



TRIAL APPLICATION

Purpose:

The purpose of this document is to establish a written record of guidelines for the use of Trial Life Insurance Applications. As all insurance carriers have minimum guidelines on cases they will consider on a trial basis, it is important to follow these guidelines in order to manage yours and your client's expectations.

Medical Record Fees:

If you take an AdvisorNet Insurance Trial Application without then taking a carrier specific formal application, you will be billed for costs incurred by AdvisorNet Insurance for obtaining medical records.

Minimum Face and Premium Amount Guidelines:

- Permanent Insurance of at least \$500,000 of death benefit AND \$10,000 of target premium.
- Term Insurance of at least \$2,000,000 of death benefit AND \$10,000 of annual premium.

If Client is Healthy and Case Meets Minimum Guidelines:

| Step | Action |
|------|---|
| 1. | You determined, through field underwriting, your client is healthy and has no major health concerns. Feel free to consult with your case manager for underwriting guidance. |
| 2. | Have AdvisorNet Insurance run illustrations with several carriers to determine best rates at standard or preferred assumptions. |
| 3. | Take a FORMAL application with the carrier of choice as well as a TRIAL AdvisorNet Insurance application. This will expedite the process and allow you to pivot to a new carrier if you receive an adverse offer. |
| 4. | The formal application will be processed with the carrier of choice. The informal application will be held in case of an adverse offer. |

If Client Has Significant Health Impairments and Case Meets Minimum Guidelines:

| Step | Action |
|------|--|
| 1. | You determined, through field underwriting, your client has significant health issues that will likely result in a rated case. |
| 2. | Consult with your case manager as to the client's insurability and ball park rating. |
| 3. | Take a FORMAL application with the carrier of choice as well as a TRIAL AdvisorNet Insurance application. |
| 4. | Both the formal and informal applications will be processed simultaneously for multiple tentative offers. |

If Client Has Significant Health Impairments and Does Not Meets Minimum Guidelines:

| Step | Action |
|------|--|
| 1. | You determined, through field underwriting, your client has significant health issues that will likely result in a rated case. |
| 2. | Share DETAILED information with your case manager. The field underwriting information will be used to determine a potential ballpark offer based on the provided information. This will NOT be a tentative offer. The TRIAL application may be used as a fact finder for health information but will not be used to order medical records until a formal application is submitted. |
| 3. | Have AdvisorNet Insurance run illustrations with several carriers using the potential ballpark offer. |
| 4. | Take a FORMAL application with the carrier of choice as well as a TRIAL AdvisorNet Insurance application. |
| 5. | The formal application will be processed with the carrier of choice. The informal application will be held in case of an adverse offer. |

IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT YOUR CASE MANAGER:

Alison LaBelle **Jenny Turberville** **Claudia Miller Stack**
 alabelle@advisornetinsurance.com jturberville@advisornetinsurance.com cstack@advisornetinsurance.com
 612.347.7802 612.347.7803 612.347.8612

CONFIDENTIAL TRIAL APPLICATION

| | | | |
|--|------------------------------|--|--|
| RETURN TO: ADVISORNET INSURANCE 1221 NICOLLET MALL, SUITE 400 MINNEAPOLIS, MN 55403 Toll Free: (877) 285-5799 | | AGENT NAME: | |
| FULL NAME | | ADDRESS: | PHONE: |
| RESIDENT ADDRESS (STREET & NUMBER) | | PLACE OF BIRTH (STREET & NUMBER) | |
| CITY, STATE & ZIP | HOW LONG? | OCCUPATION | |
| AMOUNT OF INSURANCE | COVERAGE (TERM, UL, VUL, WL) | BENEFICIARY (NAME & RELATIONSHIP) | |
| HEIGHT | WEIGHT | YOUR MOTHER'S AGE (IF DECEASED, AGE AT DEATH): <input type="checkbox"/> LIVING <input type="checkbox"/> DECEASED—CAUSE? | YOUR FATHER'S AGE (IF DECEASED, AGE AT DEATH): <input type="checkbox"/> LIVING <input type="checkbox"/> DECEASED—CAUSE? |

MEDICAL BACKGROUND AND HISTORY

| | |
|---|--|
| NAME & ADDRESS OF YOUR PERSONAL PHYSICIAN | DATE AND REASON LAST CONSULTED |
| CITY, STATE & ZIP | WHAT ADVICE OR TREATMENT WAS PRESCRIBED? |

| A. Have you ever been treated for or had any: | YES | NO |
|--|--------------------------|--------------------------|
| 1. Disorders of the eyes, ears, nose or throat? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Dizziness, fainting, convulsions, headache, speech defect, paralysis or stroke, mental or nervous disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Shortness of breath, persistent hoarseness or cough, blood spitting, asthma, emphysema, tuberculosis, or chronic respiratory disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Chest pain, palpitations, high blood pressure, heart murmur, heart attack, or other disorder of the heart or blood vessels? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Jaundice, intestinal bleeding, ulcer, hernia, hepatitis, colitis, diverticulitis, recurrent indigestion, or other disorder of the stomach, intestine, liver or gall bladder? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Sugar, albumin, blood or pus in urine, venereal disease, nephritis, stone, or other disorder of the kidney, bladder, prostate or reproductive organs? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Diabetes, thyroid, or other endocrine disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Neuritis, sciatica, rheumatism, arthritis, gout, or disorder of the muscles or bones? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Deformity, lameness, or amputation? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Disorder of skin, lymph glands, cyst, tumor or cancer? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Allergies, anemia or other disorder of the blood? | <input type="checkbox"/> | <input type="checkbox"/> |
| B. In the past 10 years have you: | | |
| 1. Been told you have tested positive for antibodies of, received treatment or advice for acquired immune deficiency syndrome, AIDS related complex, or AIDS related conditions? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Used barbiturates, amphetamines, hallucinogenic drugs (including marijuana), narcotics, or any prescription drug except as prescribed by a physician? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Ever received counseling, advice or treatment regarding the use of alcohol or drugs? (See questionnaire on Page 2) | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Are you now under observation by a physician for any disorder, or taking treatment for any disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Have you smoked cigarettes in the past 12 months? | <input type="checkbox"/> | <input type="checkbox"/> |
| E. Do you use any other nicotine products? | <input type="checkbox"/> | <input type="checkbox"/> |
| F. Have you had life or health insurance declined, modified, rated, or its renewal refused? | <input type="checkbox"/> | <input type="checkbox"/> |

Please furnish complete details of any "YES" answers: _____

Please complete all applicable questions on both pages and have the proposed insured sign the Authorization.

CONFIDENTIAL TRIAL APPLICATION

Consideration requires completion of both pages including signature of the proposed insured

| SUPPLEMENTAL IMPAIRMENT QUESTIONS | | | | | | | | | | | | | | | | | | | | |
|---|--------------------------|---|--|--|--|--|-----|----|--|--------------------------|--------------------------|--|--------------------------|--------------------------|--|--------------------------|--------------------------|---|--------------------------|--------------------------|
| FULL NAME | | DATE OF FIRST DIAGNOSIS OF: CHEST PAIN? DIABETES? CANCER? | | | | | | | | | | | | | | | | | | |
| NAME AND ADDRESS OF SPECIALIST FIRST CONSULTED | | CITY, STATE & ZIP | | | | | | | | | | | | | | | | | | |
| CORONARY QUESTIONS | | DIABETES QUESTIONS | | CANCER QUESTIONS | | | | | | | | | | | | | | | | |
| Have you ever had or been treated for: Chest pain? (Angina pectoris) <input type="checkbox"/> <input type="checkbox"/> Heart attack? (Infarction) <input type="checkbox"/> <input type="checkbox"/> How often do you get heart symptoms (pressure, pain or discomfort)? Number times/month? _____ Number times/year? _____ Date of MOST RECENT treadmill (stress) EKG? _____ Have you had or ever been advised to have: Cardiac catheterization? <input type="checkbox"/> <input type="checkbox"/> Coronary angioplasty? <input type="checkbox"/> <input type="checkbox"/> Coronary bypass surgery? <input type="checkbox"/> <input type="checkbox"/> How long were you out of work due to any of the above? _____ Date of last: Blood pressure check? _____ Results: _____ Cholesterol check? _____ Results: _____ Is there family history of stroke, diabetes or heart disease? <input type="checkbox"/> <input type="checkbox"/> | | What treatment do you use for your diabetes? Diet only? <input type="checkbox"/> <input type="checkbox"/> Oral tablets? <input type="checkbox"/> <input type="checkbox"/> Insulin injection? <input type="checkbox"/> <input type="checkbox"/> Type: _____ Daily Dose: _____ What type of self-testing do you do? Blood? <input type="checkbox"/> <input type="checkbox"/> Urine? <input type="checkbox"/> <input type="checkbox"/> Results: Usually negative? <input type="checkbox"/> <input type="checkbox"/> Usually a trace? <input type="checkbox"/> <input type="checkbox"/> Usually more than a trace? <input type="checkbox"/> <input type="checkbox"/> Frequency: _____ Last result: _____ Avg.: _____ Last Hemoglobin A1C test readings: Date: _____ Result: _____ Have you ever been treated for: Insulin reactions <input type="checkbox"/> <input type="checkbox"/> Diabetic coma? <input type="checkbox"/> <input type="checkbox"/> Eye trouble? <input type="checkbox"/> <input type="checkbox"/> High blood pressure? <input type="checkbox"/> <input type="checkbox"/> Kidney trouble (Albumin)? <input type="checkbox"/> <input type="checkbox"/> Neuritis or neuralgia? <input type="checkbox"/> <input type="checkbox"/> Arteriosclerosis? <input type="checkbox"/> <input type="checkbox"/> Liver disorders? <input type="checkbox"/> <input type="checkbox"/> Skin problems/infections? <input type="checkbox"/> <input type="checkbox"/> Has weight changed in the last year? <input type="checkbox"/> <input type="checkbox"/> Weight one year ago _____ | | Type of cancer? (give the full medical name, if known) _____ _____ _____ Stage, Level, or Grade? _____ Location of cancer? _____ _____ Type of treatment given? _____ _____ Date treatment started: _____ Most recent treatment: _____ Date of last follow-up _____ <h3 style="text-align: center;">ALCOHOL & DRUG QUESTIONS</h3> <table style="width: 100%; border: none;"> <thead> <tr> <th style="width: 80%;"></th> <th style="text-align: center;">YES</th> <th style="text-align: center;">NO</th> </tr> </thead> <tbody> <tr> <td>Do you use alcohol or drugs at the present time?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Are you involved in AA, NA or any other support group?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Ever been arrested or convicted for any alcohol or drug violation?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Have you ever received treatment or counseling?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </tbody> </table> | | | YES | NO | Do you use alcohol or drugs at the present time? | <input type="checkbox"/> | <input type="checkbox"/> | Are you involved in AA, NA or any other support group? | <input type="checkbox"/> | <input type="checkbox"/> | Ever been arrested or convicted for any alcohol or drug violation? | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever received treatment or counseling? | <input type="checkbox"/> | <input type="checkbox"/> |
| | YES | NO | | | | | | | | | | | | | | | | | | |
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| Ever been arrested or convicted for any alcohol or drug violation? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | |
| Have you ever received treatment or counseling? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | |
| Please furnish complete details of any "YES" answers: _____ | | | | | | | | | | | | | | | | | | | | |
| _____ | | | | | | | | | | | | | | | | | | | | |
| _____ | | | | | | | | | | | | | | | | | | | | |
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| _____ | | | | | | | | | | | | | | | | | | | | |
| _____ | | | | | | | | | | | | | | | | | | | | |

AVIATION QUESTIONNAIRE

1. As a pilot or student pilot indicate:
 - a) The number of hours flown in command: _____
 - b) Date of last flight: _____
 - c) Type of license currently held: Student Private Commercial Senior ATR
 - d) Do you hold a valid instrument rating? Yes No
2. Number of hours flown in the last 12 months: _____ HOURS
AND last 12-24 months: _____ HOURS
3. Number of flying hours contemplated in the next 12 months: _____ HOURS
4. Purpose of present and future flying: Pleasure Commercial Military Personal Business Other
If other, please specify: _____
5. Indicate category, class, and type of aircraft flown: _____
6. Do you engage or expect to engage in Student Instruction, Charter Flying, Freight Carrying, Sight Seeing, Photography, Crop Dusting, Prospecting, Test or Inspection Flying? Yes No Which?

7. If aviation requires an extra premium or exclusion rider, which would you prefer? Extra Premium Exclusion Rider

SCUBA DIVING QUESTIONNAIRE

1. Do you dive for pleasure? Yes No OR commercial purposes? Yes No
If yes, details: _____
2. Do you engage in: Ice Diving? Cave or Night Diving? Search/Rescue Work? Salvage?
3. What are the locations of you diving activities? Lakes Rivers Pools Ocean Deep Sea Other
If other, please clarify: _____

4. Diving History:

| | Last 12 Months | | Next 12 Months | |
|-----------------|----------------|--------------|----------------|--------------|
| | # of Dives | Average Time | # of Dives | Average Time |
| < 50 Feet | | | | |
| 50 - 75 Feet | | | | |
| 76 - 100 Feet | | | | |
| 101 - 150 Feet | | | | |
| 151 Feet & Over | | | | |

5. Do you dive alone? Yes No If yes, how often? _____
6. Are you a certified diver? Yes No A member of an organized club? Yes No
If yes, give details: _____

RACING QUESTIONNAIRE

1. Type of Racing: Automobile Motorcycle Snowmobile Boat
 Make and Model of vehicle used in races: _____

2. How many races did you enter in the past 12 months? _____ 12-24 Months? _____
 Contemplate entering in the next 12 months? _____

3. What is the maximum speed attained? _____ Average Speed? _____

4. What types of racing or competition do you engage in? _____
(EXAMPLE: Automobile – Midge, Sports Car, Stock Car, Championship, Drag, Sprint, Etc. Motorcycle – Hill Climbing, Cross Country, Drag, Track, Etc.)

5. Class _____ IMSA SCCA

6. Purpose of Racing: Professional Amateur Both (DETAILS) _____

FOREIGN TRAVEL & RESIDENCE QUESTIONNAIRE

1. Country of Birth: _____

2. Date of Entry to USA: _____

3. Country of Citizenship (IF US CITIZEN SKIP TO #5): _____

4. a) Visa Type: _____ b) Symbol: _____
 c) Number: _____ d) Expiration Date: _____

5. a) Have you traveled or resided outside of the US in the past 24 months? Yes No
 b) Do you plan to in the next 12 months? Yes No

DETAILS:

| | DESTINATION | DATES | DURATION OF STAY |
|----------------|-------------|-------|------------------|
| 12-24 Months | | | |
| | | | |
| Past 12 Months | | | |
| | | | |
| Next 12 Months | | | |
| | | | |
| | | | |

6. What kind of accommodations do you stay in while outside of the USA?
 Hotel Hostel Privately Owned Home Family RV Park Camping Other
 If other, please explain: _____

7. What mode of transportation do you use while outside of the USA?
 Own Car Rent Car Train/Subway Boat/Ferry Airplane Other
 If other, please explain: _____



AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I understand that the life insurance companies listed below, their reinsurers, any insurance support organizations and the authorized representatives of those companies may need to collect information on me in regard to proposed coverage. Therefore, on the basis of this, or the attached Authorization for Release of Information Form, as needed I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance or reinsurance companies, the Medical Information Bureau, Inc., consumer reporting agency, financial sources, employers and any institution or person to furnish to AdvisorNet Insurance and the insurance companies named below the types of information specified in this authorization upon presentation of this authorization or a photocopy. To facilitate rapid submission of such information, I authorize all said sources, except the Medical Information Bureau, Inc. to give such records or knowledge to AdvisorNet Insurance.

The types of information will include records or facts relating to employment, other insurance coverage, past and present physical and mental state of health, drug and/or alcohol use, character, habits, avocations, finances, general reputation, credit or other personal traits. The information will be used by the insurance companies named below and their reinsurers to determine eligibility of insurance, claims and/or by the insurance agent to aid in updating and improving my insurance program. The information collected may be disclosed to other insurance companies to which I have applied or may apply, reinsurance companies, the Medical Information Bureau, I or other persons or organizations performing business, professional or insurance functions for the insurance companies named below, or as may be otherwise legally allowed.

This authorization will be valid for two years after the date of signing. I understand I or my authorized representative has the right to receive a copy of this authorization. I acknowledge receipt of the attached Notice To Proposed Insured and Notice of Information Practices.

Signed at _____ on _____

Signature of Proposed Insured: _____

We Represent:

- | | | |
|-------------------------------------|---------------------------|--|
| <i>Advantage Insurance Network</i> | <i>IBU</i> | <i>Principal</i> |
| <i>American General</i> | <i>Illinois Mutual</i> | <i>Prudential Financial</i> |
| <i>American National</i> | <i>ING-Reliastar Life</i> | <i>Secura DI</i> |
| <i>Aviva</i> | <i>John Hancock</i> | <i>Security Life of Denver</i> |
| <i>AXA</i> | <i>Lincoln Benefit</i> | <i>Standard</i> |
| <i>Banner</i> | <i>Lincoln Financial</i> | <i>Sun Life</i> |
| <i>Cincinnati Life</i> | <i>LTCI Partners</i> | <i>Summit Alliance</i> |
| <i>Crump</i> | <i>Mass Mutual</i> | <i>Transamerica Life Insurance Company</i> |
| <i>Financial Independence Group</i> | <i>MetLife</i> | <i>West Coast Life</i> |
| <i>Genworth Life & Annuity</i> | <i>Pacific Life</i> | <i>What Matters For Life, LLC</i> |
| <i>Guardian Insurance</i> | <i>Phoenix Insurance</i> | |

AdvisorNet Insurance, 1221 Nicollet Mall, #400, Minneapolis, MN 55403



NOTICE TO PROPOSED INSURED

In connection with your informal inquiry or application about insurance, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted. This report includes information as to your character, general reputation, personal characteristics, and mode of living. You may request to be interviewed in connection with preparation of this report. Upon written request to the life insurance companies listed in this Notice, you will be informed whether or not an investigative consumer report was requested, and if so, you will be advised of the name and address of the consumer reporting agency to whom the request was made. The consumer reporting agency, upon request, will furnish information as to the nature and scope of its investigation. You have the right to inspect a copy of any such report by contacting the consumer reporting agency.

Information regarding your insurability will be treated as confidential. The life insurance companies listed in this notice or their reinsurers may, however, make a brief report thereon to the Medical Information Bureau, Inc. a non-profit membership organization of life insurance companies, which operates an informational exchange bureau 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 it may have 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 the 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 P. O. Box 105, Essex Station, Boston, Massachusetts 02112 Tel. (617) 426-3660.

The companies listed in this notice or their reinsurers may also release information in their files to other insurance companies to whom you apply for life or health insurance, or to whom a claim for benefits may be submitted.

NOTICE OF INFORMATION PRACTICES

In the course of properly underwriting and administering your insurance coverage, the listed insurance companies will rely heavily on information provided by you. The companies may also seek information from others such as medical professionals who have treated you.

You have the right to be told about, and to see and copy, if you wish, items of personal information about you which appear in the insurance companies file, including information contained in investigative consumer reports. You also have the right to seek correction of information you believe to be inaccurate.

The above is a general description of the listed insurance companies and your agent's information practices. If you would like to receive a more detailed explanation of those practices, please send your written request to AdvisorNet Insurance

We Represent:

| | | |
|-------------------------------------|---------------------------|--|
| <i>Advantage Insurance Network</i> | <i>IBU</i> | <i>Principal</i> |
| <i>American General</i> | <i>Illinois Mutual</i> | <i>Prudential Financial</i> |
| <i>American National</i> | <i>ING-Reliastar Life</i> | <i>Secura DI</i> |
| <i>Aviva</i> | <i>John Hancock</i> | <i>Security Life of Denver</i> |
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| <i>Cincinnati Life</i> | <i>LTCI Partners</i> | <i>Summit Alliance</i> |
| <i>Crump</i> | <i>Mass Mutual</i> | <i>Transamerica Life Insurance Company</i> |
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AdvisorNet Insurance, 1221 Nicollet Mall, #400, Minneapolis, MN 55403

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Information

_____ Birthdate _____ SS# _____
(PRINT name of patient)

Information to be released from: _____
Name of designated Facility of Provider

Address

Information to be sent to: _____
Name of designated Recipient

Address

_____ Telephone Number
City, State, Zip Code

Information to be released:

- The most recent five years of patient records (chart notes, labs, x-rays, and special tests).
- Specific information (please specify): _____

Purpose for which disclosure is being made: (Please check one of the following)

- Insurance Attorney Doctor Personal

Patient Authorization

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

EXCLUDE the following information from the records released (please initial):

_____ Drug/alcohol abuse/treatment & diagnosis _____ Sexually transmitted disease
_____ HIV/AIDS diagnosis/treatment/testing _____ Mental illness or psychiatric diagnosis/treatment

My Rights:

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under privacy laws. A photocopy of this authorization will be treated in the same manner as the original.

SIGNATURE: _____ DATE: _____
(Patient, Guardian*, or Authorized Representative*)

[*Please provide documents to prove authority to sign on behalf of the patient.]

This authorization will expire 180 days from the date signed.