APPLICATION FOR FINAL EXPENSE WHOLE LIFE

LIFE INSURANCE SINCE 1939

SBLI USA Life Insurance Company, Inc.
460 W. 34th Street, Suite 800, New York, NY 10001-2320
Toll Free: 1-877-SBLI-USA / 1-877-725-4872
website: www.sbliusa.com

1. PROPOSED INSURED INFORMATION

Last Name	First Name	MI	Phone Number for Contact Day:

Social Security Number	Sex	Date of Birth	State of Birth	Country of Birth	Evening: / Best Time To Call

Mailing Address (Number, Street, Apt. #)	City	State	Zip Code

Driver's License State and Number	E-Mail Address	Are you a United States citizen or legal permanent resident? ❑ Yes ❑ No

2. BENEFICIARY INFORMATION

Beneficiary ❑ Primary ❑ Contingent	Social Security # or Tax ID #

Address (Number, Street, Apt. #)	City	State	Zip Code

Date of Birth	Relationship	Percent of Proceeds	Telephone Number

Beneficiary ❑ Primary ❑ Contingent	Social Security # or Tax ID #

Address (Number, Street, Apt. #)	City	State	Zip Code

Date of Birth	Relationship	Percent of Proceeds	Telephone Number

Please attach another page for additional beneficiary information. The Percent of Proceeds for each type of beneficiary must equal 100%.

3. OWNER INFORMATION *(if other than Proposed Insured)*

Last Name	First Name	MI	Social Security # or Tax ID #

Address (Number, Street, Apt. #)	City	State	Zip Code

Date of Birth	Relationship	Telephone Number

4. REPLACEMENT INFORMATION

1. Is there any life insurance or annuity contract in force on the Proposed Insured with this or any other company? ..... ❑ Yes ❑ No
2. Is the insurance applied for intended to replace or change any life insurance or annuity contract in force with this or any other company? ..... ❑ Yes ❑ No
3. Are any other life insurance or annuity applications pending with this or any other company? ..... ❑ Yes ❑ No

List all current or pending life insurance or annuity coverage below.

Insured's Name	Company	Owner	Replacement	Face Amount	Accidental Death Benefit	Year Issued
			❑ Yes ❑ No			
			❑ Yes ❑ No			
			❑ Yes ❑ No			
			❑ Yes ❑ No			
			❑ Yes ❑ No			

5. HEALTH INFORMATION

SINCE THIS POLICY IS ISSUED WITH MINIMAL OR NO MEDICAL UNDERWRITING, THE PREMIUM RATE CHARGED INCLUDES AN EXTRA MORTALITY RISK CHARGE. IF YOU ARE HEALTHY ENOUGH TO QUALIFY AS A "STANDARD" RISK, PREMIUMS WOULD LIKELY HAVE BEEN LOWER IF YOU HAD APPLIED FOR A FULLY UNDERWRITTEN POLICY.

Has the Proposed Insured smoked cigarettes in the past 12 months? ..... ❑ Yes ❑ No

Please state the Proposed Insured's height _____ and weight _____.

Part A - if any question is answered "Yes", the Proposed Insured is not eligible for coverage

1. Is the Proposed Insured currently or in the last 30 days been: hospitalized, committed to a psychiatric facility, bedridden, confined to a nursing facility, receiving hospice or home health care, confined to a wheelchair due to a disease or chronic illness, or waiting for an organ transplant? ..... ❑ Yes ❑ No
2. Does the Proposed Insured currently require assistance with activities of daily living such as taking medications, moving about, bathing, dressing, eating or toileting? ..... ❑ Yes ❑ No
3. Within the past 12 months has the Proposed Insured:
   a. been advised by a member of the medical profession to have a diagnostic test (other than an HIV test), surgery, home health care or hospitalization which has not yet started, been completed or for which results are not known? ..... ❑ Yes ❑ No
   b. used or been advised by a member of the medical profession to use oxygen equipment for assistance in breathing (excluding CPAP or nebulizer)? ..... ❑ Yes ❑ No
   c. had or been advised to have Kidney Dialysis? ..... ❑ Yes ❑ No
4. Has the Proposed Insured ever been diagnosed or treated for Acquired Immune Deficiency Syndrome (AIDS) and/or Human Immunodeficiency Virus (HIV) infection by a licensed member of the medical profession? ..... ❑ Yes ❑ No
5. Has the Proposed Insured ever been diagnosed or received treatment for Alzheimer's disease, dementia, Lou Gehrig's/Amyotrophic Lateral Sclerosis (ALS), Cirrhosis of the Liver (Stage C) or been diagnosed as having a terminal medical condition that is expected to result in death within the next 24 months? ..... ❑ Yes ❑ No
6. Has the Proposed Insured ever been diagnosed with more than one occurrence of the same or different type of cancer or is the Proposed Insured currently receiving treatment (including taking medication) for any form of cancer (excluding basal cell skin cancer)? ..... ❑ Yes ❑ No

Part B - if any question is answered "Yes", the Proposed Insured may be eligible for the Modified Death Benefit Individual Whole Life Policy

1. In the past 2 years, has the Proposed Insured been diagnosed or received treatment from a member of the medical profession, or other practitioner, or been hospitalized for any of the following:
   a. the use of alcohol or drugs; or been advised by a physician, practitioner, health facility or counselor to restrict the use of alcohol or drugs? ..... ❑ Yes ❑ No
   b. complications of diabetes such as diabetic coma or insulin shock or had an amputation due to complications of any disease? ..... ❑ Yes ❑ No
   c. heart attack, angina (chest pain), congestive heart failure, cardiomyopathy stroke, transient ischemic attack (TIA), or aneurysm or had heart or circulatory surgery? ..... ❑ Yes ❑ No
2. In the past 3 years, has the Proposed Insured been diagnosed, treated, or prescribed medication for: internal cancer, including but not limited to, malignant brain tumor, malignant melanoma (but excluding basal/squamous cell skin cancer), leukemia, or multiple myeloma? ..... ❑ Yes ❑ No
3. In the past 2 years, has the Proposed Insured had more than 1 conviction for reckless driving or for driving under the influence of alcohol or drugs (DUI or DWI)? ..... ❑ Yes ❑ No

Part C - if any question is answered "Yes", the Proposed Insured may be eligible for the Graded Death Benefit Individual Whole Life Policy

1. Has the Proposed Insured ever been diagnosed, treated, or prescribed medication by a member of the medical profession for:
   a. Parkinson's disease, Systemic Lupus (SLE) or sickle cell disease? ..... ❑ Yes ❑ No
   b. Cirrhosis (Stage A or Stage B) of the liver, chronic hepatitis or other liver disorder, kidney failure or other chronic kidney disease? ..... ❑ Yes ❑ No
   c. Chronic Obstructive Pulmonary Disease (COPD), which includes emphysema, black lung disease or tuberculosis? ... ❑ Yes ❑ No
   d. Bipolar Disorder or Schizophrenia or been hospitalized in the past 2 years for any mental or nervous disorder? ... ❑ Yes ❑ No

If all questions in Parts A, B and C are answered "No", the Proposed Insured may be eligible for the Level Death Benefit Individual Whole Life Policy

6. INSURANCE APPLIED FOR

a. ❑ Level Death Benefit Individual Whole Life Policy

❑ Modified Death Benefit Individual Whole Life Policy

❑ Graded Death Benefit Individual Whole Life Policy

b. Face Amount ..... $_____

7. RIDERS APPLIED FOR

❑ Accidental Death Benefit Rider ..... 1X Amount of Insurance

8. PREMIUM AND BILLING INFORMATION

1. Payment Options:

   a. ❑ **I hereby authorize, until further notice, the deduction of the premium from my checking account.**

   Please attach a voided check or provide the following information:

   _____ Bank Routing Number _____ Account Number

   _____ Bank Name

   b. ❑ **I hereby authorize, until further notice, the payment of the premium from my credit card.**

   Please provide the following information:

   _____ Credit Card Number _____ Expiration Date

   _____ Cardholder Name _____ Cardholder Address

   c. ❑ **I would like to be billed directly.**

2. Premium Mode:

   ❑ Monthly (Not available for direct bill) ❑ Quarterly ❑ Semi-Annual ❑ Annual

   NOTE: If you choose to pay your policy premium in semi-annual, quarterly or monthly payments, you will pay more over the year than if you choose to pay your premium in one annual premium payment.

3. Payment with Application ..... $_____

4. Premium notices sent to: ..... ❑ Proposed Insured ❑ Owner ❑ Other *(indicate below)*

Name	Relationship to Insured	Social Security # or Tax ID #

Address (Number, Street, Apt. #)	City	State	Zip Code

5. Automatic Premium Loan ..... ❑ Yes ❑ No

   I understand that by selecting this option a loan may be made against the cash value of my policy to pay premiums due.

9. HOME OFFICE ENDORSEMENTS	SPECIAL REQUESTS

10. DECLARATIONS AND AUTHORIZATIONS

I understand and agree that the statements and answers in this application are complete and true to the best of my knowledge and belief and shall be attached to and form a part of the contract of insurance. I also understand and agree that the insurance applied for, if issued, shall be subject to such statements and answers and take effect on the effective date stated in the Policy Data page provided the applicable first premium has been paid.

I understand that the amount applied for may be reduced or denied if other simple issue policies from the company or its affiliates are in-force or pending on the life of the Proposed Insured.

I have received and read the required MIB, Inc. and Fair Credit Reporting Act Notices.

AUTHORIZATION: I, the Proposed Insured, authorize any physician, medical professional, hospital, clinic, pharmacy, pharmacy benefit manager, laboratory, medical care facility, insurer, reinsurer, MIB, Inc., or any other similar organization or person having knowledge of me or my health to release information about me to the Medical Director of SBLI USA Life Insurance Company, Inc. (the "Company"), or its reinsurers for underwriting or claims purposes. The information collected may relate to the symptoms, examination, diagnosis, treatment or prognosis of any physical or mental condition but excludes psychotherapy notes and records pertaining to treatment for drug use and alcoholism. If we need those records, we will ask for them on a separate authorization form. This authorization also includes information about prescription drug records. To facilitate rapid submission of such information, I authorize all said sources, except MIB, Inc., to give such records or knowledge to any agency employed by the Company to collect and transmit such information. I understand a telephone interview may be necessary to verify information given to the Company on this application. This interview may be from the Company or from a consumer-reporting agency by a trained interviewer acting on the Company's behalf.

I, the Proposed Insured, authorize the Company or its reinsurers to make a brief report of my personal health information to MIB, Inc.

I, the Proposed Insured, also authorize the Company to obtain an investigative consumer report as described in the Company's NOTIFICATION IN ACCORDANCE WITH FEDERAL AND STATE LAW. This Authorization is for the purpose of underwriting the life insurance. It is in effect for 24 months from the latest date shown below, and a photocopy may be accepted as valid. The authorization will survive the Insured's death if it occurs during such 2 year period.

I understand that this Authorization may be revoked by contacting us at the address listed at the top of this application; however, the Company retains the right to use any information obtained under my authorization prior to my revocation.

ACCELERATED DEATH BENEFIT: **Receipt of accelerated death benefits may affect eligibility for public assistance programs and may be taxable.** There is no premium charge for this benefit. However, upon election, the benefit is discounted because it is an early payment and a one-time processing fee of $150 is deducted.

LIMITED DEATH BENEFIT: I understand that if I am approved for the Modified or Graded benefit plan, during the first two years the insurance has a limited death benefit for death other than by accident.

I certify under penalties of perjury that the Social Security Number (Taxpayer Identification Number) above is correct and I am not subject to back-up withholding.

Signed by the Proposed Insured at _____ on _____ .
City, State Date

X_____
Signature of **Proposed Insured**

Signed by the Owner at _____ on _____ .
City, State Date

X_____
Signature of **Owner**, if other than Proposed Insured

11. AGENT CERTIFICATION

1. To the best of your knowledge and belief, is there an existing life insurance policy or annuity contract insuring the proposed insured's life? ..... ❑ Yes ❑ No
2. To the best of your knowledge and belief, replacement is or may be involved in this transaction. ..... ❑ Yes ❑ No

   If "Yes" to either of these questions, complete any required replacement forms.

I certify that the above statements and responses are true and accurate.

Agent Number	Email Address of Agent
Print Agent's Name	**X** Agent's Signature
Agency Name	Agency Number
Telephone Number of Agent	Date

Conditional Receipt provided? ..... ❑ Yes ❑ No

FOR SBLI USE ONLY

MK Code _____ Sales Number _____

GA Agency Name _____ GA Agency Number _____

SBLI USA Life Insurance Company, Inc.

APPENDIX 11
DEPARTMENT OF FINANCIAL SERVICES 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 OR BROKER 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 REGULATION 60 HAS OCCURRED OR IS LIKELY TO OCCUR AND YOUR AGENT OR BROKER IS REQUIRED TO PROVIDE YOU WITH THE **IMPORTANT** NOTICE REGARDING REPLACEMENT OR CHANGE OF LIFE INSURANCE POLICIES OR ANNUITY CONTRACTS. YOU WILL ALSO RECEIVE A COMPLETED DISCLOSURE STATEMENT NO LATER THAN THE TIME YOUR NEW POLICY OR NEW CONTRACT IS DELIVERED.

Date: _____ Signature of Applicant: _____

Date: _____ Signature of Applicant: _____

TO THE BEST OF MY KNOWLEDGE, A REPLACEMENT IS INVOLVED IN THIS TRANSACTION: YES ☐ NO ☐

Date: _____ Signature of Agent or Broker: _____

INSTRUCTIONS

NEW YORK INSURANCE REGULATION NO. 60 REQUIRES THAT WITH EACH NEW APPLICATION FOR INSURANCE A DETERMINATION SHOULD BE MADE AS TO WHETHER IT WILL REPLACE EXISTING INSURANCE. IN THAT REGARD, PLEASE:

1. Answer Questions 1-6 On the Reverse Side of this Form.
2. Date and Sign the Form.
3. Retain the Copy for your Records.
4. Attach the Original to your Application for Insurance.
5. ***If you Answer Yes to any of Questions 1-6, Please Sign the REGULATION 60 AUTHORIZATION also enclosed.***
6. Return all Completed Forms to your SBLI Representative

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SBLI USA Life Insurance Company, Inc.

AUTHORIZATION FOR RELEASE OF HEALTH-RELATED INFORMATION

THIS AUTHORIZATION COMPLIES WITH THE HIPAA PRIVACY RULE

Print Name of Proposed Insured/Patient

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 within the past 10 years ("my providers") to disclose my entire medical record, prescription history, medications prescribed and any other health information concerning me ("protected health information") to SBLI USA Life Insurance Company, Inc. ("the Company"). I also authorize any insurance company or agent from which I have applied for or obtained insurance, any consumer reporting agency such as MIB, Inc., and any other entity or person having protected health information about me, to disclose it to the Company. Protected health information includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. Protected health information also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

Further, protected health information includes genetic information and genetic test results, and I specifically authorize my providers to disclose such information and results to the Company, subject to the terms and conditions of this Authorization.

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 my providers and other entities or persons referred to above to release and disclose my entire medical record without restriction.

I further authorize the disclosure of protected health information by the Company to its affiliates, service providers, reinsurers, agents and representatives, and to any consumer reporting agency such as MIB, Inc.

This protected health information is to be used or disclosed under this Authorization so that the Company may: 1) underwrite my application for insurance, make eligibility, risk rating, and policy issuance 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 the 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 sending a written request for revocation to the Company at the address below, Attention: Underwriting Department. I understand that a revocation is not effective to the extent that any person or entity has already relied on this Authorization to disclose or use information about me or to the extent that the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that if any of my protected health information is re-disclosed, it may no longer be protected 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, the 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 and acknowledge that I or any authorized representative will receive or have received a copy of this Authorization.

Printed Name of the Proposed Insured/Patient or Personal Representative

Description of Personal Representative's Authority or Relationship to Proposed Insured/Patient (if applicable)

Signature of Proposed Insured/Patient or Personal Representative

Date (required)

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SBLI USA Life Insurance Company, Inc.

LIFE INSURANCE SINCE 1939

Regulation 194 Mandatory Initial Disclosure

(As required by the New York State Department of Financial Services)

Agency Name

Agency Address

( )	( )	
Telephone #	**Fax #**	**E-mail**

is an insurance producer licensed by the State of New York. Insurance producers are authorized by their license to engage in the following activities:

- Confer with insurance purchasers about the benefits, terms and conditions of insurance contracts
- Render advice concerning the substantive benefits of particular insurance contracts
- Sell insurance and
- Obtain insurance for purchasers

The role of the producer in any particular transaction typically involves one or more of the above listed activities.

Compensation will be paid to the producer, based on the insurance contract the producer sells. Depending on the insurer(s) and insurance contract(s) the purchaser selects, compensation will be paid by the insurer(s) selling the insurance contract or by another third party. Such compensation may vary depending on a number of factors, including the insurance contract(s), and the insurer(s) the purchaser selects. In some cases, other factors such as the volume of business a producer provides to an insurer or the profitability of insurance contracts a producer provides to an insurer also may affect compensation.

The insurance purchaser may obtain information about compensation expected to be received by the producer based in whole or in part on the sale of insurance to the purchaser, and (if applicable) compensation expected to be received based in whole or in part on any alternative quotes presented to the purchaser by the producer, by requesting such information from the producer.

SBLI USA Life Insurance Company, Inc.

LIFE INSURANCE SINCE 1939

POLICY CONDITIONAL RECEIPT

We received $ _____ from _____
(Name of payor, even if other than person to be insured)

on _____. This in connection with the application to SBLI USA Life Insurance Company, Inc., for life insurance made

on _____.

The name of the person to be insured is _____.
(Name of person to be insured)

I. INSURABILITY.

No change in health or insurability occurring after the "Effective Date" (as defined in Section II below) shall affect the underwriting of this application if:

a) the amount above is at least equal to a monthly premium for the insurance applied for; and

b) on the Effective Date the person to be insured is in the state of health and insurability as stated on the application (including Part II of that application, if required); and

c) that person is, on the "Effective Date," a risk acceptable to the Company for the amount and type of coverage applied for; and

d) all required medical or paramedical tests and examinations are completed.

II. EFFECTIVE DATE.

The "Effective Date" of the insurance is:

a) the date of the application, if no medical or paramedical tests and examinations are required under the insurer's underwriting rules, or

b) the date all medical or paramedical tests and examinations are completed, if any are initially required under the insurer's underwriting rules.

If the coverage is approved at a premium rate other than the amount shown above, and if the additional premium amount is not received within 15 days after the Company notifies the applicant, the Company shall refund all monies and the Company will have no liability.

III. MAXIMUM DEATH BENEFIT AMOUNT.

If the person to be insured dies before the date the insurance is approved by an underwriter, no more than $150,000 in total will be paid with respect to all conditional receipts issued by SBLI USA Life Insurance Company, Inc. on all applications pending at the time of that death. No amount shall be paid under any Accidental Death Benefit rider or other rider.

IV. DATE OF ISSUE OF INSURANCE.

The Date of Issue of the policy applied for, if it is approved for issue, is the "Effective Date", unless the applicant requests an earlier Date of Issue. That earlier Date of Issue can be any date within the six months prior to the date of Part I of the application.

_____ By: _____
Company

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IMPORTANT: Read The Information Below Before Completing Application.

NOTIFICATION IN ACCORDANCE WITH FEDERAL AND STATE LAW

This is to inform you that as part of our procedure for processing your insurance application, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends or others with whom you are acquainted. The inquiry includes information as to your character, general reputation, personal characteristics and mode of living. You have the right upon written request to be informed whether an investigative consumer report was requested, and if so, the name and address of the consumer reporting agency to whom the request was made. You may inspect and receive a copy of your investigative consumer report from the reporting agency.

NOTIFICATION IN ACCORDANCE WITH MIB, INC.

Information regarding your insurability will be treated as confidential. SBLI USA Life Insurance Company, Inc. or its reinsurers may, however, make a brief report thereon to MIB, Inc., 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 866-692-6901. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734.

SBLI USA Life Insurance Company, Inc., 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. Information for consumers about MIB may be obtained on its website at www.mib.com.

UNDERWRITING YOUR APPLICATION

As you are considering giving SBLI USA Life Insurance Company, Inc. the opportunity to help satisfy your life insurance needs, we thought you might be interested in learning about our underwriting process.

- Your application, the initial source of information to help us determine your eligibility for insurance, will be promptly and carefully reviewed by experienced, highly skilled underwriters. To expedite your application, please be certain that all changes and corrections you make are initialed.
- Usually, an underwriter will be able to make a decision without getting additional information from doctors, hospitals, etc., and the handling of your application will be quickly completed. Be sure to answer all questions completely and leave no blank spaces.
- If additional underwriting information is needed, you will be kept informed on the status of your application.
- Please complete the definition of replacement form.

Some applicants present a greater risk due to adverse medical findings or history, or possibly a dangerous occupation or avocation. In these instances, a higher premium may be charged or an application may be declined.

Every effort is made to fairly place each applicant in his or her proper insurance class, so that each person assumes his or her share of the insurance cost. Otherwise, the vast majority who qualify for standard rates would have to bear the extra cost of insuring those who do not qualify, resulting in unnecessarily high premiums for all insureds.

SBLI USA Life Insurance Company, Inc.

CUSTOMER IDENTIFICATION PROGRAM NOTICE

Important Information You Need to Know About Buying a Life Insurance Policy or Annuity

To help the government fight the funding of terrorism and money laundering activities, federal law requires financial institutions to obtain, verify, and record information that identifies each person who buys a life insurance policy or annuity.

This notice answers some questions about our Customer Identification Program.

What products are covered by this notice?

- A permanent life insurance policy, other than a group life insurance policy;
- An Annuity contract, other than a group annuity contract
- Any other insurance product with features of cash value or investment.

What types of information will I need to provide?

When you buy a life insurance policy or annuity, we are required to collect information such as the following from you:

- Your name
- Date of birth
- Address
- Identification number:
  - U.S. Citizen: taxpayer identification number (social security number or employer identification number)
  - Non-U.S. Citizen: taxpayer identification number, passport number, and country of issuance, alien identification card number, or government-issued identification showing nationality, residence and a photograph of you.

You may also need to show your driver's license or other identifying documents.

A corporation, partnership, trust or other legal entity may need to provide other information, such as its principal place of business, local office, employer identification number, certified articles of incorporation, government-issued business license, a partnership agreement, or trust agreement.

The U.S. Department of the Treasury already requires you to provide most of this information. We may also require you to provide additional information such as your net worth, annual income, occupation, and employment information.

What happens if I don't provide the information requested or my identity can't be verified?

We may not be able to issue a policy or annuity or carry out transactions for you. If you already have a policy or annuity, we may have to suspend transactions.

We thank you for your patience and hope that you will support the financial industry's efforts to deny terrorists and money launderers access to America's financial system.

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