insurance Company (National Life) and its agents, employees, and 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 National Life 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 National Life.

This authorization shall remain in force for 30 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 sending a written request for revocation to National Life at One National Life Drive, Montpelier, VT 05604, Attention: Privacy Official. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that National Life 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 may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

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, National Life may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I acknowledge that I have received a copy of this Authorization.

Signature of Proposed Insured/Patient or Personal Representative:

Date: *(mm/dd/yyyy)*

Description of Personal Representative's Authority or Relationship to Patient:

Questions & Answers about Release of Protected Health Information to a Life or Disability Income Insurer.

1. May I release complete personal medical information to a life or disability income insurance company?

Yes. As you did before the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule became effective, a medical care provider may disclose complete Protected Health Information (PHI) to organizations not subject to the Privacy Rule as long as the applicant has signed a HIPAA compliant authorization.

2. Does the "minimum amount necessary" rule apply to this release to a life or disability income insurer?

No. The "minimum amount necessary" rule does not apply as long as a HIPAA compliant authorization is signed. This question was specifically addressed by Health and Human Services (HHS) in a Q and A published December 4, 2002: "Uses and disclosures that are authorized by the individual are exempt from the minimum necessary requirements. For example, if a covered health care provider receives an individual's authorization to disclose medical information to a life insurer for underwriting purposes, the provider is permitted to disclose the information requested on the authorization without making any minimum necessary determination. The authorization must meet the requirements of 45 CFR 164.508."

3. Can an insurer request disclosure of a person's "entire" medical record or does it have to refer to specific items in a medical file only?

Yes. HIPAA allows insurers to seek and providers to disclose a person's entire medical record, if the authorization used clearly states that the entire medical record is to be disclosed (e.g., "I authorize you to disclose my entire medical record.")

4. Does HIPAA mandate the use of one specified form of authorization by everyone?

No. HIPAA requires that certain specified "elements" be included in a valid authorization to disclose protected health information. HIPAA does not mandate that a specific form be used. Both covered and non-covered entities are free to use any format they wish so long as it is compliant with HIPAA's requirements. The signed authorization contains all of the elements required by HIPAA.

5. What should I do if I had previously agreed to a restriction and now receive an authorization to release the "entire medical record?" Does the authorization cover PHI that was restricted?

You may release all medical records, restricted and otherwise if a patient has previously requested a restriction and later signs an authorization which removes the restriction. The wording of this authorization specifically releases any restricted information.

This HIPAA compliant authorization and Questions and Answers were created by the American Council of Life Insurers.

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

Unless precluded by law, tests may be performed 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. Other tests which may be performed include determinations of blood cholesterol and related lipids (fats) and screening for liver or kidney disorders, diabetes, and immune disorders.

The results of any prior antibody test need not be disclosed by you or the applicant on the application for insurance or considered by you or the applicant in answering questions on the application.

All tests' 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 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. Other test results may be reported to the MIB, Inc. in a more specific manner. 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.

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 you. The Insurer may also contact you if there are other abnormal test results which, in the Insurer's opinion, are significant.

The Insurer may 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. You may designate below the physician or other health care provider to whom positive or indeterminate HIV test results or other abnormal test results will be reported. We may but will not routinely send normal test results to your physician or other health care provider unless you send us a separate request and authorization to do so.

Name:

Address: *(Street, City, State, Zip Code)*

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. If your test is positive, you may want to consider further independent testing. 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 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.

You may call the New York Department of Health's statewide toll free number, 1-800-541-AIDS, for further information about AIDS, the meaning of HIV related test results, and the availability and location of HIV related counseling services.

I have read and I understand this Notice and Consent For Blood Testing Which May 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's Name: *(Print or type.)*

Date of Birth:

State of Residence:

Signature of Proposed Insured or Parent/Guardian:

Date:

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

Unless precluded by law, tests may be performed 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. Other tests which may be performed include determinations of blood cholesterol and related lipids (fats) and screening for liver or kidney disorders, diabetes, and immune disorders.

The results of any prior antibody test need not be disclosed by you or the applicant on the application for insurance or considered by you or the applicant in answering questions on the application.

All tests' 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 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. Other test results may be reported to the MIB, Inc. in a more specific manner. 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.

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 you. The Insurer may also contact you if there are other abnormal test results which, in the Insurer's opinion, are significant.

The Insurer may 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. You may designate below the physician or other health care provider to whom positive or indeterminate HIV test results or other abnormal test results will be reported. We may but will not routinely send normal test results to your physician or other health care provider unless you send us a separate request and authorization to do so.

Name:

Address: *(Street, City, State, Zip Code)*

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. If your test is positive, you may want to consider further independent testing. 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 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.

You may call the New York Department of Health's statewide toll free number, 1-800-541-AIDS, for further information about AIDS, the meaning of HIV related test results, and the availability and location of HIV related counseling services.

I have read and I understand this Notice and Consent For Blood Testing Which May 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's Name: *(Print or type.)*

Date of Birth:

State of Residence:

Signature of Proposed Insured or Parent/Guardian:

Date:

The Underwriting Process and Consumer Rights

Thank you for your application. A primary goal of the Company is to provide insurance protection that best meets your needs and to service these needs through the years. To keep costs at a minimum, we evaluate every proposed insured to be sure that the premium rate for each person is in relation to each person's fair share of the cost.

This evaluation - the underwriting process - may consist of a physical examination, review of medical history and reports from physicians or medical facilities which you have visited for treatment or consultation. In addition, a routine investigative consumer report is sometimes obtained.

We also check the records of the Medical Information Bureau. The Medical Information Bureau is a nonprofit membership organization of life insurance companies which operates an information exchange on behalf of its members. The basic purpose of this organization is the protection of policyholders of member companies. It is not a repository of medical records. The information in its files serves only as an indication that additional data may be needed to evaluate the risk. No member company can refuse coverage on the basis of this information, nor does the information reveal whether an application was approved, rated or declined.

This program helps to assure that the true cost of the insurance is shared proportionately. Consumer rights bearing on insurance cost, needs and service are just as important to us as they are to you.

Prenotification - Investigative Consumer Report

This is to inform you in compliance with Public Law 91-508, known as the Fair Credit Reporting Act, that as part of our processing procedure for your insurance application an investigative consumer report may be made. This means information is obtained through personal interviews with third parties such as family members, business associates, financial sources, friends, neighbors or others with whom you are acquainted. This report may include information as to your character, general reputation, personal characteristics and mode of living. Upon written request, made within a reasonable period of time, you will be informed whether or not an investigative consumer report was requested and, if so, the name and address of the consumer reporting agency that prepared the report. By contacting that agency you will be permitted to inspect and receive a copy of that report.

Prenotification - Personal History Interview

To obtain the information described in Investigative Consumer Report Prenotification, the Company may telephone you directly for a Personal History Interview. A Home Office interviewer may phone you to review and clarify information you provided on your application and to ask additional questions which will aid in considering your application.

Whenever possible, calls will be made at your convenience and to the telephone number you have provided. A separate form contains the information we need to complete the call. If for any reason it is necessary to make a change, please let your Agent know promptly.

Prenotification - Medical Information Bureau

Information regarding your insurability and/or any past or future claims will be treated as confidential. The Company or its reinsurers may, however, make a brief report to the Medical Information Bureau. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file. Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. Medical information can be released to you or to your attending physician. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734, telephone number: (866) 692-6901, website: www.mib.com.

The Company may also release information in its files to its reinsurers and to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.