

# Agent's Report

Minnesota Life Insurance Company - A Securian Company  
 Life New Business • 400 Robert Street North • St. Paul, Minnesota 55101-2098

**MINNESOTA LIFE**

<b>Checklist</b>	<p>1. Did you give the Proposed Insured the Your Privacy Is Important To Us notice? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Do you know anything not disclosed which might affect the underwriting of this risk? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Will the Part 2 be completed through Tele-Interview? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Is replacement of existing life insurance or annuities involved in this application? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Owner Identity Verification (Not for Term or Variable)</p> <p><input type="checkbox"/> I certify that I personally met with the applicant and reviewed the identification documents. To the best of my knowledge the documents accurately reflect the identity of the individual.</p> <p><input type="checkbox"/> I did not meet in person with the individual or was otherwise unable to personally review the identification documents.</p> <p>6. Is the purpose of this insurance to provide an Employee Benefit Plan as defined under ERISA? If yes, complete the Employee Benefit Plan Disclosure Statement and Qualified Plan Data. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Will this insurance be part of a pension plan with administrative services provided by Minnesota Life? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. Information for Business Insurance (Buy/Sell, Split Dollar, Key Person)</p> <ul style="list-style-type: none"> <li>• Is this part of a Split Dollar plan? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>• What is the value of the business? \$ _____</li> <li>• What percentage does the Proposed Insured own or control? _____ %</li> <li>• Are there other key individuals applying? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> </ul> <p>If yes, indicate the name of each person. If no, indicate the reason.</p> <p>8. I explained to this customer that I represent Minnesota Life with respect to the sale and service of the purchased product. <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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<b>Additional Information</b>	
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<b>Compensation</b>	If compensation will be split between two or more Representatives, please complete this section:		
	Additional representative name	Firm/rep code	Commission %
	Additional representative name	Firm/rep code	Commission %
	Additional representative name	Firm/rep code	Commission %

I believe the information provided by this applicant is true and accurate. I certify that I have accurately recorded all information given by the Proposed Insured(s) and my statements on this Representative's Report are correct to the best of my knowledge.

Servicing representative signature <b>X</b>	Date	Firm/rep code	Commission %
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# Application Part 1

**MINNESOTA LIFE**

Minnesota Life Insurance Company • Life New Business  
400 Robert Street North • St. Paul, Minnesota 55101-2098

<b>A. Proposed Insured Information</b>	Proposed insured name (last, first, middle)																																					
	Social Security number	Date of birth (month, day, year)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female																																			
	Driver's license number	Issue state	Expiration date																																			
	Home telephone number	Business telephone number																																				
	Birthplace (state or, if outside the US, country)	E-mail address																																				
	Street address (no P.O. Box)	City	State	Zip code																																		
	Occupation	Years in occupation	Income																																			
<b>B. Product</b>	Product applied for	Base face amount \$																																				
	Total annual planned premium	Death benefit qualification test (If applicable, defaults to GPT if none selected) <input type="checkbox"/> Guideline Premium Test (GPT) <input type="checkbox"/> Cash Value Accumulation Test (CVAT)																																				
	Death benefit option (If applicable, defaults to Level if none selected) <input type="checkbox"/> Level <input type="checkbox"/> Increasing <input type="checkbox"/> Sum of Premiums																																					
<b>C. Additional Benefits and Agreements</b>	<input type="checkbox"/> Waiver of Premium Agreement		<input type="checkbox"/> Death Benefit Guarantee Agreement																																			
	<input type="checkbox"/> Waiver of Charges Agreement		<input type="checkbox"/> Term Insurance Agreement																																			
<b>D. Special Dating</b>	<input type="checkbox"/> Date to save age																																					
	<input type="checkbox"/> Specific date: _____ (month, day, year)																																					
Are there any other Minnesota Life applications associated with this application? <input type="checkbox"/> Yes <input type="checkbox"/> No																																						
If yes, please provide details and whether the policies should have the same issue date.																																						
<b>E. Life Insurance In Force and Replacement</b>	Does the proposed insured have any life insurance or annuity in force or pending, including life insurance sold or assigned to a life settlement, viatical or secondary market provider? If yes, provide details below. <input type="checkbox"/> Yes <input type="checkbox"/> No																																					
	Has there been or will there be replacement of any existing life insurance or annuity, as a result of this application? (Replacement includes, but is not limited to, a lapse, surrender, 1035 Exchange, loan, withdrawal, or other change to any existing life insurance or annuity.) If yes, provide details below. <input type="checkbox"/> Yes <input type="checkbox"/> No																																					
	<b>Life Insurance In Force</b>																																					
<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:30%;">Full Company Name</th> <th style="width:15%;">Amount</th> <th style="width:10%;">Year Issued</th> <th style="width:25%;">Type</th> <th style="width:20%;">Will it be Replaced?</th> </tr> </thead> <tbody> <tr> <td></td> <td></td> <td></td> <td><input type="checkbox"/> Individual or <input type="checkbox"/> Group</td> <td><input type="checkbox"/> Yes</td> </tr> <tr> <td></td> <td></td> <td></td> <td><input type="checkbox"/> Personal or <input type="checkbox"/> Business</td> <td><input type="checkbox"/> No</td> </tr> <tr> <td></td> <td></td> <td></td> <td><input type="checkbox"/> Individual or <input type="checkbox"/> Group</td> <td><input type="checkbox"/> Yes</td> </tr> <tr> <td></td> <td></td> <td></td> <td><input type="checkbox"/> Personal or <input type="checkbox"/> Business</td> <td><input type="checkbox"/> No</td> </tr> <tr> <td></td> <td></td> <td></td> <td><input type="checkbox"/> Individual or <input type="checkbox"/> Group</td> <td><input type="checkbox"/> Yes</td> </tr> <tr> <td></td> <td></td> <td></td> <td><input type="checkbox"/> Personal or <input type="checkbox"/> Business</td> <td><input type="checkbox"/> No</td> </tr> </tbody> </table>				Full Company Name	Amount	Year Issued	Type	Will it be Replaced?				<input type="checkbox"/> Individual or <input type="checkbox"/> Group	<input type="checkbox"/> Yes				<input type="checkbox"/> Personal or <input type="checkbox"/> Business	<input type="checkbox"/> No				<input type="checkbox"/> Individual or <input type="checkbox"/> Group	<input type="checkbox"/> Yes				<input type="checkbox"/> Personal or <input type="checkbox"/> Business	<input type="checkbox"/> No				<input type="checkbox"/> Individual or <input type="checkbox"/> Group	<input type="checkbox"/> Yes				<input type="checkbox"/> Personal or <input type="checkbox"/> Business	<input type="checkbox"/> No
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			<input type="checkbox"/> Personal or <input type="checkbox"/> Business	<input type="checkbox"/> No																																		



<b>K. Special Mailing Address</b>	<p>If mail (other than the premium notice) should be sent somewhere other than the owner's Home Address, please indicate here.</p> <p><input type="checkbox"/> Owner's Business Address</p> <p><input type="checkbox"/> Other - Indicate Name and Address</p> <hr/> <p>Name (last, first, middle)</p> <hr/> <p>Address</p> <hr/> <table style="width: 100%; border: none;"> <tr> <td style="border: none; width: 60%;">City</td> <td style="border: none; width: 20%;">State</td> <td style="border: none; width: 20%;">Zip code</td> </tr> </table>	City	State	Zip code
City	State	Zip code		
<b>L. Proposed Insured Underwriting Information</b>	<p>1. Is the proposed insured a US citizen? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <p style="margin-left: 20px;">If no, citizen of _____</p> <p style="margin-left: 20px;">Indicate visa type _____</p> <p>2. Does the proposed insured plan to travel or reside outside the US in the next two years? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <p style="margin-left: 20px;">If yes, provide the city(s) and country(s), dates, length of stay, and purpose of travel:</p> <p style="margin-left: 20px;">_____</p> <p style="margin-left: 20px;">_____</p> <p>3. Has the proposed insured within the last five years, or does the proposed insured plan to engage in piloting a plane? If yes, complete the Military and Aviation Statement. <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <p>4. Has the proposed insured within the last five years, or does the proposed insured plan to engage in sky diving, motor vehicle or boat racing, mountain/rock climbing, hang gliding, or underwater diving? If yes, complete Sports and Avocation Statement. <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <p>5. Is the proposed insured in the Armed Forces, National Guard, or Reserves? If yes, complete Military and Aviation Statement. <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <p>6. Has the proposed insured applied for insurance within the last six months? If yes, provide details below. <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <p>7. Has the proposed insured applied for life insurance in the past five years that was declined or rated? If yes, provide details below. <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <p>8. Has the proposed insured, within the past ten years, been convicted of a driving while intoxicated violation, had a driver's license restricted or revoked, or been convicted of a moving violation? If yes, provide dates and details below. <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <p>9. Except for traffic violations, has the proposed insured ever been convicted of a misdemeanor or felony? If yes, provide dates and details below. <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p>			
<b>M. Additional Remarks</b>				
<b>N. Home Office Endorsements</b>	<p><b>Home Office Corrections or Additions</b></p> <p>Acceptance of the policy shall ratify changes entered here by Minnesota Life. Not to be used in IA, IL, KS, KY, MD, MI, MN, MO, NH, NJ, OR, PA, TX, VT, WA, WI, or WV for change in age, amount, classification, plan or benefits unless agreed to in writing.</p>			

# Application Part 2

Minnesota Life Insurance Company • Life New Business  
400 Robert Street North • St. Paul, Minnesota 55101-2098

**MINNESOTA LIFE**

Proposed Insured Name (last, first, middle)	Date of Birth
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Height and Weight	Change in Past Year	Cause of Weight Gain or Loss
FT.      IN.      LBS.	LBS. <input type="checkbox"/> GAIN <input type="checkbox"/> LOSS	

	Yes	No					
1. A. Have you ever smoked cigarettes?	<input type="checkbox"/>	<input type="checkbox"/>					
<table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:25%; border: 1px solid black;">Current Smoker <input type="checkbox"/></td> <td style="width:25%; border: 1px solid black;">Past Smoker <input type="checkbox"/></td> <td style="width:25%; border: 1px solid black;">Packs Per Day</td> <td style="width:25%; border: 1px solid black;">Date Last Cigarette Smoked (MM, DD, YY)</td> </tr> </table>	Current Smoker <input type="checkbox"/>	Past Smoker <input type="checkbox"/>	Packs Per Day	Date Last Cigarette Smoked (MM, DD, YY)			
Current Smoker <input type="checkbox"/>	Past Smoker <input type="checkbox"/>	Packs Per Day	Date Last Cigarette Smoked (MM, DD, YY)				
B. Have you ever used tobacco, other than cigarettes, in any form?	<input type="checkbox"/>	<input type="checkbox"/>					
<table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:25%; border: 1px solid black;">What Type</td> <td style="width:25%; border: 1px solid black;">Current User <input type="checkbox"/></td> <td style="width:25%; border: 1px solid black;">Past User <input type="checkbox"/></td> <td style="width:25%; border: 1px solid black;">How Much</td> <td style="width:25%; border: 1px solid black;">Date of Last Use (MM, DD, YY)</td> </tr> </table>	What Type	Current User <input type="checkbox"/>	Past User <input type="checkbox"/>	How Much	Date of Last Use (MM, DD, YY)		
What Type	Current User <input type="checkbox"/>	Past User <input type="checkbox"/>	How Much	Date of Last Use (MM, DD, YY)			
2. Are you taking or do you take any prescription or non-prescription medications or drugs?	<input type="checkbox"/>	<input type="checkbox"/>					
3. During the past 10 years have you had or been treated for:							
A. Seizures; epilepsy; paralysis; fainting spells; headaches; dizziness; sleep disorder; or any other disorder of the brain or nervous system?	<input type="checkbox"/>	<input type="checkbox"/>					
B. Depression; stress; anxiety; nervousness; nervous breakdown; or any other nervous, mental, or emotional disorder?	<input type="checkbox"/>	<input type="checkbox"/>					
C. High blood pressure; chest pain; chest discomfort or tightness; heart attack; heart murmur; stroke; irregular heart beat; or any other disease or disorder of the heart or blood vessels?	<input type="checkbox"/>	<input type="checkbox"/>					
D. Asthma; shortness of breath; bronchitis; pneumonia; emphysema; chronic cough; or any other lung or respiratory disorder?	<input type="checkbox"/>	<input type="checkbox"/>					
E. Abdominal pain; ulcer; colitis; cirrhosis; hepatitis; recurrent diarrhea; intestinal bleeding; or any other disease of the liver, gallbladder, pancreas, stomach, or intestines?	<input type="checkbox"/>	<input type="checkbox"/>					
F. Kidney stone; protein, sugar, blood or blood cells in the urine; or any disorder of the urinary tract, bladder or kidneys?	<input type="checkbox"/>	<input type="checkbox"/>					
G. Disorder or abnormality of the prostate, uterus, ovaries, or breasts; pregnancy complication; testicular disease; genital herpes, syphilis, gonorrhea, or other sexually transmitted disease?	<input type="checkbox"/>	<input type="checkbox"/>					
H. Diabetes; thyroid disorder; lymph node enlargement; skin disorder; or disorder of any other glands?	<input type="checkbox"/>	<input type="checkbox"/>					
I. Cancer; tumor; or cyst?	<input type="checkbox"/>	<input type="checkbox"/>					
J. Anemia, leukemia, or other blood disorder?	<input type="checkbox"/>	<input type="checkbox"/>					
K. Back or neck pain; spinal strain or sprain; sciatica; arthritis; gout; carpal tunnel syndrome; or any bone, joint, or muscle disorder?	<input type="checkbox"/>	<input type="checkbox"/>					
L. Disorder of the eyes, ears, nose or throat?	<input type="checkbox"/>	<input type="checkbox"/>					
M. Any physical deformity or defect?	<input type="checkbox"/>	<input type="checkbox"/>					
N. Any immune deficiency disorder including AIDS or AIDS-Related Complex (ARC), or AIDS-related conditions?	<input type="checkbox"/>	<input type="checkbox"/>					
O. A blood test showing evidence of antibodies to the AIDS (HIV) virus for the purpose of obtaining insurance?	<input type="checkbox"/>	<input type="checkbox"/>					
P. Any chronic or recurrent fever, fatigue or viral illness?	<input type="checkbox"/>	<input type="checkbox"/>					
4. Do you consume alcoholic beverages? If yes, what kinds, how much and how often?	<input type="checkbox"/>	<input type="checkbox"/>					
5. During the past 10 years:							
A. Have you been advised to limit the use of alcohol or drugs; sought or received treatment, advice, or counseling for alcohol or drugs; or joined a group because of alcohol or drug use?	<input type="checkbox"/>	<input type="checkbox"/>					
B. Have you tried or used cocaine, heroin, marijuana, barbiturates or other controlled substances?	<input type="checkbox"/>	<input type="checkbox"/>					

6. Other than above, have you in the past five years:

- A. Consulted or been advised to consult a physician, psychiatrist, psychologist, therapist, counselor, chiropractor, or other health care practitioner? (Include regular check-ups.)  Yes  No
- B. Had a check-up, illness, or surgery, or been treated or evaluated at a hospital or any other health care facility?  Yes  No
- C. Had an EKG, x-ray, stress test, echocardiogram, angiography, blood studies or any other diagnostic test?  Yes  No
- D. Been advised to have any test, hospitalization, or surgery which was not completed?  Yes  No

7. Family History: Make a note of diabetes, cancer, melanoma, heart, and kidney disease.

		Age(s)	Health History		Age(s)	Cause of Death
Father	Living			Deceased		
Mother						
Siblings						
Siblings						

8. Do you have a personal physician or belong to an H.M.O. or clinic? If so, please provide information below.  Yes  No

Name		Phone Number	
Street Address			
City		State	Zip Code
Date Last Seen		Reason	

**Give details of all yes answers, including doctors' names, addresses and dates.**

# Application Part 3

## Agreements and Authorizations

**MINNESOTA LIFE**

Minnesota Life Insurance Company, a Securian Financial Group affiliate  
 Life New Business • 400 Robert Street North • St. Paul, Minnesota 55101-2098

Proposed Insured Name (last, first, middle)

**AGREEMENTS:** I have read, or had read to me the statements and answers recorded on my application. They are given to obtain this insurance and are, to the best of my knowledge and belief, true and complete and correctly recorded. I understand that any false statement or misrepresentation on this application may result in loss of coverage under this policy subject to the incontestability provision. I agree that they will become part of this application and any policy issued on it. The insurance applied for will not take effect unless the policy is issued and delivered and the full first premium is paid while the health of the Proposed Insured remains as stated in this application. **If such conditions are met, the insurance will take effect as of the earlier of the Policy Date specified in the policy or the date the policy is delivered to me; the only exception to this is provided in the Life Receipt and Temporary Insurance Agreement, issued if the premium is paid in advance.**

**VARIABLE LIFE:** I understand that the amount or the duration of the death benefit (or both) of the policy applied for may increase or decrease depending on the investment results of the sub-accounts of the separate account. I understand that the actual cash value of the policy applied for increases and decreases depending on the investment results. There is no minimum actual cash value for the policy values invested in these sub-accounts.

**AUTHORIZATION:** I authorize any physician, medical practitioner, hospital, clinic or other health care provider, insurance or reinsuring company, consumer reporting agency, the Medical Information Bureau, Inc. (MIB), or employer which has any records or knowledge of the physical or mental health of me or my minor children, to give all such information and any other non-medical information relating to such persons to Minnesota Life or its reinsurers. This shall include ALL INFORMATION as to any medical history, consultations, diagnoses, prognoses, prescriptions or treatments and tests, including information regarding alcohol or drug abuse and AIDS or AIDS-related conditions. To facilitate rapid submission of such information, I authorize all said sources, except MIB, to give such records or knowledge to any agency employed by Minnesota Life to collect and transmit such information.

I understand this information is to be used for the purpose of determining eligibility for insurance and may be used for determining eligibility for benefits. I understand this information may be made available to Underwriting, Claims, support staff, licensed representatives, and firms of Minnesota Life. I authorize Minnesota Life or its reinsurers to release any such information to reinsuring companies, the MIB, or other persons or organizations performing business or legal services in connection with my application, claim or as may be otherwise lawfully required or as I may further authorize.

I agree this authorization shall be valid for twenty-four months from the date it is signed. I may revoke this authorization at any time by sending a written request addressed to the Individual Underwriting Department, Minnesota Life Insurance Company, 400 Robert Street North, St. Paul, MN 55101-2098.

I understand that I have the right to request and receive a copy of this authorization and that a photocopy of this authorization shall be as valid as the original.

I acknowledge that I have been given the Your Privacy Is Important To Us notice.

**FRAUD WARNING:** Any person who, with intent to defraud or knowing that he/she 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.

Proposed insured signature <b>X</b>	Date	City	State
Owner signature (if other than proposed insured) (give title if signed on behalf of a business) <b>X</b>	Date	City	State
Parent/conservator/guardian signature (juvenile applications) <b>X</b>	Date	City	State

I believe that the information provided by this applicant is true and accurate. I certify I have accurately recorded all information given by the Proposed Insured(s).

Licensed representative signature <b>X</b>	Date
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*HIPAA Authorization  
for Release of Health-Related Information  
To Minnesota life Insurance Company*

**MINNESOTA LIFE**

Minnesota Life Insurance Company • Life New Business  
400 Robert Street North • St. Paul, Minnesota 55101-2098

This authorization complies with the HIPAA Privacy Rule.

Proposed Insured/Patient Name	Date of Birth
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I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record and any other protected health information concerning me to Minnesota Life Insurance Company (Minnesota Life) and its agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this Authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that Minnesota Life may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with Minnesota Life.

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 Minnesota Life at 400 Robert Street North, St. Paul, Minnesota 55101-2098. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that Minnesota Life has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this Authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization. I further understand that if I refuse to sign this Authorization to release my complete medical record, Minnesota Life may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I acknowledge that I have received a copy of this Authorization.

Signature of Proposed Insured/Patient or Personal Representative	Date
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**X**  
Description of Personal Representative's Authority or Relationship to Patient

## IDG Allocation Options for Indexed and Variable Life Products

Minnesota Life Insurance Company - A Securian Company  
Life New Business • 400 Robert Street North • St. Paul, Minnesota 55101-2098

**MINNESOTA LIFE**

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### INSTRUCTIONS

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For **INDEXED UNIVERSAL LIFE (IUL) PRODUCTS**, complete page 1.

For **VARIABLE UNIVERSAL LIFE (VUL) PRODUCTS**:

- Select Net Premium Allocations on page 2.
- For existing policies, if a Systematic Account Rebalance arrangement is currently active, then the account allocation in the arrangement will automatically be changed for future rebalances to match the new Net Premium Allocation being selected today.
- If the Death Benefit Guarantee Agreement (DBGGA) is added to a policy, then only the Guaranteed Account and/or the 5 Ibbotson Exchange Trade Fund sub-accounts can be selected.
- For Monthly Charge Allocations:
  - Select one of the Monthly Charge Allocations boxes on page 2.
  - If the policy date is one month or more prior to the date the initial premium is applied, then monthly charges will be assessed proportionately until the date the premium is applied.
- For Rebalancing, Transfers, or Dollar Cost Averaging, complete page 3.
  - The start date for rebalancing, transfer, and dollar cost averaging must be in the future—it cannot be in the past.
  - If completing Section D, then the cash value of the selected FROM accounts will be allocated in total to the TO accounts according to the percentages or dollar amounts indicated.
- For Partial Surrender Allocations, complete the Loan/Partial Surrenders column and submit a Policy Change Application Packet.
- For Loan Allocations, complete the Loan/Partial Surrenders column and submit a Policy Service Request.

## IDG Allocation Options for Indexed and Variable Life Products

Policy number (for existing policies)	Insured name	Owner name (if different from insured)	Date	Firm/rep code
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### INDEXED UNIVERSAL LIFE PRODUCTS

This transaction was initiated by:  Policyowner  Representative

#### Select Net Premium Allocations

Allocations must be in increments of 1%; minimum is 1%. Allocations must total 100%.

ALLOCATION OPTIONS	ECLIPSE	ECLIPSE PROTECTOR
	NET PREMIUM %	NET PREMIUM %
Fixed Account		N/A
Index A: S&P 500 100% Participation		N/A
Index B: S&P 500 140% Participation		N/A
Index C: DJ World 100% Participation		N/A
Fixed Account 2	N/A	
Index A2: S&P 500 100% Participation	N/A	
Index B2: S&P 500 140% Participation	N/A	
Index C2: DJ World 100% Participation	N/A	

#### One-Time Transfer Allocation (**NOT** available for policies at issue)

Percentages must be in increments of 1%; minimum is 1%. TRANSFER TO amounts must total 100%.

FROM		TO	
Account:	%	Account:	%
Account:	%	Account:	%
Account:	%	Account:	%
Account:	%	Account:	%
Account:	%	Account:	%
Account:	%	Account:	%
Account:	%	Account:	%

# IDG Allocation Options for Indexed and Variable Life Products

Policy number (for existing policies)	Insured name	Owner name (if different from insured)	Date	Firm/rep code
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## VARIABLE UNIVERSAL LIFE PRODUCTS

This transaction was initiated by:  Policyowner  Representative

- Select Net Premium Allocations. Allocations must be in increments of 1%; minimum is 1%. Allocations must total 100%.
- Check one for Monthly Charge Allocations:
  - Request to assess Monthly Charge Allocations other than proportionately (indicate below).
  - Request the same Monthly Charge Allocations as the Net Premium Selection.
  - Request to cancel existing Monthly Charge Allocations.

ACCOUNT OPTIONS	NET PREMIUM %	MONTHLY CHARGES%	LOAN/PARTIAL SURRENDER %
Guaranteed Account			
Advantus Bond <sup>1</sup>			
Advantus Index 400 Mid-Cap <sup>1</sup>			
Advantus Index 500 <sup>1</sup>			
Advantus International Bond <sup>1</sup>			
Advantus Mortgage Securities <sup>1</sup>			
Advantus Real Estate Securites <sup>1</sup>			
AllianceBernstein VPS International Value <sup>2</sup>			
Fidelity VIP Equity-Income <sup>3</sup>			
Fidelity VIP Mid Cap <sup>3</sup>			
Franklin Small Cap Value Securities <sup>4</sup>			
Ibbotson Aggressive Growth ETF Asset Allocation <sup>5</sup>			
Ibbotson Balanced ETF Asset Allocation <sup>5</sup>			
Ibbotson Conservative ETF Asset Allocation <sup>5</sup>			
Ibbotson Growth ETF Asset Allocation <sup>5</sup>			
Ibbotson Income & Growth ETF Asset Allocation <sup>5</sup>			
Ivy Funds VIP - Asset Strategy <sup>6</sup>			
Ivy Funds VIP - Core Equity <sup>6</sup>			
Ivy Funds VIP - Global Natural Resources <sup>6</sup>			
Ivy Funds VIP - Growth <sup>6</sup>			
Ivy Funds VIP - International Value <sup>6</sup>			
Ivy Funds VIP - Science and Technology <sup>6</sup>			
Janus Aspen Overseas SS <sup>7</sup>			
Janus Aspen Janus <sup>7</sup>			
Vanguard VIF Balanced <sup>8</sup>			
Vanguard VIF Capital Growth <sup>8</sup>			
Vanguard VIF Diversified Value <sup>8</sup>			
Vanguard VIF Equity Income <sup>8</sup>			
Vanguard VIF High Yield Bond <sup>8</sup>			
Vanguard VIF International <sup>8</sup>			
Vanguard VIF Money Market <sup>8</sup>			
Vanguard VIF Short-Term Investment-Grade <sup>8</sup>			
Vanguard VIF Small Company Growth <sup>8</sup>			
Vanguard VIF Total Bond Market <sup>8</sup>			
Vanguard VIF Total Stock Market <sup>8</sup>			
Van Kampen LIT UIF Emerging Markets <sup>9</sup>			

<sup>1</sup> Invests in Advantus Series Fund, Inc. Class 1 Shares.

<sup>2</sup> Invests in AllianceBernstein Variable Products Series Fund, Inc. Class A Shares.

<sup>3</sup> Invests in Fidelity VIP Initial Class Shares.

<sup>4</sup> A series of Franklin Templeton Variable Insurance Products Trust. Invests in Class 1 Shares of the Fund.

<sup>5</sup> Invests in Financial Investors Variable Insurance Trust Class I Shares.

<sup>6</sup> Invests in Ivy Funds VIP, Inc.

<sup>7</sup> Institutional Shares.

<sup>8</sup> Invests in Vanguard® Variable Insurance Fund Portfolio.

<sup>9</sup> Invests in The Universal Institutional Funds, Inc. Class II Shares.

# IDG Allocation Options for Indexed and Variable Life Products

Policy number (for existing policies)	Insured name	Owner name (if different from insured)	Date	Firm/rep code
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## VARIABLE UNIVERSAL LIFE PRODUCTS

This transaction was initiated by:  Policyowner  Representative

**To elect a combination of Rebalance, One-Time Transfer, and DCA, complete a separate page for each.**

### REBALANCE

I elect to (check all that apply)

- One-time rebalance of account cash values (complete D)
- Start a systematic rebalance (complete A, B, C, page 2)
- Change allocations of a systematic rebalance (complete A, page 2)
- Change the frequency of a systematic rebalance (complete A, C)
- Change the systematic rebalance date (complete A, B)
- Cancel the systematic rebalance (complete A)

### TRANSFER

I elect to (check all that apply)

- One-time transfer of account cash values (complete D)

### DOLLAR COST AVERAGING (DCA)

I elect to (check all that apply)

- Start a DCA (complete A, B, C, D)
- Change allocations of a DCA (complete A, D)
- Change the frequency of a DCA (complete A, C)
- Change the DCA date (complete A, B)
- Cancel the DCA (complete A)

### Complete the appropriate sections below for the requested transaction above

#### A. Start/Change/End (end for DCA only)

- Begin on \_\_\_\_\_ Month \_\_\_\_\_ Year
- Change on \_\_\_\_\_ Month \_\_\_\_\_ Year
- End DCA on \_\_\_\_\_ Month \_\_\_\_\_ Year

#### B. Day

\_\_\_\_\_ (options 1-28)

#### C. Frequency

- Monthly  Quarterly  Semi-Annual  Annual

**D. Allocations** - Rebalance amounts indicated must all be in %. Transfer or DCA amounts indicated must all be in % or all in \$. Percentages must be in increments of 1%; minimum is 1%. Dollar amounts must be in whole dollars. The 'FROM' columns total must match the 'TO' columns total. TO REBALANCE FROM ALL ACCOUNTS WITH CASH VALUE, CHECK HERE

#### FROM

#### TO

Sub-Account:	\$	%	Sub-Account:	\$	%
Sub-Account:	\$	%	Sub-Account:	\$	%
Sub-Account:	\$	%	Sub-Account:	\$	%
Sub-Account:	\$	%	Sub-Account:	\$	%
Sub-Account:	\$	%	Sub-Account:	\$	%
Sub-Account:	\$	%	Sub-Account:	\$	%
Sub-Account:	\$	%	Sub-Account:	\$	%
Sub-Account:	\$	%	Sub-Account:	\$	%

# IDG Application Instructions & Owner Identity Verification

**MINNESOTA LIFE**

Minnesota Life Insurance Company - A Securian Company  
Life New Business • 400 Robert Street North • St. Paul, Minnesota 55101-2098

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## FORMS NEEDED FOR EVERY APPLICATION:

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- Your Privacy is Important to Us (*Give to Proposed Insured*)
- Application Part 1
- Application Part 2 or Tele-Interview (*If a Tele-Interview is completed, give the Making Life Simple form to the Proposed Insured*)
- Application Part 3
- HIPAA Authorization for Release of Health-Related Information
- Agent's Report
- In **CA only**, give Owners age 65 and older a copy of the CA Notice for Policyowners.
- In **MN only**, provide all Owners with the Guaranty Association Notice. Give Owners age 65 and older a signed and completed copy of the application within 24 hours of completion.

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## ADDITIONAL FORMS NEEDED WHEN APPLYING FOR:

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- **Variable Products**
  - Variable Life Insurance Disclosure Statement and Prospectus Authorization (*Except in MA and CT*)
  - IDG Allocation Options for Indexed and Variable Products
  - Life Insurance Disclosure Statement (*In MA and CT only*)
  - Prospectus Authorization for Variable Contracts (*In MA and CT only*)
  - Maryland Universal Life Disclosure Statement (*Give to Owner in MD only*)
- **Indexed Products**
  - IDG Allocation Options for Indexed and Variable Products
  - Life Insurance Disclosure Statement (*In MA and CT only*)
  - Maryland Universal Life Disclosure Statement (*Give to Owner in MD only*)
  - Buyer's Guide (*Give to Owner in GA, IL, ME, NH, WA, and WI only*)
  - Pennsylvania Disclosure Statement (*Complete and give to Owner in PA if the signed illustration is being collected after the application has been taken*)
- **Term Products**
  - Summary of Premium Provisions (*In MT and TX only*)
  - Buyer's Guide (*Give to Owner in GA, IL, ME, NH, WA, and WI only*)
  - Preliminary Statement of Policy Cost (*Print 2 copies in ME only. Complete and give first copy to Owner. Return second copy to Minnesota Life.*)
  - Pennsylvania Disclosure Statement (*Complete and give to Owner in PA only*)
- **Legacy Protector SUL**
  - Maryland Universal Life Disclosure Statement (*Give to Owner in MD only*)
  - Buyer's Guide (*Give to Owner in GA, IL, ME, NH, WA, and WI only*)
  - Pennsylvania Disclosure Statement (*Complete and give to Owner in PA if the signed illustration is being collected after the application has been taken*)
- **Secure Whole Life**
  - Buyer's Guide (*Give to Owner in GA, IL, ME, NH, WA, and WI only*)
  - Pennsylvania Disclosure Statement (*Complete and give to Owner in PA if the signed illustration is being collected after the application has been taken*)

**NOTE:** A signed illustration must also be submitted when applying for Eclipse IUL, Eclipse Protector IUL, Legacy Protector SUL, or Secure WL.

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**ADDITIONAL FORMS NEEDED WHEN:**

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- **Money is taken at time of application:** Life Receipt and Temporary Insurance Agreement (*Give to Owner; Use the Joint Life Receipt for survivorship products*)  
**NOTE:** Do not accept payment when the death benefit applied for and in force with Minnesota Life exceeds \$1,000,000. Make checks payable to Minnesota Life.
- **Premium is to be paid through a monthly automatic payment plan (EFT):**
  - To set up a new EFT: Complete the Electronic Funds Transfer (EFT) Authorization and attach a voided check
  - To add to an existing EFT: Complete Section E on Application Part 1
- **Applying for the Accelerated Benefit Agreement (ABA):** Accelerated Benefit Agreement form (*Not available in IN, MS, or MN unless applying for Eclipse Protector IUL. Not available on the Legacy Protector SUL product in any state.*)
- **Applying for the Family Term Agreement - Child (FTR-C) or Children's Term Agreement (CTA):** Family Term Agreement - Child/Additional Insured Agreement/Children's Term Agreement Application form (FTR-C is not available on Legacy Protector SUL or Eclipse IUL; CTA is only available on Secure WL and Eclipse Protector IUL.)
- **The Owner is not the Insured and the Owner is:**
  - *An Individual or Sole Proprietorship:* Complete the Owner Identity Verification on this form
  - *A Trust:* Complete the Certification of Trustee Authority form (*Access from our forms website*)
  - *A Corporation:* Complete the Corporate/Non-Profit Resolution form (*Access from our forms website*)
  - *A Partnership:* Complete the Partnership/LLC Resolution form (*Access from our forms website*)

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**Owner Identity Verification Disclosure**

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Your identity may be verified by Minnesota Life in accordance with the U.S. Patriot Act of 2001. This verification may include, but is not limited to, contact with financial institutions, consumer reporting agencies, and government agencies.

**COMPLETE THIS SECTION IF THE OWNER IS NOT THE INSURED. NOT NEEDED IF THE OWNER IS A TRUST, CORPORATION, OR PARTNERSHIP. NOT NEEDED IF APPLYING FOR A TERM OR VARIABLE PRODUCT.**

Indicate documentation used to verify identity.		
<input type="checkbox"/> Driver's License	<input type="checkbox"/> State ID	<input type="checkbox"/> Passport <input type="checkbox"/> Greencard <input type="checkbox"/> Other _____
Identification number	State/country	Expiration date
Owner name		

## In Force Coverage and Replacement Instructions

Minnesota Life Insurance Company - A Securian Company  
Life New Business • 400 Robert Street North • St. Paul, Minnesota 55101-2098

**MINNESOTA LIFE**

*Regulations governing the handling of in force life insurance coverage and the replacement of existing life insurance coverage vary by state. These instructions provide an easy road map to follow. Complete any forms listed in the **For All States** section and review the **Additional Instructions** section for your state of sale. These instructions are for the following states: Delaware, California, Idaho, Michigan, Missouri, Pennsylvania, Tennessee, and Wyoming.*

### FOR ALL STATES

- If there is any life insurance or annuities in force on the Proposed Insured, complete **Section E on Application Part 1** for new business or **Section L on the Policy Change Applications**.
- If the application involves replacement of any kind (including external replacement of non-term group policies in Michigan):
  - Complete **Section E on Application Part 1** for new business or **Section L on the Policy Change Applications**.
  - Complete the **Replacement Disclosure Statement** and return it to Minnesota Life.
- If the application specifically involves **external** replacement (including external replacement of non-term group policies in Michigan), **also** complete two copies of the **Replacement Notice**. Leave one copy with the Owner and return one copy to Minnesota Life.
- If the application involves a 1035 Exchange, complete the **1035 Exchange Agreement** and return it to Minnesota Life.
- For all sales, indicate by check mark on the Representative/Agent's Report whether the application will involve replacement.

### ADDITIONAL INSTRUCTIONS

#### Delaware, Idaho, Missouri, Pennsylvania, Tennessee, and Wyoming

- If the application involves **external** replacement, leave with the Owner a copy of all **written and printed communications** used.

#### California

- If the application involves **external** replacement, leave with the Owner a copy of all **printed communications** used for the presentation.
- If the application involves **internal** replacement:
  - Complete the **Replacement Notice** and leave it with the Owner.
  - Leave with the Owner both an **in force illustration** and a **new illustration**.

#### Michigan

- If the application involves **external** replacement (including external replacement of non-term group policies in Michigan):
  - Complete two copies of the **Replacement Information Statement**. Leave one copy with the Owner and return one copy to Minnesota Life.
  - Leave with the Owner a copy of all **sales proposals** used and send a copy to Minnesota Life.

# Making life simple

*Applying for life insurance doesn't have to be difficult*

We appreciate that you selected Minnesota Life to provide your life insurance and we want to make applying for insurance as fast and simple as possible. That's why we created a confidential, accurate and professional process designed to be easy for you.

## The first steps

By now you and your advisor have completed the initial steps in the application process. In most cases, two steps remain:

- A telephone interview (tele-interview)
- A physical examination

## The tele-interview

The tele-interview typically takes place soon after we receive your application — sometimes within 24 hours. The phone interview can take place at a time and location of your choice — at your home or your office, during the day or in the evening. If we are unable to reach you and leave a message, please return the call at your earliest convenience.

It typically takes 20-25 minutes to complete the interview; longer if your answers warrant additional information. The confidential interview is conducted by an experienced professional. *It is only with your authorization that the information you provide may be discussed with your Licensed Representative.*

The interviewer will gather information about your medical and personal history. You can prepare for the interview by gathering the following information in advance:

- Names, addresses and telephone numbers of physicians, clinics, and hospitals you have visited in the past 10 years
- Prescribed medications used in the past 10 years including dosage and frequency

Depending on the amount of insurance you are applying for, you may also be asked about:

- Your income, net worth and other life insurance
- Hobbies such as scuba diving, mountain climbing or racing
- Aviation experience if you are a pilot

The tele-interview is the best way to collect accurate information in a way that's comfortable and convenient for you. We've also found that it reduces the time required to approve an insurance application.

## The physical exam

Most life insurance applications require an abbreviated physical examination. An examiner will contact you to set a time and date for the exam. While the exam can occur at a location of your choosing, it will require privacy.

Depending on your age, medical history and the amount of coverage you are applying for, the examiner may need to collect:

- Measurements of your height and weight
- A blood pressure reading
- A blood sample
- A urine sample
- An electrocardiogram (EKG)

## The best contract at the best price

After the interview and exam are complete, Minnesota Life will use the information to provide insurance at the best possible price. We're committed to providing excellent products, prices and service throughout the life of your policy.

Thank you for choosing Minnesota Life.  
We'll go all out to keep life simple for you.

**Minnesota Life Insurance Company**  
A Securian Financial Group affiliate  
www.minnesotalife.com

400 Robert Street North, St. Paul, MN 55101-2098  
651.665.3500 • 651.665.4488 Fax  
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A07093-1207

# Request For Illustration

Minnesota Life Insurance Company - A Securian Company  
Life New Business • 400 Robert Street North • St. Paul, Minnesota 55101-2098

**MINNESOTA LIFE**

*An illustration is required with all applications for Adjustable Life Legend, Adjustable Life Summit, Annual Renewal Term '89, Eclipse Indexed Universal Life, Eclipse Protector Indexed Universal Life, Legacy Protector Survivorship Universal Life, and Secure Whole Life in states where the NAIC Model Illustration regulation has been adopted. If an illustration is not submitted with the application or if the illustration differs from the policy applied for, this form is required at application and the illustration must be obtained upon delivery.*

COMPLETE THIS SECTION IF THE POLICY IS APPLIED FOR OTHER THAN ILLUSTRATED (A REVISED ILLUSTRATION IS NECESSARY):

**I certify that I received an illustration of policy values that differs from the policy I am applying for. I understand that an illustration conforming to the policy as issued will be provided no later than at the time of policy delivery.**

Applicant/policyowner name

Applicant/policyowner signature

**X**

Date

Representative signature

**X**

Date

COMPLETE THIS SECTION IF NO ILLUSTRATION WAS PRESENTED TO THE CLIENT:

**I certify that no illustration of policy values was presented to me and understand that an illustration conforming to the policy as issued will be provided no later than at the time of policy delivery.**

Applicant/policyowner name

Applicant/policyowner signature

**X**

Date

Representative signature

**X**

Date

# Your Privacy Is Important To Us

After completing this application, you may wonder why we've asked so many questions and how we intend to use your answers. We need this information to evaluate your application and calculate the basic cost of your insurance policy.

## Our Sources of Information

Your health, as well as your personal activities are two of the most important factors we consider when evaluating your application for insurance. To learn more about these factors, we gather information from several sources:

- Your application.
- Your physical examination (if one is required).
- Physicians, clinics or medical practitioners who have treated you.
- Insurance companies you have applied to in the past.
- The Medical Information Bureau and/or a consumer reporting agency.

The Medical Information Bureau (MIB) is a nonprofit organization of life insurance companies that acts as an information exchange for its members. This means that we, or our reinsurers, may send the MIB or reinsurers a brief report of factors affecting your insurability and information about any past or future claims. (Underwriting decisions, however, are **not** reported. Information about your insurability will be treated as confidential.) Then, if you apply to another MIB member company for life or disability insurance or submit a claim for benefits, that company has access to the information in your MIB file.

You may request to see the information in your MIB file. If you question the accuracy of any information in your file, you may seek correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act, by contacting the MIB at:

MIB, Inc. • 50 Braintree Hill, Suite 400 • Braintree, MA 02184-8734 • (866) 692-6901 • TTY (866) 346-3642

Minnesota Life, or its reinsurers, may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

In addition to the MIB, we may use a consumer reporting agency to gather information about your personal activities, character, general reputation, personal characteristics (such as health, occupation and finances), and mode of living.

The agency may also interview you or family members, business associates, acquaintances and financial institutions. They may also check public records, including police and motor vehicle records. This report is for insurance purposes only. If you ask, the agency will give you a copy of their report and explain their retention and release practices. You may request to be interviewed in connection with the preparation of the consumer investigative report.

## Safeguarding Your Privacy

Your privacy is important to us. We handle all information we receive from consumer reporting agencies or the MIB according to the provisions of the Federal Fair Credit Reporting Act. Ordinarily, we won't release information about you to third parties unless you authorize us in writing to do so. In rare instances, we may be required to provide some or all of the information without your consent (for example, in response to a summons, a subpoena or a request from a state insurance department). Furthermore, you may request a copy of all information acquired by us. We won't, however, release information we might gather in connection with any claim or civil or criminal proceeding.

Detailed medical information will only be disclosed through the physician of your choice. In addition, we may use some of the information we gather for statistical purposes or marketing research, but you won't be identified individually.

You have the right to find out what personal information is contained in our files, the source of the information, who may have received copies of it within the past two years and to receive by mail or copy in person any such information. If you feel any of the information is incomplete or inaccurate, you may send us a written statement of why you disagree and request to correct it. We will respond within 30 days of your request. If we agree with you, we will make any necessary corrections and inform you and anyone who may have received such information. If we don't agree with you, we will notify you of our decision and add your statement to your file.

## If We Modify Your Policy

If we are unable to issue your coverage as applied for, we will notify you of our decision in writing. We'll also give you specific reasons for our action.

## Questions

If you have any questions or need further details, please contact your agent, or write us at Minnesota Life Insurance Company, P.O. Box 64113, St. Paul, MN 55164-0113.

# Outline of Coverage Accelerated Benefit Agreement

**MINNESOTA LIFE**

Minnesota Life Insurance Company • Life New Business  
400 Robert Street North • St. Paul, Minnesota 55101-2098

This outline describes features of the Accelerated Benefit Agreement which will be issued with your policy. This outline is not a contract, as only the actual Agreement provisions control. It is, therefore, important that, when presented to you for delivery, you Read Your Policy Carefully!

The Accelerated Benefit Agreement provides the option to have part of the policy's death benefit paid to you if the insured has a terminal condition. The payment is a loan against the death benefit, which is repaid when the insured dies. Any balance of the death proceeds will be paid to the beneficiary. The agreement will be included in the policy without premium cost to you. Here are some highlights of the benefit:

1. A terminal condition is one, caused by sickness or accident, which directly results in reducing the insured's life expectancy to 12 months or less. You must supply us with evidence of this fact, certified by a qualified physician. We may also ask for independent verification at our expense.
2. The maximum accelerated benefit is the lesser of 75% of the death benefit or \$1,000,000. The minimum payment is \$10,000. You can have the payment in one sum, or in another mutually agreeable manner.
3. The interest rate will be set when we process the benefit payment. The rate will not exceed the greater of the published Moody's Composite Average of Yields on Bonds, or the policy loan interest rate. Interest on the portion of the unpaid benefit balance, equal to the policy loan value, will not exceed the policy loan interest rate. Unpaid interest will be added to the balance of the accelerated benefit.

If your policy is a term policy, the interest rate will not exceed the greater of the published Moody's Composite Average of Yields on Bonds, or 8%. Interest on the portion of the unpaid benefit balance, equal to the policy loan value, will not exceed 8%. Unpaid interest will be added to the balance of the accelerated benefit.

**4. The policy is affected by accelerated benefits you receive, as follows:**

- **Death proceeds are reduced by the amount of accelerated benefits paid plus accrued interest.**
- **Loan or cash surrender values, if any are associated with this policy, are available only if they exceed the accelerated benefits paid plus accrued interest.**
- **If your policy is a participating policy, we expect no further dividends will be declared for participating policies after the accelerated benefit has been paid.**

**5. This is not long term care or nursing home insurance. And, you may not be eligible for this benefit if:**

- **creditors, in bankruptcy or otherwise, require this option to meet claims; or**
- **a government agency requires this option to apply for, obtain, or keep entitlement benefits.**

**6. The receipt of any accelerated benefit payment may be taxable to you. You should seek assistance from your personal tax advisor.**

Please date and sign as indicated and keep a copy. Send the original copy to Minnesota Life with the insurance application.

I have read this Outline of Coverage on \_\_\_\_\_ (Date).

Witness/Registered Representative Signature

**X**

Applicant Signature

**X**

# Replacement Disclosure Statement

Minnesota Life Insurance Company - A Securian Company  
 Life New Business • 400 Robert Street North • St. Paul, Minnesota 55101-2098

**MINNESOTA LIFE**

Policy number (for existing policies)	Insured name	Owner name (if different from insured)
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This replacement was initiated by:  Policyowner  Representative

## REPLACEMENT DISCLOSURE

I have/will liquidate (includes surrender, loan, or withdrawal) the following products/investments, in conjunction with my insurance purchase:

COMPANY NAME & POLICY NUMBER	PRODUCT LIQUIDATED (i.e.: mutual fund, annuity, cash value or term life insurance)	FULL OR PARTIAL	FACE AMOUNT (Insurance Only)	ANNUAL PREMIUM (Insurance Only)	AMOUNT LIQUIDATED (Surrender or cash value)	SURRENDER CHARGES OR REDEMPTION FEE (\$ Amount)
		<input type="checkbox"/> Full <input type="checkbox"/> Partial	\$	\$	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No \$
		<input type="checkbox"/> Full <input type="checkbox"/> Partial	\$	\$	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No \$
		<input type="checkbox"/> Full <input type="checkbox"/> Partial	\$	\$	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No \$

## PRODUCT SUITABILITY (Life to Life Replacements Only)

To be completed by the Representative:

1. Did you sell the client the replaced policy?  Yes  No
2. Does the client have an exchange or conversion feature with the insurance product they intend to replace? If yes, why is the client not taking advantage of it? \_\_\_\_\_  Yes  No
3. What is the benefit of this replacement to the client? \_\_\_\_\_

## REPLACEMENT ACKNOWLEDGEMENTS

If funds used to purchase this insurance policy come from a lapse, surrender, 1035 Exchange, loan, withdrawal, or other change to any existing life insurance, annuity, or mutual fund, this is considered a replacement and this Disclosure Statement must be completed.

By signing this Disclosure Statement, you acknowledge your understanding of the following in regard to a replacement transaction:

- Issuance of a new policy is subject to underwriting review and approval, and higher risk rating due to health;
- If issued, my new insurance policy will be subject to a new contestability period;
- I will incur new first year expense charges when purchasing this policy;
- I may be subject to capital gain/loss resulting in a tax consequence and have been advised to contact a qualified tax professional to inquire about my individual situation; and
- My policy may be subject to extended surrender charge periods.

## SIGNATURES

I have read and understand the statements in this Disclosure, and the information provided is true and accurate.

Owner signature <b>X</b>	Date
-----------------------------	------

I have appropriately acted on behalf of my client by reviewing all points in this Disclosure. I believe the information provided in this Disclosure Statement is complete and accurate to the best of my knowledge and that this transaction is suitable for the client.

Representative signature <b>X</b>	Date	Firm/rep code
--------------------------------------	------	---------------

Field principal signature ( <b>required only</b> for Variable and Indexed Life sales through Securian Financial Services) <b>X</b>	Date
---	------

Home office signature <b>X</b>	Date
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# Notice Regarding Replacement

**MINNESOTA LIFE**

**Minnesota Life Insurance Company**  
400 Robert Street North • St. Paul, Minnesota 55101-2098

NAME OF APPLICANT *(Please Print)*

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## REPLACING YOUR LIFE INSURANCE OR ANNUITY?

Are you thinking about buying a new life insurance policy or annuity and discontinuing or changing an existing one? If you are, your decision could be a good one - or a mistake. You will not know for sure unless you make a careful comparison of your existing benefits and the proposed benefits.

Make sure you understand the facts. You should ask the agent or company that sold you your existing policy to give you information about it.

Hear both sides before you decide. This way you can be sure you are making a decision that is in your best interest. We are required by law to notify your existing company that you may be replacing their policy.

List below the identification of policies which are involved in the replacement transaction.

COMPANY NAME	COMPANY NAME	COMPANY NAME	COMPANY NAME
CONTRACT NUMBER	CONTRACT NUMBER	CONTRACT NUMBER	CONTRACT NUMBER
APPLICANT'S SIGNATURE <b>X</b>			DATE
AGENT'S SIGNATURE <b>X</b>			DATE



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