

Policy Change Application

INSURER

OM Financial Life Insurance Company

GENERAL INSTRUCTIONS

SUBMIT ONE FORM for each policy to be converted or changed. If converting a Joint Life policy, complete separate forms for each Insured. Also, separate forms must be filled out if more than one Other Insured's rider is added. We may require the policy be returned to our Home Office with the application. State policy number, name of Insured or Annuitant and Owner's Social Security Number.

OWNERSHIP AND BENEFICIARY designations will remain unchanged unless the appropriate change forms are submitted.

COST OF CHANGE. Except for term conversions, no policy change will be processed until the cost of change, if any, is received by the Home Office. No exception to this rule will be made for any reason.

CONVERSION OF ALL OR PART OF TERM POLICY OR TERM RIDER TO A NEW POLICY. Complete appropriate parts of Sections I, II and III. If a rider is added, complete Section IV.

ADDITION OR DELETION OF A RIDER. Complete appropriate parts of Section II. Also, complete Sections III and IV if a Rider is added.

REMOVAL OR REDUCTION OF EXTRA PREMIUM. Complete appropriate parts of Sections II and IV.

CHANGE TO A LOWER OR HIGHER PREMIUM PLAN. Complete appropriate parts of Sections II, III and IV.

***IF ITEMS HAVE A SINGLE ASTERISK NEXT TO THEM,** fill out Section IV, Evidence of Insurability.

SUBMITTED BY

Agency Name or Solicitor _____

Code Number _____

Address _____

Note: If any commission or product credit is applicable, it should be given:

- As shown above;
- To the original agency or soliciting agent.

Policy Change Application

Part 1

Policy Number

Insured's or Annuitant's Name
 First Name _____ Middle Initial _____ Last Name _____

Owner's Social Security No. _____
 Tax I.D. No. _____

SECTION I – TERM INSURANCE CONVERSIONS

1. Conversion of:
 Policy _____ (Name of Plan)
 Rider _____ (Name of Plan)
 To Be Converted To: (Name of Permanent Plan of Insurance) _____

2. Amount Being Converted \$ _____
 Increase Conversion By \$ _____ *
 Total Amount \$ _____
 The Balance, if any, of \$ _____ should:
 Continue as of original policy's date;
 Continue as of new policy's date;
 Lapse

SECTION II – PROVISIONS OF NEW POLICY OR CHANGE IN EXISTING POLICY

A. Universal Life Plans
 1. Plan _____
 2. Policy Date _____
 3. Specified Amount _____
 4. Maturity Age _____
 5. Death Benefit Option A B*
 6. Planned Premium _____

B. Universal Life Plans
 1. Plan _____
 2. Policy Date _____
 3. Face Amount _____
 4. If Participating Plan, Dividend Option:
 Cash Paid-Up Additions
 Reduce Premiums Accumulate at Interest*
 One Year Term Insurance Additions* -- not to exceed cash value, balance to:
 Accumulate at Interest Reduce Premiums
 Buy Paid-Up Additions N / A

C. Mode of Premium Payment:
 Annual Semi-Annual Quarterly
 Monthly Monthly Bank Draft [EFT Authorization]
 Payroll Deduction Government Allotment

D. Smoked cigarettes in the past 12 months? Yes No

E. Total premium enclosed \$ _____

F. Change in Benefit or Premium	Add*	Increase*	Decrease	Remove	**Fill in amount if less than policy's
1. Waiver rider	<input type="checkbox"/>			<input type="checkbox"/>	
2. Accidental Death Benefit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____ **
3. Guaranteed Insurability Rider	<input type="checkbox"/>			<input type="checkbox"/>	\$ _____ **
4. Spouse's Rider	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Units _____
5. Child's Rider	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Units _____
6. Disability Income Rider		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Units _____
7. Decreasing Term Rider			<input type="checkbox"/>	<input type="checkbox"/>	\$ _____ Years _____
8. Level Term Rider	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	\$ _____ Years _____
9. Payor Benefit	<input type="checkbox"/>			<input type="checkbox"/>	
10. Extra Premium			<input type="checkbox"/> *	<input type="checkbox"/> *	
11. Other Insured's Rider	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____ Social Security No. _____
Beneficiary: Primary: _____ Relationship: _____ Contingent: _____ Relationship: _____					
12. Other (Specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

G. Will the insurance applied for replace any existing insurance or annuities? Yes No
 (If "Yes," give full details including name of company, plan and amount, date issued and reasons for replacement.)

(We) have read the above questions and answers. To the best of my (our) knowledge and belief, the statements made are: complete, true and correctly recorded. I (We) agree that: the application on which the original policy was issued together with this application, including any medical examination form shall be attached to and form a part of the changed policy; the Company will be liable on the changed policy after the approval of the application at its Home Office but not before payment of the amount required for the policy change; and that no agent can pass on insurability or modify any policy issued by the Company. I (We) also agree that any outstanding assignments of the original policy are to continue in effect as assignments of the changed policy.

Policy Change Application (Continued)

Part 1

Policy Number

Signed at _____
City and State

Date _____

Witness to all Signatures _____
(Licensed Resident Agent, When Required)

Signature of Insured(s), Annuitant, or Proposed Insured(s) age 15 or older

Signature of Spouse if to be Insured or Other Insured

Signature of Owner(s) if Other than Insured(s)

Signature of Any Irrevocable Beneficiary or Assignee

Policy Change Application (Continued)

Part 2

Policy Number

SECTION III – PERSON(S) PROPOSED FOR INSURANCE

First Name	Middle Initial	Last Name	Relationship to Insured	Birthdate	Birthplace (State)	Age Last Birthday	Sex	Hgt.	Wt.	Occupation	Social Security No.

SECTION IV – EVIDENCE OF INSURABILITY

	Insured		Other		Name of
	Yes	No	Yes	No	Other Person
A. Has any person named in Section III:					
1. Been declined, postponed or offered a rated or modified life or health policy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2. Been denied to reinstate or renew a life or health policy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3. Within the past 10 years had, or been told they had, or had any known symptoms of, or been treated by a member of the medical profession for:					
a. Any disorder or disease of the:					
• Blood or circulatory system, such as heart disease; rheumatic fever; heart murmur; chest pain; high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
• Respiratory system, such as: tuberculosis; asthma; bronchitis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
• Brain or nervous system, such as: convulsions; epilepsy; fainting spells; mental illness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
• Urinary tract, such as kidney or bladder; or of the reproductive system?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
• Stomach, intestines, liver or gall bladder, such as: ulcer; colitis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
• Endocrine system, such as: diabetes; thyroid?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
• Muscles or bones (including the spine, back or joints), such as: arthritis, gout?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
• Immune system, such as: Acquired Immune Deficiency Syndrome (AIDS); AIDS Related Complex (ARC); exposure to the AIDS virus?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
b. Cancer or tumor?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
c. Use of barbiturates, narcotics, excitants or hallucinogens except as medication prescribed by a physician?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4. Within the past 5 years:					
a. Been in a hospital, clinic, sanatorium, or other medical facility for operation, observation or treatment; or been advised to and not done so?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
b. Been treated or counseled for tobacco or alcohol use?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
c. Had or now have any mental or physical disorder or disease not listed above?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Policy Change Application (Continued)

Policy Number

SECTION IV – EVIDENCE OF INSURABILITY (CONT'D)

	Insured		Other		Name of Other Person
	Yes	No	Yes	No	
d. Made a claim for or received benefits, disability compensation, or a pension because of sickness or injury?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
e. Had electrocardiogram, X-ray or other diagnostic tests; or been advised to and not done so?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
5. Within the past 2 years:					_____
a. Been convicted for motor vehicle moving violations or had their driver's license suspended or revoked?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
b. Taken part in any type of racing, or in mountain climbing, sky diving, skin or scuba diving, hang gliding, balloon ascension, or as a rodeo performer or plan to?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
c. Flown other than as passenger, or plan to? If "Yes" complete Aviation Supplement.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
d. Within the past 12 months, smoked cigarettes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

B. Give details of "Yes" answers. State question number, person's name, and include where appropriate: diagnoses; dates; durations; names and addresses of all attending physicians and medical facilities.

B. Additional Directions and Remarks.

I (We) have read the questions and answers in Sections III and IV of the applications. To the best of my (our) knowledge and belief, the statements made in this application are: complete; true; and correctly recorded.

I (We) agree that: copies of this entire application will form a part of any policy issued; and that no agent can pass on insurability or modify any policy issued by the Company. I (We) acknowledge that I (We) have received, read and understand the notices required by: the Medical Information Bureau, Inc.; and the Federal Fair Credit Reporting Act regarding investigative consumer reports.

Signed at: _____
City and State *Signature of Insured(s), Annuitant or Proposed Insured(s) age 15 or older*

Date: _____
Signature of Spouse if to be Insured or Other Insured

Witness to All Signatures: _____
Licensed Resident Agent *Signature of Owner(s) if other than Insured(s)*

Agency Code No.: _____ LSM No.: _____

AUTHORIZATION

In order to evaluate my (our) application for life insurance, I (we) authorize any licensed physician, medical practitioner, hospital, clinic, the Veteran's Administration or other medical or medically related facility, the Medical Information Bureau, Inc., insurance companies, a consumer reporting agency and my employer (our employers) to give to OM Financial Life Insurance Company and its reinsurers, medical and other information which is pertinent to the evaluation regarding me or of any member of my family who is also applying for life insurance.

I (We) understand such information may concern my (our): physical history, condition and treatment, including drug and alcohol abuse or mental health information protected by Federal law; general character, habits, reputation, mode of living, financial status, income, occupation, avocations, sports, hobbies and aviation activities. A brief report regarding me (us) or of any member of my family who is also applying for life insurance may be made only to other life insurance companies to which I (we) have applied for may apply, or to the Medical Information Bureau, Inc. by OM Financial Life Insurance Company or its reinsurers.

I (We) also authorize OM Financial Life Insurance Company to obtain an investigative consumer report on me or of any member of my family who is also applying for life insurance. I (We) understand that I am (we are) entitled to be interviewed by any consumer reporting agency which may be requested to prepare such a report as long as I (we) can reasonably be contacted during normal business hours. CHECK IF INTERVIEW REQUESTED

I (We) also understand that: this Authorization will be as valid from the date signed for a period of 2½ years; a photographic copy of this Authorization will be as valid as the original; I am (we are) entitled to receive a copy of this Authorization.

_____, 20____ Business Hours Telephone:
(AC _____)
*(Signature of Annuitant or Insured age 18 or more;
otherwise Parent or Legal Guardian of Annuitant or Insured)*

(Name of Minor Child) *(Signature of Spouse if to be insured or Other Insured)* (AC _____)

CONDITIONAL RECEIPT

OM FINANCIAL LIFE INSURANCE COMPANY – Baltimore, Maryland

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE COMPANY. DO NOT MAKE CHECK PAYABLE TO AGENT OR LEAVE PAYEE BLANK.

Received from _____ the sum of \$_____ paid with a life insurance application to the Company for a _____ policy. The application bears the same date as this Receipt.

The Insured is _____

If a partial first premium is paid, any insurance which may go into effect will be in force only for such fraction of one year as the partial premium bears to the total annual premium for the proposed insurance. If the above sum is paid by check or draft which is uncollectible, this Receipt is void.

No agent or broker is authorized to: alter the terms of this Receipt; waive any requirements; pass on insurability; or modify any policy. Payment is received subject to the above and the terms on the reverse side of this Receipt.

Dated at _____ on _____, 20____
(City and State) *(Date)* *(Agent's Signature)*

THIS RECEIPT DOES NOT CREATE TEMPORARY OR INTERIM INSURANCE.

If you do not receive the policy or a refund of payment within two months, contact the Company.

INVESTIGATIVE CONSUMER REPORT PRE-NOTIFICATION TO PROPOSED INSURANCE AND OTHER PERSONS PROPOSED TO BE INSURED, IF ANY

We may ask for an investigative consumer report in connection with your application. In addition, a report may be requested to update our records if you apply for more coverage. You may ask to be interviewed when such a report is being prepared. We will, upon your written request, let you know whether a report was requested and, if so, give you the name, address and telephone number of the agency making the report. By contacting that agency and giving proper identification, you may inspect or obtain a copy of the report.

Typically, the report will contain information as to character, general reputation, personal characteristics, health, job and finances. When applicable, it will contain information of your: past and present employment record (including job duties); driving record; health history; use of alcohol or drugs; sport, hobby or aviation activities; marital status. The agency may get information by talking to you or members of your family, business associates, financial sources, neighbors and others you know.

CONDITIONAL RECEIPT AGREEMENT

Insurance under the terms of this policy will take effect only if the following conditions are met:

- Each person proposed to be insured is found to be insurable exactly as applied for in accordance with the Company's underwriting rules;
- The minimum premium payment is made.

The effective date will be the latest of the following:

- The dates of signature for any: Policy change application; Non-medical application; Supplemental application; Medical examination;
- Any date which may be requested in Application Part I if it is acceptable to the Company;
- The date that any test(s) and/or medical examination(s) required by the Company are performed;
- The date shown on this Receipt which is the date the required first premium is made to the Agent;
- The date any additional information required by us is received by the Home Office.

The maximum amount of insurance which may become effective under this Receipt on each Proposed Insured will be the lesser of the amount applied for or \$400,000 of life insurance, and \$100,000 of accidental death benefit, if applied for, less all other sums payable or which become payable by the Company due to the death of such person, excluding group and accident and health coverage.

If one or more of the Receipt's conditions have not been met, we will be free from any liability except to return the premium payment.

MEDICAL INFORMATION BUREAU, INC. (MIB) PRE-NOTIFICATION TO PROPOSED INSURED AND OTHER PERSONS PROPOSED TO BE INSURED, IF ANY

Information regarding your insurability will be treated as confidential. We or our reinsurer(s) may, however, make a brief report thereon to the Medical Information Bureau, Inc., a non-profit membership organization of life insurance companies which operates as information exchange on behalf of its members. 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. 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 Post Office Box 105/Essex Station; Boston, Massachusetts 02112; telephone number (617) 426-3660. We or our reinsurer(s) may also release information in our file to other insurance companies to which you may apply for life or health insurance coverage or to which a claim may be submitted.