



# Application for Life Insurance

Affiliated Life Insurance Companies of GE Financial Assurance

**First Colony Life Insurance Company    General Electric Capital Assurance Company    GE Life and Annuity Assurance Company**

Please complete this application properly and ensure that you have satisfied all of our requirements. Follow the submission instructions provided through your marketing distribution channel. If special mailing envelopes have been provided, submitting the application in such an envelope will help avoid delays in processing your client's application. We sincerely appreciate your business.

## LICENSED INSURANCE AGENT CHECKLIST

*This checklist is not part of the application. Please remove this page before submitting the application to the Insurer.*

### DO

- ▶ Give the *Notice to Proposed Insured and Owner* to the Proposed Insured or Owner before completing the application.
- ▶ Make sure that the circle for the appropriate Insurer is marked in item 4.a. on Page 1.
- ▶ Ask all questions and fully and accurately record all answers given — the application will be part of any policy issued.
- ▶ Enter each beneficiary's SSN — it will help us locate the beneficiary at claim time.
- ▶ Print in dark ink.
- ▶ Obtain all the necessary signatures.
- ▶ Complete and sign the Licensed Insurance Agent's Report.
- ▶ Promptly schedule any required medical exam.
- ▶ Obtain proper identification and sufficient information about the customer and source of funds to ensure that money laundering is not involved in the transaction.
- ▶ If you accept payment with the application:
  - Accept payment only in the form of a currently dated check or money order made payable to the selected Insurer.
  - Enter the full amount accepted in Section 7.f. on Page 1.
  - Complete the Temporary Insurance Application section of the Temporary Insurance Application and Agreement (TIAA), making sure that all questions are answered "No."
  - Explain the terms and conditions of the TIAA to the Owner and Proposed Insured and have them sign it.
  - Complete and sign the Licensed Insurance Agent's Statement on the TIAA.
  - Give the Owner the COPY of the TIAA. Keep the ORIGINAL with the application.
  - Promptly send the payment and the Application – Part I, including the ORIGINAL of the TIAA to the Insurer marked in item 4.a. on Page 1.
- ▶ For Term and Excess Interest Whole Life plans — explain that for premiums not paid on an annual basis at the beginning of a policy year, we adjust the annual premium by a modal factor to compensate for the lost investment earnings, additional administrative costs, and expected early lapses. These modal factors and associated APRs are available and will be provided on request.

### DO NOT

- ▶ DO NOT use pencil or correction fluid.
- ▶ DO NOT attempt to waive any of our requirements or any information that we request; you do not have the authority to make or modify contracts.
- ▶ DO NOT promise or imply that we will provide insurance.
- ▶ DO NOT accept payment in the form of cash/currency or Traveler's checks.
- ▶ DO NOT accept a check or money order made payable to you or with the payee left blank.
- ▶ DO NOT do the following:
  - Do not accept payment when the amount applied for plus existing insurance with the Insurer exceeds \$1,000,000.
  - Do not accept payment if the Proposed Insured's age nearest birthday exceeds 70 years or is less than 15 days.
  - Do not accept payment if any question on the Temporary Insurance Application is answered "Yes" or left blank.



# Application for Life Insurance – Part I



Affiliated Life Insurance Companies of GE Financial Assurance

First Colony Life Insurance Company (FCL) • General Electric Capital Assurance Company (GECA) • GE Life and Annuity Assurance Company (GE Life & Annuity)  
700 Main Street • Lynchburg, VA 24504

## 1. Proposed Insured

Please print all answers.

a. Full Name (First, Middle, Last. Include maiden name in parentheses.)	b. Sex <input type="radio"/> F <input type="radio"/> M	c. Date of Birth Mo. Day Yr.	d. State of Birth	e. Social Security Number
f. Home Address (Number, Street, City, State, and Zip Code.) e-mail: _____			How Long At Address?	g. Legal Residency <input type="radio"/> U.S. <input type="radio"/> Other (Specify):
h. Driver's License Number/State	i. Marital Status <input type="radio"/> M <input type="radio"/> S <input type="radio"/> W <input type="radio"/> D	j. Home Phone Number		k. Work Phone Number
l. Occupation (Include duties.)	m. Employer Name and Address			How Long w/ Employer?

## 2. Ownership (Complete if Owner is other than Proposed Insured. If trust, give full name of trust and date of trust agreement.)

a. Owner: (Full Name and Address) e-mail: _____	b. Rel. to Prop. Ins.	c. SSN or TIN	d. Date of Birth/Trust Mo. Day Yr.
e. Owner is: <input type="radio"/> Individual <input type="radio"/> Partnership <input type="radio"/> Corporation <input type="radio"/> Trust <input type="radio"/> Other (Specify):			
f. Contingent Owner: (Full Name and Address) e-mail: _____	g. Rel. to Prop. Ins.	h. SSN or TIN	i. Date of Birth/Trust Mo. Day Yr.
j. Contingent Owner is: <input type="radio"/> Individual <input type="radio"/> Partnership <input type="radio"/> Corporation <input type="radio"/> Trust <input type="radio"/> Other (Specify):			

## 3. Beneficiary (If percentage shares are not given, they will be equal. Use REMARKS to name additional Beneficiaries.)

a. Primary: (Full Name and Address)	b. % Share	c. Rel. to Prop. Ins.	d. SSN or TIN	e. Date of Birth/Trust Mo. Day Yr.
f. Primary: (Full Name and Address)	g. % Share	h. Rel. to Prop. Ins.	i. SSN or TIN	j. Date of Birth/Trust Mo. Day Yr.
k. Contingent: (Full Name and Address)	l. % Share	m. Rel. to Prop. Ins.	n. SSN or TIN	o. Date of Birth/Trust Mo. Day Yr.
p. Contingent: (Full Name and Address)	q. % Share	r. Rel. to Prop. Ins.	s. SSN or TIN	t. Date of Birth/Trust Mo. Day Yr.

## 4. Insurer, Plan and Amount of Insurance

## 5. Death Benefit Option (Universal Life only)

## 6. Riders (If available with Plan)

a. Insurer: (Select one) <input type="radio"/> FCL <input type="radio"/> GECA <input type="radio"/> GE Life & Annuity	<input type="radio"/> Level (Specified Amount only)	<input type="radio"/> Waiver
b. Plan of Insurance:	<input type="radio"/> Increasing (Specified Amount plus cash value)	<input type="radio"/> Children's Term Ins.: Units <input type="text"/>
c. Amount of Insurance: \$	<input type="radio"/> Scheduled Increases (if available): <input type="radio"/> Simple _____% <input type="radio"/> Compound _____%	<input type="radio"/> Other (Amount and Description):

## 7. Premiums

a. Payment Method: <input type="radio"/> Pre-Arranged Withdrawal (PAW) <input type="radio"/> Direct Bill <input type="radio"/> Other (Specify):	c. Automatic Premium Loan: <input type="radio"/> Yes <input type="radio"/> No (if available)
b. Payment Mode: <input type="radio"/> Monthly (PAW only) <input type="radio"/> Quarterly <input type="radio"/> Semiannual <input type="radio"/> Annual <input type="radio"/> Single	d. Send Premium Notices to: <input type="radio"/> Insured (Section 1.f.) <input type="radio"/> Owner (Section 2.a.) <input type="radio"/> Other (Specify):
e. Premium Source: <input type="radio"/> Salary <input type="radio"/> Investments <input type="radio"/> Savings <input type="radio"/> Gifts/Inheritance <input type="radio"/> Other (Specify):	f. Amount Remitted in Exchange for Temporary Insurance: \$

**8. Proposed Insured's Tobacco and Nicotine Use**

- a. Mark the **one** item that best describes your history of tobacco and other nicotine product use:  Never Used  Totally Stopped  Use Now  
 b. If you have "Totally Stopped," indicate number of **years** since you totally stopped and give date and reason in **REMARKS**.  
 Less than 1  1 or more/less than 2  2 or more/less than 3  3 or more/less than 5  5 or more

**9. Proposed Insured's Insurance Needs (Complete either the Personal or Business section. Explain "Yes" answers in REMARKS.)**

- a.  **Personal:**  Income Replacement  Debt Repayment  Estate Conservation  Other
1. Personal Finances: Gross Annual Income \$  Total Assets \$  Total Liabilities \$   
 2. Within the past 5 years, have you filed for bankruptcy or had any judgments or liens filed against you? .....  Yes  No
- b.  **Business:**  Buy-Sell  Key Employee  Secure Credit  Other
1. Business Finances: Total Assets \$  Total Liabilities \$  Net Worth \$   
 2. What percentage of the business do you own?  % 3. Your Gross Annual Salary (include bonus) \$   
 4. Is business insurance applied for or in force on other key members of the business? (Explain either answer in **REMARKS**.) .....  Yes  No   
 5. Within the past 5 years, has the business filed for bankruptcy or had any lien or judgments filed against it? .....  Yes  No

**10. Proposed Insured's Existing Insurance/Replacement (Explain "Yes" answers in REMARKS.)**

- a. Do you have existing life insurance or annuities? .....  Yes  No   
 b. If "Yes," to Question 10.a., will the insurance applied for in this application replace, end or change any existing life insurance or annuities? .....  Yes  No   
 (If "Yes," you may be required to review and sign additional forms.)  
 c. If "Yes," to Question 10.a., list all existing life insurance policies and annuity contracts. For additional policies/contracts, use **REMARKS**.

Full Name of Company	To Be Replaced?	Amount	Year Issued	Beneficiary(ies)
	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/>	\$		
	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/>	\$		
	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/>	\$		
	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/>	\$		

**11. Proposed Insured's History (Explain "Yes" answers in REMARKS.)**

- |  |                       |                       |
|--|-----------------------|-----------------------|
|  | Yes                   | No                    |
| a. Do you have any other application or informal inquiry for life insurance pending in any company or society? .....   | <input type="radio"/> | <input type="radio"/> |
| b. Have you ever had an application or reinstatement request for life or disability insurance refused, postponed, limited, withdrawn or cancelled, or have you been asked to pay a higher premium? .....   | <input type="radio"/> | <input type="radio"/> |
| c. Have you ever been convicted of a misdemeanor or felony? .....  | <input type="radio"/> | <input type="radio"/> |
| d. Have you ever requested or received a Worker's Compensation, Social Security or disability income payment, excluding a pregnancy-related payment? .....   | <input type="radio"/> | <input type="radio"/> |
| e. In the past 5 years, has your driver's license been suspended or revoked? .....   | <input type="radio"/> | <input type="radio"/> |
| f. In the past 5 years, have you been convicted of, or pled guilty or no contest to, reckless driving or driving under the influence of alcohol or drugs? .....  | <input type="radio"/> | <input type="radio"/> |
| g. In the past 5 years have you flown, or do you intend to fly, as a pilot, student pilot, or crew member other than for a scheduled commercial airline? (If "Yes," complete Aviation Supplement.) .....   | <input type="radio"/> | <input type="radio"/> |
| h. In the past 2 years have you engaged in, or do you intend to engage in, hang gliding, ultra-light flying, hot-air ballooning, mountain, rock, or ice climbing, motor vehicle or boat racing, or scuba or sky diving? (If "Yes," complete appropriate activities Supplement[s].) ..... | <input type="radio"/> | <input type="radio"/> |
| i. In the next 2 years, do you intend to travel or reside outside of the U.S. for more than 4 consecutive weeks other than for vacation? (If "Yes," complete Foreign Residence/Travel Supplement.) .....   | <input type="radio"/> | <input type="radio"/> |

**12. REMARKS (For explanations and special requests. Identify applicable item number and letter. If additional space is needed, use an overflow form.)**

**Authorization to Collect and Disclose Information**

**Information** Information means facts about the Proposed Insured. It includes facts about these topics: mental and physical health, including facts about communicable diseases such as HIV infection, AIDS, tuberculosis, and sexually transmitted diseases; other insurance coverage; hazardous activities; character; general reputation; mode of living; finances; vocation; and other personal traits. It does not include facts about sexual orientation. The following statements apply to Information being collected in the states named: **New Jersey** Information does not include facts about previously administered tests for HIV Antibodies, T-Cell Counts, or AIDS. **Vermont** Information does not include facts about previously administered tests for HIV Antibodies, T-Cell Counts, or AIDS. In Vermont, the Company will not forward the results of any new tests it requests to any other entity.

**Source** Medical physicians; chiropractors; physical therapists; psychologists; drug, alcohol, or mental health counselors; hospitals; clinics; drug or alcohol treatment or consultation facilities; nursing homes; mental health facilities; ambulatory care centers; facilities or offices staffed or run by care providers; insurers; reinsurers; MIB; consumer reporting agencies; financial sources; employers; the Social Security Administration; neighbors; friends; and relatives.

**Insurer** First Colony Life Insurance Company, General Electric Capital Assurance Company, and GE Life and Annuity Assurance Company

**Proposed Insured** The Proposed Insured is the person whose life is proposed to be insured.

**Authorization** The Authorization is this Authorization to Collect and Disclose Information.

**MIB** MIB is the medical information bureau known as MIB, Inc.

The following parties may need to collect Information in regard to proposed coverage: the Insurer and its reinsurers; MIB; consumer reporting agencies; and all persons authorized to represent these parties. Those parties that may need to collect Information may generally disclose Information to the following: other insurers to which the Proposed Insured has applied or may apply; reinsurers; MIB; or persons who perform business, professional, or insurance tasks for them. They may disclose Information as allowed or required by law. MIB and consumer reporting agencies may disclose Information only as set forth in an agreement with a member company or organization. Certain laws may pertain to some kinds of Information and may further restrict disclosure of that Information. The Insurer and its reinsurers will use Information to evaluate the application.

By signing this Application – Part I, the Proposed Insured or the person authorized to act on the Proposed Insured’s behalf: (1) authorizes each Source to give Information when this Authorization is presented; and (2) acknowledges receipt of the Notice to Proposed Insured and Owner. A copy of this Authorization will be as valid as the original. The Proposed Insured or the person authorized to act on the Proposed Insured’s behalf may revoke this Authorization by sending written notice to the Insurer. Failing to sign, changing, or revoking this Authorization will impair processing of the application; as a result, the application may be denied.

In all states except Rhode Island and Vermont, this Authorization will be valid for thirty (30) months after the date this Application – Part I is signed. In Rhode Island and Vermont, this Authorization will be valid for twenty-four (24) months after the date this Application – Part I is signed. The Proposed Insured or an authorized representative of the Proposed Insured may ask to receive a copy of this Authorization.

**Representations**

The application includes the Application – Parts I and II and all approved supplemental forms or amendments the Insurer specifically designates as parts of the application by attaching copies of them to any policy delivered to the Owner. No licensed insurance agent is authorized to: (a) make or modify contracts; (b) waive any Insurer rights or requirements; or (c) waive any information the Insurer requests.

I represent: (1) the statements and answers given in the application are true, complete, and correctly recorded to the best of my knowledge and belief; and (2) the insurance being applied for is suitable for the Owner’s insurance needs.

I agree that: (1) I will notify the Insurer if any statement or answer given in the application changes prior to policy delivery; and **(2) except as provided in the Temporary Insurance Application and Agreement, if any, insurance will not begin unless all persons proposed for insurance are living and insurable as set forth in the application at the time a policy is delivered to the Owner and the first modal premium is paid.**

State in which Owner Signed Application

State in which Policy will be Delivered

\_\_\_\_\_  
Signature of Proposed Insured

\_\_\_\_\_  
Date

\_\_\_\_\_  
Owner (if not Proposed Insured: Signature and any Title)

\_\_\_\_\_  
Signature of Licensed Insurance Agent

\_\_\_\_\_  
Signature of Licensed Insurance Agent

\_\_\_\_\_  
Licensed Insurance Agent’s Printed Name

\_\_\_\_\_  
Licensed Insurance Agent’s Printed Name

\_\_\_\_\_  
Social Security No.      License No.      Managing Agency/  
Brokerage No.

\_\_\_\_\_  
Social Security No.      License No.      Managing Agency/  
Brokerage No.

**1. Licensed Insurance Agent's Report (Not part of the Application)**

a. Full Name (Please print)	b. Agent's Company Code No.*	c. SSN or Tax ID No.	d. Phone and FAX Numbers Phone: FAX:
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e. 1. Does the proposed insured have any existing life insurance or annuity? .....  Yes  No

2. Is this insurance applied for intended to replace, end or change any existing insurance or annuity? .....  Yes  No

If "Yes," to either question, replacement forms may be required by state law. Include copies of any required forms with the application. If existing insurance may be replaced, ended or changed, attach a full explanation to the application and explain to the Owner and Proposed Insured that new suicide and contestable periods may apply.

f. If you accepted money with this application, a Temporary Insurance Application and Agreement (TIAA) is required. Was a TIAA given? .....  Yes  No

g. Has a medical or paramedical exam been scheduled? If "Yes," give date and Provider with whom scheduled. ....  Yes  No

Date (Mo. Day Yr.): \_\_\_\_\_ Provider's Name: \_\_\_\_\_

h. If Proposed Insured is married, amount of insurance on spouse. If spouse is not insured, give reason.

Amount: \$ \_\_\_\_\_ Reason: \_\_\_\_\_

i. If Proposed Insured is a minor, amount of insurance on parents and any siblings. If parents and siblings are not insured, give reason.

Father	Mother	Siblings (Name and Amount)
\$ _____	\$ _____	_____

I represent that to the best of my knowledge and belief: (1) the insurance being applied for is suitable for the Owner's insurance needs and financial objectives; (2) the information provided in this report and by the Owner and Proposed Insured in the application is complete, accurate, and correctly recorded; and (3) there is nothing adversely affecting the insurability of the Proposed Insured other than as indicated in the application. I also represent that I gave all required form(s) on or before the date the application was taken.

Signature(s) of Licensed Insurance Agent(s) \_\_\_\_\_ Date \_\_\_\_\_

**2. Managing Agency/Brokerage Report (Not part of the Application)**

a. Managing Agency/Brokerage Name (Please print) e-mail: _____	b. Managing Agency/Brokerage No.	c. Date
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**3. Licensed Insurance Agents to Receive Commission (Please print)**

Complete for each licensed agent to receive commission.

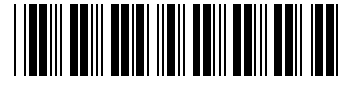
Total Commission Share(s) to equal 100%. Each licensed agent will share equally unless otherwise indicated.

a. Full Name, Address, and SSN or TIN (Please print) e-mail: _____	b. Agent's Commission Share %	c. Agent's Company Code No.*
d. Full Name, Address, and SSN or TIN (Please print) e-mail: _____	e. Agent's Commission Share %	f. Agent's Company Code No.*
g. Full Name, Address, and SSN or TIN (Please print) e-mail: _____	h. Agent's Commission Share %	i. Agent's Company Code No.*
j. Full Name, Address, and SSN or TIN (Please print) e-mail: _____	k. Agent's Commission Share %	l. Agent's Company Code No.*
m. Full Name, Address, and SSN or TIN (Please print) e-mail: _____	n. Agent's Commission Share %	o. Agent's Company Code No.*

\*The code number assigned by the Insurer selected in item 4.a. on Page 1 of the application.



# Temporary Insurance Application and Agreement (TIAA)



Affiliated Life Insurance Companies of GE Financial Assurance

First Colony Life Insurance Company (FCL) • General Electric Capital Assurance Company (GECA) • GE Life and Annuity Assurance Company (GE Life & Annuity)  
700 Main Street • Lynchburg, VA 24504

**Notice to Proposed Insured and Owner.** Payment of the Amount Remitted may only be made at the same time that both the Application - Part I and this TIAA are completed. If the Insurer does not respond to you within 90 days, notify the Insurer at the above address. **Make the Amount Remitted payable to the Insurer. Do not make it payable to the licensed insurance agent or leave the payee blank. Do not pay cash.**

## Temporary Insurance Application (Answer all Questions.)

**Insurer** The Insurer designated in Section 4.a. of the Application - Part I. Yes No

**Temporary insurance cannot begin and you should make no payment if any question below is answered "Yes" or left blank.**

1. Is the Proposed Insured less than 15 days old or more than 70 years old (age nearest birthday) on the Date of this TIAA? .....  Yes  No
2. Is the Policy applied for a joint life insurance policy? .....  Yes  No
3. Does the total amount of insurance on the Proposed Insured's life in force with the Insurer under any policies, conditional receipts, or temporary insurance agreements exceed \$1,000,000? .....  Yes  No
4. In the past 90 days, has the Proposed Insured been admitted, or medically advised to be admitted, to a hospital or other licensed health care facility, had surgery performed or recommended, or been medically advised to have any diagnostic test (excluding an AIDS-related test) that was not completed? .....  Yes  No
5. In the past 5 years, has the Proposed Insured had, been treated for, or been advised to be treated for, heart disease, stroke, cancer, or alcohol or drug dependence or abuse? .....  Yes  No
6. Has a medical physician diagnosed the Proposed Insured as having Hepatitis C or Acquired Immunodeficiency Syndrome (AIDS)? .....  Yes  No

**I represent that: (1) I have read and received a copy of this TIAA and agree to all of its terms and conditions; (2) I understand and agree that temporary insurance will not begin if any question above is answered "Yes" or left blank; (3) the answers given above are true to the best of my knowledge and belief, and I understand that, if they are false, temporary insurance may be denied or declined; (4) I understand that completing this TIAA does not guarantee that the Insurer will issue a policy on the Proposed Insured's life; and (5) I understand that the licensed insurance agent is not authorized to change or waive the terms of this TIAA.**

Signature of Proposed Insured

Date of this TIAA

Signature of Owner (if other than Proposed Insured)

## Temporary Insurance Agreement

**Agreement.** Subject to the terms of the policy applied for and this TIAA, the Insurer agrees to pay the Limited Amount to the beneficiaries listed in the Application - Part I upon receipt of due proof that the Proposed Insured died while temporary insurance was in effect. The consideration for temporary insurance is the Temporary Insurance Application and payment of an amount equal to the first modal premium for the plan applied for.

**Limited Amount.** The Limited Amount is the lesser of: (1) the Amount of Insurance applied for in the Application - Part I; and (2) \$1,000,000 minus the amount of any insurance on the Proposed Insured's life in force with the Insurer under any policies, conditional receipts, or temporary insurance agreements.

**Start Date.** Temporary insurance equal to the Limited Amount will begin on the Start Date subject to the terms of this TIAA. The Start Date is the Date of this TIAA.

**Stop Date - 90 Day Maximum.** Temporary insurance automatically ends on the Stop Date and the entire amount remitted will be returned without interest to or for the benefit of the Owner. The Stop Date is the earliest of the following: (1) the date the Owner withdraws the application; (2) 45 days after the Start Date if the Insurer has **not** received a properly completed and signed Application Part II – Medical History and all medical examinations and tests required by the Insurer as set forth in its Initial Submission Guidelines; (3) the date the Owner refuses to accept any policy issued or offered; (4) the date the Insurer sends notice to the Owner at the address shown in the Application - Part I that the Insurer has declined to issue insurance; and (5) 90 days after the Start Date.

**Policy Date.** The Policy Date of any policy issued will be the Start Date unless the policy is backdated at the Owner's request. The Amount Remitted will be applied to the first modal premium for the policy. Upon policy delivery, the policy will replace this TIAA and coverage will continue under the policy without interruption.

**Other Limitations.** The Insurer's liability will be limited to a return of the Amount Remitted if: (1) any part of the life insurance application or this TIAA contains a misrepresentation material to the Insurer; or (2) the Proposed Insured dies by suicide.

## Licensed Insurance Agent's Statement

Amount Remitted \$

Person from Whom Received

On the Date of this TIAA, I received the Amount Remitted in exchange for this TIAA. The TIAA bears the same date as the Application - Part I. I agree that I am not authorized to change or waive the terms of this TIAA and represent that I have not attempted to do so. I have read and explained the terms of this TIAA to the Proposed Insured and Owner. I have left the Copy with the Owner.

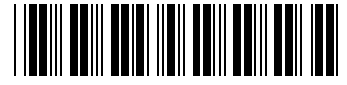
Signature(s) of Licensed Insurance Agent(s)  
Form No. GEFA-599 (TIAA)

**ORIGINAL** Return with the application and the payment.  
Licensed Insurance Agent Number(s)

4/2001  
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# Temporary Insurance Application and Agreement (TIAA)



Affiliated Life Insurance Companies of GE Financial Assurance

First Colony Life Insurance Company (FCL) • General Electric Capital Assurance Company (GECA) • GE Life and Annuity Assurance Company (GE Life & Annuity)  
700 Main Street • Lynchburg, VA 24504

**Notice to Proposed Insured and Owner.** Payment of the Amount Remitted may only be made at the same time that both the Application - Part I and this TIAA are completed. If the Insurer does not respond to you within 90 days, notify the Insurer at the above address. **Make the Amount Remitted payable to the Insurer. Do not make it payable to the licensed insurance agent or leave the payee blank. Do not pay cash.**

## Temporary Insurance Application (Answer all Questions.)

**Insurer** The Insurer designated in Section 4.a. of the Application - Part I. Yes No

**Temporary insurance cannot begin and you should make no payment if any question below is answered "Yes" or left blank.**

1. Is the Proposed Insured less than 15 days old or more than 70 years old (age nearest birthday) on the Date of this TIAA? .....  Yes  No
2. Is the Policy applied for a joint life insurance policy? .....  Yes  No
3. Does the total amount of insurance on the Proposed Insured's life in force with the Insurer under any policies, conditional receipts, or temporary insurance agreements exceed \$1,000,000? .....  Yes  No
4. In the past 90 days, has the Proposed Insured been admitted, or medically advised to be admitted, to a hospital or other licensed health care facility, had surgery performed or recommended, or been medically advised to have any diagnostic test (excluding an AIDS-related test) that was not completed? .....  Yes  No
5. In the past 5 years, has the Proposed Insured had, been treated for, or been advised to be treated for, heart disease, stroke, cancer, or alcohol or drug dependence or abuse? .....  Yes  No
6. Has a medical physician diagnosed the Proposed Insured as having Hepatitis C or Acquired Immunodeficiency Syndrome (AIDS)? .....  Yes  No

**I represent that: (1) I have read and received a copy of this TIAA and agree to all of its terms and conditions; (2) I understand and agree that temporary insurance will not begin if any question above is answered "Yes" or left blank; (3) the answers given above are true to the best of my knowledge and belief, and I understand that, if they are false, temporary insurance may be denied or declined; (4) I understand that completing this TIAA does not guarantee that the Insurer will issue a policy on the Proposed Insured's life; and (5) I understand that the licensed insurance agent is not authorized to change or waive the terms of this TIAA.**

Signature of Proposed Insured

Date of this TIAA

Signature of Owner (if other than Proposed Insured)

## Temporary Insurance Agreement

**Agreement.** Subject to the terms of the policy applied for and this TIAA, the Insurer agrees to pay the Limited Amount to the beneficiaries listed in the Application - Part I upon receipt of due proof that the Proposed Insured died while temporary insurance was in effect. The consideration for temporary insurance is the Temporary Insurance Application and payment of an amount equal to the first modal premium for the plan applied for.

**Limited Amount.** The Limited Amount is the lesser of: (1) the Amount of Insurance applied for in the Application - Part I; and (2) \$1,000,000 minus the amount of any insurance on the Proposed Insured's life in force with the Insurer under any policies, conditional receipts, or temporary insurance agreements.

**Start Date.** Temporary insurance equal to the Limited Amount will begin on the Start Date subject to the terms of this TIAA. The Start Date is the Date of this TIAA.

**Stop Date - 90 Day Maximum.** Temporary insurance automatically ends on the Stop Date and the entire amount remitted will be returned without interest to or for the benefit of the Owner. The Stop Date is the earliest of the following: (1) the date the Owner withdraws the application; (2) 45 days after the Start Date if the Insurer has **not** received a properly completed and signed Application Part II – Medical History and all medical examinations and tests required by the Insurer as set forth in its Initial Submission Guidelines; (3) the date the Owner refuses to accept any policy issued or offered; (4) the date the Insurer sends notice to the Owner at the address shown in the Application - Part I that the Insurer has declined to issue insurance; and (5) 90 days after the Start Date.

**Policy Date.** The Policy Date of any policy issued will be the Start Date unless the policy is backdated at the Owner's request. The Amount Remitted will be applied to the first modal premium for the policy. Upon policy delivery, the policy will replace this TIAA and coverage will continue under the policy without interruption.

**Other Limitations.** The Insurer's liability will be limited to a return of the Amount Remitted if: (1) any part of the life insurance application or this TIAA contains a misrepresentation material to the Insurer; or (2) the Proposed Insured dies by suicide.

## Licensed Insurance Agent's Statement

Amount Remitted \$

Person from Whom Received

On the Date of this TIAA, I received the Amount Remitted in exchange for this TIAA. The TIAA bears the same date as the Application - Part I. I agree that I am not authorized to change or waive the terms of this TIAA and represent that I have not attempted to do so. I have read and explained the terms of this TIAA to the Proposed Insured and Owner. I have left the Copy with the Owner.

Signature(s) of Licensed Insurance Agent(s)  
Form No. GEFA-599 (TIAA)

**COPY** Give to the Owner only if payment is made at the time the Application – Part I is signed.

Licensed Insurance Agent Number(s)

4/2001  
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# Pre-Arranged Withdrawals Authorization (PAW)



Affiliated Life Insurance Companies of GE Financial Assurance

First Colony Life Insurance Company (FCL) • General Electric Capital Assurance Company (GECA) • GE Life and Annuity Assurance Company (GE Life & Annuity)

700 Main Street • Lynchburg, VA 24504

**1. Instructions: Please complete this form and attach a void check or deposit slip from your account.**

Insurer (Select only one):

- FCL
- GECA
- GE Life & Annuity

Proposed Insured

**2. Account Information**

a. Name of Account Holder (as shown on Account)

b. Account Identification Number

c. Kind of Account

d. Name of Financial Institution

**3. Premium Payment Frequency: Please indicate premium payment frequency by checking the appropriate box.**

- Monthly
- Quarterly
- Semi-annually
- Annually

**Non-annual payment frequencies include an additional cost; therefore, your yearly premium cost will be higher if you choose to pay more frequently than annually.**

I authorize the Insurer to initiate withdrawals against the account identified in item 2. above. I understand and agree that this Authorization is subject to the following conditions:

- (1) It will be effective only after the first premium (first two premiums if premium payment frequency chosen is Monthly) has been paid by check or money order.
- (2) If any withdrawal request is not paid upon presentation, the Insurer may terminate this premium payment method and bill directly for premium payments. Please be aware that if any premium due remains unpaid, the policy will terminate subject to its terms.
- (3) The payment of premiums under this plan may be discontinued by the Insurer or the undersigned upon thirty (30) days written notice to the other.

Authorized Signature of Premium Payor

Date

**Remember to attach a void check or deposit slip to your completed form.**



# Notice to Proposed Insured and Owner

Affiliated Life Insurance Companies of GE Financial Assurance

**First Colony Life Insurance Company (FCL) • General Electric Capital Assurance Company (GECA) • GE Life and Annuity Assurance Company (GE Life & Annuity)**

700 Main Street • Lynchburg, VA 24504

Thank you for your application. We greatly appreciate your completing each part truthfully and accurately. This Notice tells you what to expect after completing the Application – Part I and provides other important information, including information required by state law and regulation. If you have any questions, please ask the soliciting licensed insurance agent (licensed agent). The licensed agent should gather information about your personal situation, insurable needs, and financial objectives and explain how the insurance recommendations are appropriate to fulfill those needs and objectives. When deciding insurance needs, consider the following: the losses you want to protect against; the kind of insurance; how long you will need the coverage; your future liquidity needs, e.g., college funding; your ability to pay the planned premium; taxes; and your other financial assets, e.g., Social Security, pension plans.

## What Happens Next

### Underwriting

Once we receive your application, we will begin an evaluation process called underwriting to determine whether you are eligible for insurance and, if so, the rate you should pay for that insurance. We may seek information from other sources to help us in our evaluation. During underwriting we may find that we are unable to give you the insurance you have applied for or that we are able to give it to you only on a modified basis or at a rate greater than our lowest rate. For example, if you have ever used any kind of tobacco or other nicotine product, you may not be eligible for our lowest rate.

### Physical Exam

Virtually all Proposed Insureds are required to take a physical exam. The exam is done by a qualified examiner and takes approximately 30 minutes. During the exam, you should expect the following: to provide your medical history; to be weighed and measured; to have an EKG (not always required); to provide a blood or saliva sample and a urine sample; to have your blood pressure and pulse taken.

Here are some of the ways you can help with the exam process:

- Schedule your exam within 24 hours after you complete the Application – Part I
- Have a list of the names and addresses of all licensed health care providers and facilities seen during the past 20 years and be prepared to provide reasons, dates and any treatments received as a result of those visits
- Do not eat or drink (except water) for 12 hours prior to your scheduled exam time
- Have a photo ID ready, e.g., driver's license, passport, or green card

## Other Important Information

### Contestability

Because your application will be our primary source of information, we strongly urge you to review the completed application closely for accuracy. You must inform us of a change to any answer in any part of your application before accepting delivery of a policy; in fact, you agree to do so when you sign your application. A claim may be denied or your coverage may be contested by a lawsuit if the application is incomplete or if it contains false statements or misrepresentations. If the lawsuit is successful, the policy will be void and coverage will be lost. Any policy that is delivered to you will indicate when and under what circumstances it may be contested. In addition, you may be violating state law if you knowingly conceal material facts or submit an application that contains materially false information.

### Replacement of Existing Coverage

If you have existing coverage, answer "yes" to this question in the application. If you intend to replace existing coverage, tell the licensed agent of your intention and answer "yes" to the replacement question in the application. State law may require the licensed agent to give you information that will help you compare the policy you are applying for with the policy you intend to replace. If you are undecided about keeping existing coverage, answer the replacement question "yes." Doing so may help you get the information you need to make a decision. If you do replace existing coverage, the new policy may contain new suicide and contestable periods. Stopping premium payments, surrendering, or borrowing from an existing policy as a result of applying for this policy could be considered replacement. State law may define replacement to include other situations. Ask the licensed agent if you are unsure about replacement.

### Insurance Information Practices

We will rely primarily on information provided by you. We may supplement that information with information from other sources such as medical professionals who have treated you. In some cases, we may ask a consumer reporting agency to collect information and submit an investigative consumer report to us as explained in this Notice under **Federal Fair Credit Reporting Act**. You may request to be interviewed in connection with the preparation of this report.

In certain limited situations, we are allowed by law to disclose necessary items of personal information to third parties without your specific authorization. You have the right to be told about, and to see and copy if you wish, items of personal information about you that appear in our files, including information contained in investigative consumer reports. You also have the right to seek correction of information you believe to be inaccurate.

We will send you a more detailed explanation of our information practices if you send us a written request. You may send your request to P.O. Box 461, Lynchburg, Virginia 24505-0461.

### Premium Payments on Term and Excess Interest Whole Life

For premiums not paid on an annual basis at the beginning of a policy year, we adjust the annual premium by a modal factor to compensate for the lost investment earnings, additional administrative costs, and expected early lapses. These modal factors and associated APRs are available and will be provided. Ask the licensed agent for this information.

## **Federal Fair Credit Reporting Act**

As part of our underwriting, we may ask that an investigative consumer report be prepared. An independent source known as a consumer reporting agency will prepare the report. The report will typically include information as to your character, general reputation, mode of living and personal characteristics. ("Mode of living" does not include information related directly or indirectly to your sexual orientation.) The agency will conduct personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted in order to get this information. If you write to us within a reasonable time after you receive this Notice, we will tell you whether or not a report was requested. If a report was requested, we will tell you the name, address and telephone number of the agency to whom the request was made. Upon request, the agency will furnish information as to the nature and scope of its investigation. If you would like to inspect and to receive a copy of the report, you may do so by contacting the agency directly.

## **MIB (Medical Information Bureau) Disclosure**

We will treat the information regarding your insurability as confidential. We and our reinsurers may, however, make a brief report to the MIB, Inc. MIB, Inc. is a non-profit membership organization of life insurance companies. It operates an information exchange bureau on behalf of its members. If you apply to another member company for life, health, or disability insurance, or a claim for benefits is submitted to such a company, MIB, Inc., upon request, will supply that company with any information it may have in its file.

Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in that file, you may contact MIB, Inc. and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. To contact MIB, Inc., you may: write P.O. Box 105, Essex Station, Boston, MA 02112; phone (617) 426-3660; or use the website <http://www.mib.com>.

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

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## **FRAUD WARNINGS**

### **ARKANSAS and LOUISIANA**

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information on an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

### **COLORADO**

**It is unlawful to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or insurance agent who knowingly provides false, incomplete, or misleading information for the purpose of defrauding or attempting to defraud a policy holder or claimant with regard to an insurance settlement shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.**

### **DISTRICT OF COLUMBIA**

It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

### **FLORIDA**

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

### **KENTUCKY**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

### **MAINE**

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

### **NEW JERSEY**

Any person who includes any false or misleading information on an application for an insurance policy, is subject to criminal and civil penalties.

### **NEW MEXICO**

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information on an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

### **OHIO**

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

### **PENNSYLVANIA**

Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.