

IMO - SECTION B

Agent's Manual

	Page
General Information	B-3
General Information - Traditional Policies	
Policy Provisions	B-4
Nonforfeiture Options	B-5
Payment Plans and Policy Dating	B-6
NAIC Illustration Software and Expense Allocation Method	B-6
Underwriting	
Selection of Risks, Insurable Interest, and Eligible Beneficiaries	B-7
Financial Underwriting, Juvenile Insurance	B-8
Income Factor Chart	B-8
Sports and Hobbies	B-9
Nonmedical Underwriting	
Evidence of Insurability for New Business and Nonmedical Underwriting	B-10
Special Plans and Limits	B-10
Medical Examinations	
Medical Examiners	B-10
Medical Examinations and Unnecessary Medical Expense	B-11
Blood Testing Authorization and Confidentiality	B-11
Approved Paramed Facilities	B-12
Permanent Product Medical Requirements	B-13
Term Product Medical Requirements	B-13.1
Cumulative Rules	B-13.2
Permanent Preferred Underwriting Criteria	B-14
Term Preferred Underwriting Criteria	B-14.1
Substandard	
Impaired Risks and Trial Applications	B-15
Substandard Offers and Substandard Premiums	B-15
Additional and Alternates, Application Groups	B-16
Military Risks (Active and Potential)	B-17
Insurance Information Practices	
The Federal Fair Credit Reporting Act	B-18
Insurance Information and Privacy Acts	B-18
How does our Company comply?	B-18
Applications Taken By Mail Outside Your Primary License State	B-20

Completing the Application

Application Signatures, Dates and Ownership Designation	B-21
Taxpayer Identification Numbers	B-22
Beneficiary	B-22
Section 1035 Exchanges	B-25
Premium Information	B-26
Government Allotments	B-27
Preauthorized Withdrawal Plan (PAW)	B-27
Payroll Deduction	B-28
Premium Deposit Funds	B-31
Delivery and Remittance	B-32

Commissions and Agent's Reports

Commissions	B-35
Agent's Reports	B-35

Policy Administration

Dividends	B-38
Reinstatement	B-41
Surrenders and Policy Changes	B-42
Term Conversions	B-44
Assignments and Policy Loans	B-45
Disability Claims and Death Claims	B-47
How to Make and Election under the Accelerated Death Benefit Rider	B-48
False and Fraudulent Claim Penalty Notices	B-48

Agent's Responsibilities

Contract, Authority, and Conduct of Business	B-49
Policy Replacements	B-50
Checklist for Advertising Guidelines	B-52
Advertising Guidelines	B-54
Policy for Fair Competition and Refraining from Disparaging Competitors ..	B-57
Principles and Code of Ethical Market Conduct	B-60
AR (Agent Responsibility) Form	B-62

General Information

The Lafayette Life Insurance Company was incorporated under the laws of Indiana on December 26, 1905, and commenced business on the same date.

MORTALITY TABLE - All premium rates, cash values and other nonforfeiture values for life insurance plans are based on the 2001 CSO Smoker/Non smoker Mortality Tables.

DIVIDENDS - All regular dividend options are available. Dividends being left with the Company at interest are presently being accumulated at 2.5% interest on policies with a 5% or 6% loan rate. Policies with an 8% loan rate have dividends accumulated at 3.5%. Those policies with a variable loan interest rate (may be referred to as Dynamic Loan interest rate) will have dividends accumulated at 3.5%.

VARIETY OF POLICIES - The variety of insurance contracts issued by the Company is designed to fit the needs of virtually any individual prospect, either through one of our specialized forms or through the flexibility of the Conversion Privilege and the Dividend and income Settlement Options contained in all policies.

DEATH CLAIMS - Death claims are paid promptly upon receipt and approval by the Company. Death claim payments will include a refund of premiums paid beyond the date of death. On individual products introduced for sale before January 1, 2003, interest at the rate of 3.5% per annum will be paid on the net proceeds from the date of death to the date of settlement. On individual products introduced for sale after January 1, 2003, interest at the rate of 2.5% per annum will be paid on the net proceeds from the date of death to the date of settlement. This interest rate is subject to change. State law, in some cases, may require that interest be paid at a different rate.

AUTOMATIC PREMIUM LOAN - Our Ordinary Life policies include an Automatic Premium Loan Privilege which is made operative if elected by the policyowner. This is an important provision in that it acts to prevent inadvertent lapse of the policy.

INSURANCE LIMITS - The minimum amount varies by product and is found in Section C.

AGE LIMITS - The Company will consider applications on male and female lives from ages 5 days to the maximum issue age of the plan, subject to the Company's underwriting rules. Backdating may not be used when the proposed insured is older than the plan's maximum issue age.

INSURANCE AGE - All premiums are based on the age of the proposed Insured at his or her last birthday.

UNISEX - In states where required by law, all policies will be written on a unisex basis. Qualified policies in all states will be written on a unisex basis. Also, non-qualified employee benefit policies must be unisex including payroll deduction, split dollar, reverse split dollar, and Executive Bonus.

STANDARD AND RATED CLASS PREMIUMS - Except where otherwise indicated, premiums shown are for standard risks only. Special Class extra premiums are shown in Section F.

SUBSTANDARD RISKS - Two methods of determining the required extra premiums for substandard risks are used by the Company, depending on the type and degree of the added risk: Table Ratings, and Flat Extra Premiums.

APPLICATION - For new business, Application 1459* is used for all non-qualified and qualified plans of life insurance except for Protector 15 simplified issued which uses Application 1462*. Application 2699* is used only for Marquis SP, for all other annuities please use Application 1460*.

*Forms required by your state are available on the company website or may be ordered by supply.

The page titled 'Insurance Information Practices' is to be torn off and given to the Proposed insured at time of application.

Other applications are indicated elsewhere in this manual for Conversion, Policy Increase or Policy Change.

If the applicant does not understand or read English, an application can be accepted where the agent is bilingual and speaks both English and the language of the applicant. This requirement assures that the applicant has understood the questions asked and that the Agent is signing as a witness and attesting to the answers given. Normally these applicants will need to be fully examined.

General Information - Traditional Policies

POLICY PROVISIONS - Only a brief description of a few of the various policy provisions is attempted here, and the Agent is urged to make a diligent study of the policy contracts themselves and the succeeding pages of this manual for a more complete understanding of them. In the case of older series policies, the provisions in those policies may be different from those described in this manual.

The laws of certain states require various modifications in some policy provisions. The following policy provisions are standard policy provisions. Questions regarding the requirements for your state on newly issued policies should be directed to the Underwriting Department.

PAYMENT OF PREMIUMS - Premiums are due and payable in advance at the Home Office of the Company. However, no premium is payable whose due date occurs after the date of the Insured's death. Changes in method of payment of premium may be made by written request. Failure to pay any premium when due (or within the grace period) shall cause the policy to lapse.

GRACE PERIOD - A grace period of 31 days is allowed for the payment of every premium after the first. If death occurs within the grace period and before the premium in default has been paid, the overdue premium will be deducted in the settlement of the claim.

PREMIUM REFUND AT DEATH - Where applicable, the Company will refund, as part of the policy proceeds, that portion of any premiums paid for a period beyond the date of the Insured's death.

INCONTESTABILITY - The policy becomes incontestable after it has been in force for two years during the lifetime of the insured from its date of issue, except for nonpayment of premium. The policy becomes contestable again upon reinstatement following lapse. Any increase in the death benefit that is NOT the result of GPO is also contestable for two years from the date of increase. Generally, an increase in the death benefit as a result of a dividend option will not be contestable after the policy's contestable period expires. However, an increase in the death benefit as a result of a change in the dividend option, after issue, to paid-up additions will be contestable for a period of two years from the date of the increase.

SUICIDE - The policy does not insure against death by suicide, whether sane or insane, during the first policy year. The liability of the Company is limited in this case to the premiums paid. The suicide clause is renewed as of the date of formal reinstatement of a lapsed policy. The one year suicide clause will also apply to any increase that is NOT the result of GPO or a dividend option.

LAPSE AND REINSTATEMENT - At any time within 5 years after default in premium payment, the policy, if not previously surrendered, may be reinstated if evidence of insurability satisfactory to the Company is furnished and payment of overdue premiums with interest and the payment or reinstatement of indebtedness and the interest thereon, provided that such indebtedness with interest to date of reinstatement is not greater than the loan value of the policy if reinstated. For policy series 1979 and after, interest is 6% per year. For policy series prior to 1979, interest is 5% per year. See REINSTATEMENT, Page B-41.

OWNERSHIP AND CONTROL - The Owner is the person or entity named on page three of the policy. All policy rights may be exercised by the Owner without the consent of any revocable beneficiary.

If the owner does not wish to reserve the right to change the beneficiary, the Owner may name the beneficiary irrevocably. This should be indicated on the application and the beneficiary designation will be worded accordingly.

BENEFICIARY DESIGNATIONS - See BENEFICIARY, Page B-22.

ASSIGNMENTS - See ASSIGNMENTS AND POLICY LOANS, Page B-45.

MISSTATEMENT OF AGE, SEX, OR SMOKING STATUS - If the age, sex, or smoking status of the Insured has been misstated, the Company will adjust all benefits to the amount which the premium paid would have purchased at the correct age, sex, and smoking status. Any such misstatement discovered by the Agent should be promptly reported to the Home Office so that the proper adjustment can be made.

FREE LOOK PERIOD - All policies contain a provision which allows a policyholder time from the delivery date to examine the policy and return it for any reason for a full refund of premiums paid. Most policies allow twenty days. Some plans and states differ.

STATEMENTS IN APPLICATION - All statements made in the application (including, if applicable, Part II (Answers Made to the Medical Examiner)), are representations. No such statement shall be used to invalidate the policy or shall be used in defense of a claim unless contained in an application for the policy.

DEFERMENT OF CERTAIN PAYMENTS - If the policy provides for cash or loan values, payment of the cash value or the making of any loan, other than to pay premiums on policies in the Company, may be deferred by the Company for not more than 6 months. If payment of the cash value is deferred for 30 days or more, it shall bear interest at the current rate set by the Company or as required by various state regulations.

POLICY, APPLICATIONS AND MODIFICATIONS - The entire contract consists of the policy, any riders, endorsements and the attached application. Only an officer of the Company may change policy provisions. The Company may require that the policy be submitted for endorsement to show any change.

POLICY CHANGE - The policy may be changed to another form, kind or plan of insurance not prohibited by law, subject to approval by the Company and to payment of such cost and furnishing of such requirements as the Company may consider necessary.

CHANGE OF INSURED - For the Patriot 100, Contender 100, and GPWL-15 policies only there is a provision which allows the Owner to change the Insured on the policy to a different person subject to evidence of insurability and payment of any required costs.

nonforfeiture options

All life policies, (except term insurance), have guaranteed nonforfeiture options which are available in accordance with the terms of the policy contract. These options are based on the cash value of the policy.

CASH VALUE - Surrender of the policy for its net cash value (guaranteed cash value plus cash value of any paid-up additions plus the amount of any dividend accumulations less any indebtedness less any surrender charge). (See "Surrenders" page B-42.)

PAID-UP INSURANCE - Continue the policy for reduced participating Paid-Up Insurance purchased by the net cash value at the attained age.

EXTENDED TERM INSURANCE - Continue the policy as Extended nonparticipating Term Insurance for the face amount of the policy (excluding benefits and riders) less any indebtedness, and for such term period as the net cash value will purchase at the attained age of the Insured. (We will deduct any policy indebtedness from the cash surrender value and then use the net cash value to purchase term insurance for the basic amount of the policy plus any dividend additions, less indebtedness, for the maximum period possible, but not exceeding the term of the original policy.)

Life policies, however, contain a Premium Loan Provision. This may be made automatic if the applicant requests. (See "Automatic Premium Loan Provision," page B-41.)

automatic nonforfeiture option

By automatic it is meant that if on the expiration of the grace period the premium has not been paid, the insurance will be continued under the option selected, immediately and automatically. In compliance with the requirements of the present law, our policies, having nonforfeiture values provide that the Extended Term Insurance option will apply automatically, unless the owner otherwise notifies us in writing.

SUBSTANDARD POLICIES - Extended term insurance is not granted on substandard issues with Table ratings over B or flat extra ratings of over \$5.00 per \$1,000 and over 5 years. (See "Substandard Insurance" on page B-15). In such cases, reduced paid-up insurance is the automatic nonforfeiture option.

Note: Although reduced paid-up insurance or extended term insurance may be the automatic option in the substandard issues outlined in the previous paragraph, the Owner must select the Premium Loan Privilege on the application and must make it automatic.

CHANGE IN AUTOMATIC OPTION - The automatic nonforfeiture option may be changed at any time within 3 months after the due date of any premium in default.

payment plans

ELECTION OF PAYMENT PLAN - The Owner may elect a payment plan during the lifetime of the Insured or within 60 days following the death of the Insured by written notice to the Home Office. If no election is made, the Interest Income Plan will be in effect.

ELECTION BY BENEFICIARY - If the Owner has not made an election, the beneficiary may do so within 60 days following the Insured's death.

A complete description of all Payment Plans is given in Section H.

POLICY DATING

Each policy will be dated the day that it is issued by the Company with the following exceptions.

- Policies issued on the 29th, 30th, or 31st of a month will be dated the 1st of the following month.
- Policies paid by payroll deduction will be dated on the 1st – 28th of the month.
- Policies paid by government allotment will be dated the 1st day of the month in which the first allotment is received by the Home Office.
- Policies with SPUA or LPUA riders of \$1,000 or more will be dated the day the money is received in the Home Office, when received before issue.
- 1035 External Exchanges will be dated the day the 1035 money is received in the Home Office.

BACKDATING

Some states have limitations on backdating of policies.

Two examples are:

- Ohio — Backdating is limited to 3 months
- Tennessee — May date back to last birthday if not over 6 months

Lafayette Life's general rule for backdating is as follows unless prohibited by state law:

A policy may be written with a backdate resulting in a younger age at issue, provided that such date is not more than 6 months before the date of application nonmedical or Exam Part 2, whichever is later. (In no event is the application to bear any date other than the actual date of completion.) Backdating may not be used when the proposed insured's actual age is older than the plan's maximum issue age.

Special dating requests should be indicated in the 'Special Request' section of the application.

DATING FORWARD - Occasionally there may be a request to date the policy ahead without payment. Cases so submitted cannot be dated more than 60 days in advance of the current date and the policy will be held in the Home Office and released not more than 15 days ahead of the effective date. In such cases the application should always bear the date on which it is completed and instructions as to dating a policy made in the Special Request section. The age to use in all such applications will be the insurance age of the applicant on the advanced date.

NAIC Illustration Software and Expense Allocation Method

Under the National Association of Insurance Commissioners (NAIC) regulations on illustrations, Lafayette Life is required to notify agents regarding the type of Expense Allocation Method used for calculating expenses on policy illustrations. Lafayette Life uses the fully allocated expense method.

Underwriting

selection of risks

The underlying principle of life underwriting is the selection of good risks. Responsibility for acceptance of a risk, or for its rejection, rests with the Home Office of the Company, but the screening of the risks properly begins with the Agent.

It is always the obligation of the Agent to furnish the Company with all information that has or can be secured, bearing upon the qualification for insurance of a proposed Insured. The Agent owes it to himself or herself and to the Company to pay due regard to the physical and financial aspects of each risk, and to the environment as well. The Agent will be more financially successful by expending effort in finding prospects that are good risks than utilizing this amount of effort in trying to induce the Company into taking poor risks or by trying to influence the Company to reduce an extra premium.

In every case, the Agents should carefully consider the character, habits, physical fitness, build, occupation, environment, and financial responsibility of the prospect.

If, after an application is secured and mailed to the Home Office, the life to be insured becomes impaired or if the Agent receives any information which causes the Agent to suspect an unfavorable condition of health or to doubt the good faith of the applicant, full details should be immediately sent to the Home Office. If the policy has already been sent to an Agent for delivery, it should be returned immediately to the Home Office for further review.

Each Lafayette Life representative is expected to work toward the realization of the best interest of the policyowner, the Company, and the representative. The purpose of this section of the Agents' Manual is to provide the basic information needed for underwriting in the Field and to set forth the rules applicable to such underwriting. The Company reserves the right to modify its underwriting rules and the right to establish additional requirements, where appropriate.

insurable interest

Generally, an Insured, applying for insurance on his or her own life, has an unlimited insurable interest in his or her own life and can name any person, unless prohibited by state law, as his or her beneficiary. However, the Company does reserve the right, where the Insured is to be the Owner of the proposed policy, to apply its regular underwriting rules concerning insurable interest with regard to the designation of a beneficiary.

Where an application for insurance on the life of the Insured is made by another person (who will be the Owner), the Company will only issue the policy if the Owner and the beneficiary have an insurable interest in the life of the Insured. An insurable interest ordinarily exists if the beneficiary or beneficiaries named in the application are (1) connected with the Insured by ties of blood or marriage or (2) have a business relationship with the Insured and expect to derive support or other financial advantage or benefit from the continuance of the Insured's life.

NOTE: If the Insured will be the Owner and the proceeds of the policy are intended to, at least in part, secure a debt to a financial institution or another person, a collateral assignment should be executed in favor of that institution or person and someone else named as beneficiary who would receive the balance of the net proceeds, if any, after the obligation secured by the collateral assignment has been satisfied. If permitted by the insurable interest regulations of the particular state, a creditor may own a policy on the life of the Insured, subject to the Company's underwriting requirements.

eligible beneficiaries

Although it is impossible to lay down rules covering all situations in which an insurable interest exists, the following situations are most common:

1. A husband has an insurable interest in the life of his wife; and a wife has an insurable interest in the life of her husband.
2. A child has an insurable interest in the life of a parent if the child would lose financial benefit or incur tax or financial responsibilities as a result of the death of the Insured. This may also be true of other blood relationships.
3. A parent has a limited insurable interest in the life of his child. Only under unusual circumstances does a relative other than a parent possess an insurable interest. The Agent should furnish complete information in all such cases. In all cases the written consent of a parent should be obtained and usually the parent should be named as beneficiary and owner.
4. A creditor has an insurable interest in the life of a debtor. The amount of insurance, however, must not exceed the amount of the debt and it must appear that the debtor will be able to repay if he or she lives. Such situations are handled, not by means of a beneficiary designation, but through the use of a collateral assignment of the insurance policy.
5. Business partners and stockholders of closely-held corporations have an insurable interest in the lives of each other.
6. A corporation has an insurable interest in the life of an officer or employee who is a key person in its business.
7. A religious, charitable or benevolent institution has an insurable interest in the life of an active or potential contributor.

These rules may vary from state to state.

If in any doubt as to whether an insurable interest exists, the Agent should submit the facts to the Home Office before writing the application.

financial underwriting

In determining the upper amount limits of personal insurance, good underwriting requires that the Company observe rules that will prevent speculation and avoid excess mortality when large amounts of insurance are sought. Speculation in life insurance occurs when an individual purchases more insurance than his income or financial position warrants, or where the amount payable at death creates an insurance estate not in keeping with the reasonable financial value of the life to be insured. Such overinsurance may, in fact, occur under the best intentions of applicant and Agent. Regardless, mortality statistics show conclusively that overinsurance produces costly excess mortality. For these reasons, it must be assumed that new applications will be approved only for amounts that will result in total insurance, in force and applied for, being a reasonable amount even though the premium for the plan applied for seems relatively modest.

The Underwriting Department reserves the right to request a financial supplement (Form 1277) on any application, regardless of the amount applied for when we feel it deemed appropriate. Income is an important consideration in the financial underwriting of insurance. The following income factors should be used as guidelines when determining the upper limits of personal insurance.

INCOME FACTOR CHART GUIDELINES

Current age	Income Factor
18 to 30	30x's
31 to 35	25x's
36 to 40	25x's
41 to 45	20x's
46 to 50	20x's
51 to 60	15x's
61 to 65	10x's
66 & up	05x's

Other specific financial conditions on any particular case may cause the final policy face amount to be higher or lower than the Income Factor Chart Guidelines may suggest. Multiples are maximums for income consideration. In addition, you should consider other non-financial circumstances when determining the insurance coverage amount.

BROTHERS AND SISTERS—If the proposed child Insured has any brothers or sisters who are eligible for juvenile insurance, but no insurance is sought for these brothers and sisters, a reason should be given for excluding them. Normally, it is expected that all children in a family will be insured for equal amounts. If it is desired otherwise, an explanation should accompany the application.

WHO MAKES APPLICATION—On a juvenile application, when the Owner will not be (1) a parent, (2) a legal guardian of the minor with the power to apply for an insurance policy on the life of the minor, or (3) a parent as custodian pursuant to the Uniform Gifts to Minors Act or Uniform Transfers to Minors Act, whichever is applicable, one of the parents, if living, must also sign the application.

NOTE: The Company's rules regarding insurable interest shall also apply. See *insurable interest*, Page B-7.

NONMEDICAL—No medical examination is usually required on a child unless the amount applied for, plus other insurance on the same life in this Company, totals more than the regular limit for nonmedical insurance. However, the Company reserves the right to require an examination on any case. See PAYOR Insurance, Page B-10 for nonmedical rules on the Payor Insurance Benefit.

WAIVER DISABILITY BENEFIT—The WPD or WMD benefit may be included in any juvenile policy. The benefit is effective from the date of issue.

During the past few years, civil and political unrest with its revolutions, uprisings and wars has occurred in almost every quarter of the globe. Because of this unrest in the past and the possibility of its continuing into the future, ranges of ratings rather than specific ratings for given areas are indicated below:

sports and hobbies

There are certain sports and hobbies for which there is enough hazard that an extra premium charge must be made. It would be impossible to give all of the potential ratings involved since they can vary so much, depending upon the circumstances; however, below is a list of most of the sports and hobbies for which an extra premium is charged and benefits are modified. It is important to remember that where ratings are shown, they will not necessarily apply in all cases, and that individual consideration is given to each case.

1. RACING—This sport covers all types of vehicle racing and includes professional as well as amateur. We have a special racing questionnaire which asks the information required to assess the proper rating. The rating, if any, is contingent on many factors including the number of races, the type and size of engine, the length of the racing

2. DIVING

- a. *Sky-Diving*—The best risks in this category are those affiliated with a parachute club which requires strict adherence to safety regulations, and these usually can be issued at a minimum rating of \$3.00 extra per thousand without benefits.
- b. *Skin and Scuba Diving*—Divers are usually taken on a standard basis when they dive only for sport and to depths of less than 100 feet. Higher ratings may be involved for divers going below 100 feet or engaging in an experimental type of underwater work or doing salvage work on wrecks in hazardous areas.

NONMEDICAL UNDERWRITING

evidence of insurability for new business

"Evidence of Insurability" is an all-inclusive term embracing a variety of underwriting factors (e.g. health, occupation, avocation, finances, etc.).

"NONHEALTH FACTORS" — Part 1 of the application is used to establish evidence for the "nonhealth" factors.

HEALTH FACTORS — Evidence of health is submitted in one of two ways:

1. By what is commonly referred to as the "Nonmedical" (Part 2, page 3 of the application).
2. By Medical Examination. This form (1461) is used by medical doctors or paramedical technicians for ages and/or amounts not permitted the nonmedical privilege, or for other situations when requested by the Company.

nonmedical underwriting

AGENT RESPONSIBILITY — In accepting the privilege of writing on the nonmedical basis, the Agent assumes responsibility of protecting the Company's interest, particularly by ascertaining, as completely as possible, all facts concerning the applicant which are pertinent to the insurability of the risk, and reporting these fully to the Home Office.

WITHDRAWAL OF PRIVILEGE — The Company reserves the right (a) to require any nonmedical applicant to take a medical examination by a Company examiner at its expense; (b) to withdraw or modify these rules, or to issue further rules or instructions at any time; (c) to withdraw the nonmedical privilege from any territory, agency, or Agent whenever general or local conditions are such that the nonmedical business is unsatisfactory to the Company.

APPLICANT ELIGIBILITY — Both men and women who speak, read, and write English may be written on the nonmedical basis. Persons foreign born should be fully naturalized or have a permanent visa. Standard risks only can be accepted, except that when applicant is standard physically, but a flat (and not otherwise) extra premium for occupation is required by the Company's latest published occupational ratings, the policy will usually be issued on a nonmedical basis.

MAXIMUM AMOUNTS — Contact the Home Office.

special plans and limits

GUARANTEED PURCHASE OPTION — Add the amount of the first option to the initial amount applied for and apply the total to the regular nonmedical limit.

GUARANTEED INCREASE OPTION — Add the amount of the first option to the initial amount applied for and apply the total to the regular nonmedical limit.

PAYOR INSURANCE — The nonmedical limit for Payor Insurance is determined by the annual premium for the Payor Insurance Benefit. The nonmedical limit is \$125 of annual Payor Insurance premium for payor ages 18-40 and \$50 of premium for payor ages 41-50.

ACCIDENTAL DEATH BENEFIT — The Accidental Death Benefit will be issued in connection with nonmedical policies, subject to the regular rules regarding the issuance of these benefits.

APPLICATION FORMS — Applications are submitted nonmedically by completing the "Part 2 Nonmedical" sections of the application. Do not promise or guarantee the issue of a policy on a nonmedical basis.

MEDICAL EXAMINATIONS

The Company accepts Paramedical Examinations from authorized paramedical companies. (See APPROVED NATIONWIDE PARAMED FACILITIES, Page B-12.)

medical examinations

Medical examinations are to be made privately without an Agent or third person present, and examinations are sent directly to the Home Office by the medical examiner or paramedical technician. Medical exams are to be completed using Lafayette Life's medical exam Form 1461. This form varies by state. The Agent will be provided with appropriate forms. Any out-of-state exams must be discussed with an Underwriter first so that the proper form can be provided to you.

unnecessary medical expense

BEFORE ARRANGING FOR EXAMS OR INSPECTIONS, COMPLETED APPLICATION AND AUTHORIZATION FORMS MUST BE SIGNED. In states where the Insurance Information and Privacy Protection laws are in effect, information cannot be collected or used until the proper forms have been signed and the individual is given written notice of its collection and intended use (Insurance Information Practices Form). In addition, medical questionnaires and examinations quickly become outdated for Underwriting purposes. Send the completed application to the New Business Department immediately. Do not hold on to an application. If no application is received within 30 days of our receipt of medical information for which we have been charged, our cost will be charged to you, the Agent.

Before arranging for exams, be sure to check Underwriting Requirements Charts on Pages B-13 and B-13.1. ARRANGE FOR ONLY THOSE EXAMS AND TESTS THAT ARE NECESSARY. If any unnecessary exams are received for an application, we may charge you the amount which we are charged.

blood testing authorization

Several states have adopted special Blood Testing Regulations. In those states special procedures must be followed which include obtaining special consent authorizations BEFORE THE BLOOD TEST IS SCHEDULED. The special state version of Form 1556 must be sent to the Home Office for our records, in addition to you following any other state blood test requirements.

If you are unaware of your state regulations contact the Underwriting Team.

In other states, the Paramed or Doctor will obtain the Proposed Insured's signature on a Consent and Notice Authorization Form before drawing blood. Parameds and Doctors handle only the "basic" authorization form which is part of Home Office Reference Lab's blood kit, and does not include any special state forms.

Where permitted, blood and urine samples will be tested for the presence of antibodies to the AIDS virus and for the presence of nicotine and cocaine. These tests will also disclose other relevant medical information about the health of the proposed Insured. When the results of a test sample are positive for exposure to the AIDS virus, the approved testing protocol will be utilized before a final Underwriting decision is made. This will generally not require that an additional test sample be taken.

confidentiality

Confidentiality is of primary importance in the case of the medical history of all proposed Insureds. The Underwriting Department will not tell the Agent specific information about the medical history of an individual which was discovered in the course of our underwriting of the risk. The Company has an obligation in some states to notify the proposed Insured of our decision if we have determined that we cannot offer insurance coverage. However, it is our practice to only release test results directly to the proposed Insured's doctor, unless otherwise required or permitted by applicable state law or regulations. Our Home Office personnel are aware of the need to maintain confidentiality of policy records in accordance with the applicable law, particularly those which relate to a proposed Insured's medical history.

APPROVED NATIONWIDE PARAMED FACILITIES

Call phone numbers listed for Nationwide Paramed Facilities to obtain listing of Paramed Facility in your area.

American Para Professional Systems (APPS)*

1-800-727-2101

Exam One

1-800-768-2071

For Personal Health Interview (PHI)**

Lafayette Life Home Office

1-888-283-9368

*APPS. This includes Portamedic (previously a HooperHolmes Company) purchased by APPS.

**PHI is not a paramedic provider. It is used for Protector phone interviews only, not for examinations.

PERMANENT PRODUCT MEDICAL REQUIREMENTS

Underwriting Requirements										Attending Physician Statement (APS)				
Table Based on Total Amount Applied, including Base, PUA's, and Riders														
Permanent Product Portfolio														
Age	Amount Applied For													
	From	To												
	0-17	UW Discretion												
	18-59	\$2,000,000 & up												
	60-69	\$1,000,000 & up												
70-79	\$100,000 & up													
80-85	*Any Amount													
*May not apply to the Protector Product														
0-15	\$0.00	\$999,999.99	Non-Med											
	\$1,000,000.00+		Contact Underwriting											
16-17	\$0.00	\$100,000.00	Non-Med											
	\$100,000.01	\$999,999.99	Paramed	Blood	Urine									
	\$1,000,000.00	\$5,000,000.00	Paramed	Blood	Urine	MVR	Database	Pharmacy	Fin-1277					
	>\$5,000,000.00	Paramed	Blood	Urine	MVR	Database	Pharmacy	Fin-1277	EKG	Inspection				
18-40	\$0.00	\$100,000.00 (Std)	Non-Med											
	\$100,000.00 (Pref)		Paramed	Blood	Urine									
	\$100,000.01	\$500,000.00	Paramed	Blood	Urine									
	\$500,000.01	\$999,999.99	Paramed	Blood	Urine	MVR								
	\$1,000,000.00	\$5,000,000.00	Paramed	Blood	Urine	MVR	Database	Pharmacy	Fin-1277					
	>\$5,000,000.00	Paramed	Blood	Urine	MVR	Database	Pharmacy	Fin-1277	EKG	Inspection				
41-50	\$0.00	\$100,000.00 (Std)	Non-Med											
	\$100,000.00 (Pref)		Paramed	Blood	Urine									
	\$100,000.01	\$500,000.00	Paramed	Blood	Urine									
	\$500,000.01	\$999,999.99	Paramed	Blood	Urine	MVR								
	\$1,000,000.00		Paramed	Blood	Urine	MVR	Database	Pharmacy	Fin-1277					
	\$1,000,000.01	\$5,000,000.00	Paramed	Blood	Urine	MVR	Database	Pharmacy	Fin-1277	EKG				
>\$5,000,000.00	Paramed	Blood	Urine	MVR	Database	Pharmacy	Fin-1277	EKG	Inspection					
51-60	\$0.00	\$100,000.00 (Std)	Paramed	Urine										
	\$100,000.00 (Pref)		Paramed	Blood	Urine									
	\$100,000.01	\$500,000.00	Paramed	Blood	Urine									
	\$500,000.01	\$999,999.99	Paramed	Blood	Urine	MVR								
	\$1,000,000.00		Paramed	Blood	Urine	MVR	Database	Pharmacy	Fin-1277					
	\$1,000,000.01	\$5,000,000.00	Paramed	Blood	Urine	MVR	Database	Pharmacy	Fin-1277	EKG				
>\$5,000,000.00	Paramed	Blood	Urine	MVR	Database	Pharmacy	Fin-1277	EKG	Inspection					
61-65	\$0.00	\$99,999.99	Paramed	Urine										
	\$100,000.00 (Std & Pref)		Paramed	Blood	Urine	EKG								
	\$100,000.01	\$500,000.00	Paramed	Blood	Urine	EKG								
	\$500,000.01	\$999,999.99	Paramed	Blood	Urine	EKG	MVR							
	\$1,000,000.00	\$5,000,000.00	Paramed	Blood	Urine	EKG	MVR	Database	Pharmacy	Fin-1277				
	>\$5,000,000.00	Paramed	Blood	Urine	EKG	MVR	Database	Pharmacy	Fin-1277	Inspection				
66-70	\$0.00	\$49,999.99	Paramed	Urine										
	\$50,000.00	\$99,999.99	Paramed	Urine	EKG									
	\$100,000.00 (Std & Pref)		Paramed	Blood	Urine	EKG								
	\$100,000.01	\$500,000.00	Paramed	Blood	Urine	EKG								
	\$500,000.01	\$999,999.99	Paramed	Blood	Urine	EKG	MVR							
	\$1,000,000.00	\$5,000,000.00	Paramed	Blood	Urine	EKG	MVR	Database	Pharmacy	Fin-1277				
>\$5,000,000.00	Paramed	Blood	Urine	EKG	MVR	Database	Pharmacy	Fin-1277	Inspection					
71-75	\$0.00	\$49,999.99	Paramed	Blood	Urine									
	\$50,000.00	\$99,999.99	Paramed	Blood	Urine	EKG								
	\$100,000.00 (Std & Pref)		Paramed	Blood	Urine	EKG								
	\$100,000.01	\$500,000.00	Paramed	Blood	Urine	EKG								
	\$500,000.01	\$999,999.99	MD Exam	Blood	Urine	EKG	MVR							
	\$1,000,000.00	\$5,000,000.00	MD Exam	Blood	Urine	EKG	MVR	Database	Pharmacy	Fin-1277				
>\$5,000,000.00	MD Exam	Blood	Urine	EKG	MVR	Database	Pharmacy	Fin-1277	Inspection					
76-79	\$0.00	\$49,999.99	Paramed	Blood	Urine									
	\$50,000.00	\$99,999.99	Paramed	Blood	Urine	EKG								
	\$100,000.00	\$500,000.00	Paramed	Blood	Urine	EKG	Database	Pharmacy						
	\$500,000.01	\$999,999.99	MD Exam	Blood	Urine	EKG	Database	Pharmacy	MVR					
	\$1,000,000.00	\$5,000,000.00	MD Exam	Blood	Urine	EKG	Database	Pharmacy	MVR	Fin-1277				
	>\$5,000,000.00	MD Exam	Blood	Urine	EKG	Database	Pharmacy	MVR	Fin-1277	Inspection				
80 & up	\$0.00	\$49,999.99	Paramed	Blood	Urine									
	\$50,000.00	\$99,999.99	Paramed	Blood	Urine	EKG								
	\$100,000.00	\$500,000.00	Paramed	Blood	Urine	EKG	Database	Pharmacy						
	\$500,000.01	\$999,999.99	MD Exam	Blood	Urine	EKG	Database	Pharmacy	MVR					
	\$1,000,000.00	\$5,000,000.00	MD Exam	Blood	Urine	EKG	Database	Pharmacy	MVR	Fin-1277				
	>\$5,000,000.00	MD Exam	Blood	Urine	EKG	Database	Pharmacy	MVR	Fin-1277	Inspection				

TERM PRODUCT MEDICAL REQUIREMENTS

Underwriting Requirements Table Based on Total Amount Applied, including Base, PUA's, and Riders Term Product Portfolio								Attending Physician Statement (APS)					
								Age		Amount			
								18-59	\$2,000,000 & up				
Age	Amount Applied For												
	From	To									60-69	\$1,000,000 & up	
											70-75	\$100,000 & up	
18-40	\$100,000.00	\$999,999.99	Paramed	Blood	Urine	MVR							
	\$1,000,000.00	\$5,000,000.00	Paramed	Blood	Urine	MVR	Database	Pharmacy	Fin-1277				
	>\$5,000,000.00		Paramed	Blood	Urine	MVR	Database	Pharmacy	Fin-1277	EKG	Inspection		
41-45	\$100,000.00	\$999,999.99	Paramed	Blood	Urine	MVR							
	\$1,000,000.00		Paramed	Blood	Urine	MVR	Database	Pharmacy	Fin-1277				
	\$1,000,000.01	\$5,000,000.00	Paramed	Blood	Urine	MVR	Database	Pharmacy	Fin-1277	EKG			
	>\$5,000,000.00		Paramed	Blood	Urine	MVR	Database	Pharmacy	Fin-1277	EKG	Inspection		
46-50	\$100,000.00	\$499,999.99	Paramed	Blood	Urine								
	\$500,000.00	\$999,999.99	Paramed	Blood	Urine	MVR							
	\$1,000,000.00		Paramed	Blood	Urine	MVR	Database	Pharmacy	Fin-1277				
	\$1,000,000.01	\$5,000,000.00	Paramed	Blood	Urine	MVR	Database	Pharmacy	Fin-1277	EKG			
	>\$5,000,000.00		Paramed	Blood	Urine	MVR	Database	Pharmacy	Fin-1277	EKG	Inspection		
51-60	\$100,000.00	\$499,999.99	Paramed	Blood	Urine								
	\$500,000.00		Paramed	Blood	Urine	MVR							
	\$500,000.01	\$999,999.99	Paramed	Blood	Urine	MVR	EKG						
	\$1,000,000.00	\$5,000,000.00	Paramed	Blood	Urine	MVR	EKG	Database	Pharmacy	Fin-1277			
	>\$5,000,000.00		Paramed	Blood	Urine	MVR	EKG	Database	Pharmacy	Fin-1277	Inspection		
61-65	\$100,000.00	\$499,999.99	Paramed	Blood	Urine	EKG							
	\$500,000.00	\$999,999.99	Paramed	Blood	Urine	EKG	MVR						
	\$1,000,000.00	\$5,000,000.00	Paramed	Blood	Urine	EKG	MVR	Database	Pharmacy	Fin-1277			
	>\$5,000,000.00		Paramed	Blood	Urine	EKG	MVR	Database	Pharmacy	Fin-1277	Inspection		
66-70	\$100,000.00	\$499,999.99	Paramed	Blood	Urine	EKG							
	\$500,000.00	\$999,999.99	Paramed	Blood	Urine	EKG	MVR						
	\$1,000,000.00	\$5,000,000.00	Paramed	Blood	Urine	EKG	MVR	Database	Pharmacy	Fin-1277			
	>\$5,000,000.00		Paramed	Blood	Urine	EKG	MVR	Database	Pharmacy	Fin-1277	Inspection		
71-75	\$100,000.00	\$499,999.99	Paramed	Blood	Urine	EKG							
	\$500,000.00	\$999,999.99	MD Exam	Blood	Urine	EKG	MVR						
	\$1,000,000.00	\$5,000,000.00	MD Exam	Blood	Urine	EKG	MVR	Database	Pharmacy	Fin-1277			
	>\$5,000,000.00		MD Exam	Blood	Urine	EKG	MVR	Database	Pharmacy	Fin-1277	Inspection		

CUMULATIVE RULES

These rules specify the method of applying nonmedical limits and amounts for all requirements.

Add amount of current Lafayette Life policies in force to the new amount applied for when determining limits as follows:

1. Use all in force business from the last 3 years when adding the total to determine requirements.
2. When determining Blood Profile limits, add the total amount of in force business from the last 3 years.
3. As each requirement is met, it may be waived for the next application, unless the new amount applied for calls for that requirement to be completed again.
4. Evidence on applications is good for 60 days. Other medical requirements (EKG, Blood Profile, Chest X-ray,...) are good for 12 months.
5. On replacement of in force Lafayette Life business with a new Lafayette Life policy:
 - a. If the last policy was issued medically within 3 years and replacement amount of coverage is \$ for \$ or less than the existing amount, then nonmedical evidence will be adequate.
 - b. If the last policy was issued nonmedically or, medically over 3 years ago, obtain evidence based on the current age and amount applied for.
 - c. If the new policy is greater in amount than the policy(ies) being replaced, and replaced policy(ies) are less than 3 years in force, obtain evidence based on the difference in the amounts.

Lafayette Life Permanent Preferred Underwriting Criteria

Preferred Category	Super Preferred NTU	Preferred NTU
		Preferred TU
General	Must be clearly standard; no temporary or flat extra ratings	
Tobacco or Nicotine Use	• None in last 60 months	• None in last 24 months • Occasional cigar use may qualify for NTU if 12 or fewer cigars per year and urinalysis negative for cotinine <i>Less than one pack of cigarettes per day or any amount of other tobacco is Preferred TU</i>
Personal Medical History	• No history of cardiovascular disease, cerebrovascular disease, cancer (except superficial skin cancer), diabetes, or respiratory disease • No ratable conditions or labs (HbA1c ≤ 5.6)	• No history of cardiovascular disease, cerebrovascular disease, cancer (except superficial skin cancer), diabetes, or respiratory disease • No ratable conditions or labs (HbA1c ≤ 6.0)
Blood Pressure	• Ages ≤ 50 130/80 or less • Ages > 50 135/85 or less • Ok to be under treatment	• Ages ≤ 50 135/85 or less • Ages > 50 140/90 or less • Ok to be under treatment <i>Not under treatment if Preferred TU</i>
Cholesterol	• 230 or less chol/HDL ratio 5.0 or less • Ok to be under treatment if well controlled	• 240 or less chol/HDL ratio 6.0 or less • Ok to be under treatment <i>Not under treatment if Preferred TU</i>
Build	See Non-Term Preferred Build Table	
Family History	• No parent/sibling death from heart disease prior to age 60 • No features of the family history that suggest a hereditary cancer risk • Age 66+ family history is not applicable	• One or no parent/sibling death from heart disease prior to age 60 • No features of the family history that suggest a hereditary cancer risk • Age 66+ family history is not applicable
Driving Violations	• No DUI, reckless driving, or suspensions in last 5 years • No more than 1 moving violation or accident in the last 5 years	• No more than 1 moving violation or accident in the last 2 years
Alcohol & Drugs	• No history of treatment, counseling, or adverse illegal alcohol or drug abuse	• No treatment, counseling, or abuse in last 10 years
Hazardous Sports, Occupation, Aviation	• No participation in hazardous sports • Not in hazardous occupation • No participation in private aviation unless aviation exclusion rider is applied	• No participation in ratable sports • Not in ratable occupation • No participation in ratable private aviation unless aviation exclusion rider is applied
Foreign Residence or Travel	• US citizens and permanent legal residents only (green card holders) • No residence outside US or Canada • No foreign travel plans to under-developed or politically unstable countries	

Weight (in lbs.)

Height	Super Preferred NTU			Preferred NTU/ Preferred TU
	<u>min female</u>	<u>min male</u>	<u>max</u>	<u>max</u>
4'8"	82	87	125	140
4'9"	85	90	130	145
4'10"	88	94	135	150
4'11"	91	97	140	155
5'0"	94	100	145	160
5'1"	97	103	150	165
5'2"	101	107	155	170
5'3"	104	110	160	175
5'4"	107	114	165	180
5'5"	111	117	170	185
5'6"	114	121	175	190
5'7"	117	125	180	195
5'8"	121	129	185	200
5'9"	125	132	190	205
5'10"	128	136	195	210
5'11"	132	140	200	215
6'0"	136	144	205	220
6'1"	139	148	210	225
6'2"	143	152	215	230
6'3"	147	156	220	235
6'4"	151	161	225	240
6'5"	155	165	230	245
6'6"	159	169	235	250
6'7"	163	174	240	255
6'8"	167	178	245	260
6'9"	172	182	250	265
6'10"	176	187	255	270

Preferred Issue Rules

Issue Ages: 18-75

Minimum Face Amount: \$100,000 on the base plan. The face amount of any term rider does not count towards satisfying the minimum face amount for the base plan.

Lafayette Life Term Preferred Underwriting Criteria

Preferred Category	Super Preferred NTU	Preferred Plus NTU Preferred TU	Preferred NTU
General	Must be clearly standard; no temporary or flat extra ratings		
Tobacco or Nicotine Use	• None in last 60 months	• None in last 24 months • Occasional cigar use may qualify for NTU if 12 or fewer cigars per year and urinalysis negative for cotinine <i>Less than one pack of cigarettes per day or any amount of other tobacco is Preferred TU</i>	• None in last 12 months
Personal Medical History	• No history of cardiovascular disease, cerebrovascular disease, cancer (except superficial skin cancer), diabetes, or respiratory disease • No ratable conditions or labs (HbA1c ≤ 5.6)	• No history of cardiovascular disease, cerebrovascular disease, cancer (except superficial skin cancer), diabetes, or respiratory disease • No ratable conditions or labs (HbA1c ≤ 6.0)	• No history of cardiovascular disease, cerebrovascular disease, cancer (except superficial skin cancer), diabetes, or respiratory disease • No ratable conditions or labs (HbA1c ≤ 6.0)
Blood Pressure	• Ages ≤ 50 130/80 or less • Ages > 50 135/85 or less • Not under treatment	• Ages ≤ 50 135/85 or less • Ages > 50 140/90 or less • Ok to be under treatment <i>Not under treatment if Preferred TU</i>	• 140/90 or less • Ok to be under treatment
Cholesterol	• 230 or less chol/HDL ratio 5.0 or less • Ok to be under treatment if well controlled	• 240 or less chol/HDL ratio 6.0 or less • Ok to be under treatment <i>Not under treatment if Preferred TU</i>	• 260 or less chol/HDL ratio 6.5 or less • Ok to be under treatment
Build	See Term Preferred Build Table		
Family History	• No parent/sibling death from heart disease prior to age 60 • No features of the family history that suggest a hereditary cancer risk • Age 66+ family history is not applicable	• One or no parent/sibling death from heart disease prior to age 60 • No features of the family history that suggest a hereditary cancer risk • Age 66+ family history is not applicable	• One or no parent/sibling death from heart disease prior to age 60 • No features of the family history that suggest a hereditary cancer risk • Age 66+ family history is not applicable
Driving Violations	• No DUI, reckless driving, or suspensions in last 5 years • No more than 1 moving violation or accident in the last 5 years	• No more than 1 moving violation or accident in the last 2 years	• No more than 2 moving violations or accidents in the last 3 years
Alcohol & Drugs	• No history of treatment, counseling, or adverse illegal alcohol or drug abuse	• No treatment, counseling, or abuse in last 10 years	• No treatment, counseling, or abuse in last 8 years
Hazardous Sports, Occupation, Aviation	• No participation in hazardous sports • Not in hazardous occupation • No participation in private aviation unless aviation exclusion rider is applied	• No participation in ratable sports • Not in ratable occupation • No participation in ratable private aviation unless aviation exclusion rider is applied	• No participation in ratable sports • Not in ratable occupation • No participation in ratable private aviation unless aviation exclusion rider is applied
Foreign Residence or Travel	• US citizens and permanent legal residents only (green card holders) • No residence outside US or Canada • No foreign travel plans to under-developed or politically unstable countries		

Weight (in lbs.)

Height	Super Preferred NTU			Preferred Plus NTU/ Preferred TU	Preferred NTU
	<u>min female</u>	<u>min male</u>	<u>max</u>	<u>max</u>	<u>max</u>
4'8"	82	87	123	129	139
4'9"	85	90	128	133	143
4'10"	88	94	132	138	148
4'11"	91	97	136	143	153
5'0"	94	100	142	148	160
5'1"	97	103	146	153	164
5'2"	101	107	152	159	170
5'3"	104	110	157	164	175
5'4"	107	114	162	169	181
5'5"	111	117	166	174	186
5'6"	114	121	172	179	193
5'7"	117	125	176	184	198
5'8"	121	129	182	190	204
5'9"	125	132	187	196	210
5'10"	128	136	191	200	217
5'11"	132	140	197	206	223
6'0"	136	144	202	213	230
6'1"	139	148	209	219	235
6'2"	143	152	215	224	241
6'3"	147	156	221	231	249
6'4"	151	161	227	237	255
6'5"	155	165	232	243	263
6'6"	159	169	239	250	269
6'7"	163	174	245	256	276
6'8"	167	178	251	263	284
6'9"	172	182	257	269	290
6'10"	176	187	264	276	297

Preferred Issue Rules

Issue Ages: 18-75

Minimum Face Amount: \$100,000 on the base plan. The face amount of any term rider does not count towards satisfying the minimum face amount required for the base plan.

SUBSTANDARD INSURANCE

impaired risks The Company is anxious to issue a policy to every person making an application, but it is sometimes necessary to decline applications. The Company may decline any application for insurance without specifying the cause. The cause for a declination is often not specified to the Agent or the Proposed Insured for reasons of confidentiality regarding medical records. However, some states require disclosure to the applicant, the policyholder or the individual proposed for coverage of the specific reason(s) for the adverse underwriting decision.

When an application is declined or filed as incomplete by the Company, the Agent will be so notified. After receiving this notice from the Company, the Agent MUST at once return any settlement of the first premium to the applicant, collect the conditional receipt which bears the same number as the application (if it was detached from the application and given to the applicant), and FORWARD THE CONDITIONAL RECEIPT TO THE COMPANY.

trial applications A trial application should be submitted to the Company if it is questionable whether a prospective applicant is insurable; if his occupation is of an unusually hazardous nature and cannot be classified in the rate book; if previous insurance has been denied, action postponed or a policy offered other than applied for by this or any other Company within a five year period prior to current submission; or if any other question arises regarding which an opinion is desired as to his or her insurability.

To submit a trial application, simply (1) use a regular application, (2) do not take money, (3) attach a memo saying "treat this as a trial application," and (4) complete the full nonmedical and attach a letter giving further details if you feel this would be helpful. Do not send for an inspection or arrange for a medical examination. The Home Of flee will review the information, order any physician's statements deemed necessary and will tentatively attempt to classify the risk.

substandard offers

Most (95%) of the substandard offers made on pending applications are based on our underwriting experience and judgment. Acceptance of this offer by the applicant will result in policy issue. If policy issue is subject to additional requirement (e.g. medical), the offer will be maintained for 30 days before the file is incompleted. If the offer is refused and a reinsurance offer is requested, our original offer is withdrawn. The Company cannot bind our reinsurance sources. The applicant should NOT be told the original offer is still available. The reinsurance offer requested can be higher, the same as, or lower than our original offer. This information, and any additional requirements, will be promptly communicated to the Agent.

substandard premiums

It is generally possible to offer insurance on a sub-standard basis (i.e., subject to an additional premium) to those lives who are not able to qualify for standard coverage for reasons of health impairment or exposure to higher than average mortality hazards (as in certain occupations).

Two methods of determining the required extra premiums are used by the Company, depending on the type of degree of the added risk: Table Ratings, and Flat Extra Premiums. These are well illustrated in our Occupational Manual and Impairment Guide.

TABLE RATINGS-These are expected percentages of standard mortality, as shown in the following table:

Table	% Standard	Table	% Standard
A	125	F	250
AA	137 1/2	H	300
B	150	J	350
C	175	L	400
D	200	P	500
E	225		

Many impairments exhibit a pattern of extra mortality which can be closely approximated by a percentage of standard mortality, and for such cases a substandard premium based on a "table rating" is appropriate. These ratings are translated into extra premiums which necessarily vary by plan of insurance and age. Substandard extra premiums for our whole life plans may be found in Section F.

Table rating extra premiums will automatically be removed on the later of (1) the policy anniversary on which the Insured's attained age last birthday is 65 or (2) the 20th policy anniversary.

FLAT EXTRA PREMIUMS—These are “expected extra deaths per thousand lives” and are appropriately used if the degree of extra hazard is relatively independent of plan of insurance or age. Depending on the type of impairment or added risk, flat extra premiums may be either permanent or temporary. Temporary flat extra premiums are only those flat extra premiums payable for 5 years or less. Flat extra premiums are always expressed as dollars per \$1,000 of insurance; e.g., \$5.00 per \$1,000 for 3 years. Consult the Occupational Manual for information on occupational flat extra premiums.

UNIVERSAL LIFE—See Section D.

TERM POLICIES AND RIDERS—Term insurance is issued on substandard risks, but not above Table F. Substandard premiums for term insurance are determined as the product of the standard gross premium and the percentage extra mortality.

QUOTATIONS—The Home Office will quote substandard premiums for plans and tables not shown in this manual upon request in a specific case.

ADDITIONALS AND ALTERNATES

additional policies If the Agent believes that a policy in addition to that applied for can be placed, he may request that such additional policy be issued on the basis of information in the application.

AMOUNT LIMITS—Additional policies will be issued where, on medically examined cases, the total insurance issued, including the additional insurance, does not exceed the Company issue limit; and where, on nonmedical cases, such total insurance does not exceed the maximum insurance that may be issued in accordance with the nonmedical rules of the Company.

HOW REQUESTED—If a request for an additional policy is made after the application has been submitted, such request may be made by writing the Home Office. The policy, when issued, will contain a copy of the original application together with a copy of supplemental application modifying the original application. The supplemental application in the policy must be signed and dated by the applicant and Agent on delivery, and the copy attached to the transmittal letter is completed in the same manner and returned to the Home Office. (An additional policy cannot be delivered without a request signed by the applicant for the additional policy.)

DELIVERY—In the case of additional policies, both the original policy issued as called for on the application together with the additional policy may be delivered within 60 days from date of issue. (Also see “Delivery of Policy,” Page B-32.)

alternate policies

If the Agent believes that it may be possible to deliver a policy on a different plan or for a larger amount than the originally applied for policy, the Agent may request we issue an alternate policy.

DELIVERY—The alternate policy may be delivered in lieu of, but not together with, the original policy. When the policy has been delivered (either the original or the alternate), the other policy must be returned to the Company immediately for cancellation. Until such policy is returned, all such business will be treated as outstanding.

AMOUNT AND TIME LIMITS—Attention must also be paid to the amount and time limits as outlined previously under Additional Policies.

APPLICATION GROUPS

For policies submitted together (such as families, pension, business ownership, etc.), policies will be mailed to the Agent individually as applications are approved, unless the Agent requests otherwise.

If a specific policy date or PAC withdrawal date is wanted, request it on a memo submitted with the applications. Normal policy dating rules will apply.

A special request must be submitted if the Agent wants issue delayed until all applications in the group are approved

Military Risks (Active and Potential)

I. GENERAL

A. Lafayette Life Insurance Company prohibits the solicitation, or offer of sale, of any Lafayette Life Insurance Company product to any member of the Armed Forces or a dependent thereof on a military installation of the United States. Please contact the Lafayette Life Insurance Home Office if you have any questions.

B. Restrictions—Insurance CANNOT be written on active duty personnel who have been alerted for, received orders to, or who have volunteered for (or anticipate such) duty to a hazardous overseas area where there is military action or the threat of it.

C. Amount and Pay Grade Limits:

0 – 5 and up	\$600,000 max
W-1 thru W-4 and 0-1 thru 0-4	\$400,000 max
E-7, 8, 9	\$400,000 max
E-5, 6	\$350,000 max
E-4	\$300,000 max

a. Army Special Forces & Rangers . 1/2 the above limits & no ADD

b. Non-career doctors and dentists—individual consideration

D. Restrictions on Plans of Insurance

1. Term plans—can only be written for E-6 and above on the Annual or PAC frequency of premium. 10YT-92 may be written on Government Allotment, also.
2. Term Riders—SIR and CIR may be written—UL Term Rider (TLR) available on UL—10 Year Term Rider, Term Rider, and LPUAR are available on permanent policies no other riders are available to military. The premium mode for a policy to which the Term Rider is attached must be annual or PAC; it may not be government allotment.
3. Base Plans—GPWL 15 not available on Government Allotment.

E. Benefits

1. Waiver of Premium and Waiver of Monthly Deduction Disability Usually offered Standard.
2. Accidental Death Benefit—usually offered Standard, unless otherwise noted.
3. Guaranteed Purchase Option or Guaranteed Increase Option—is offered on pay grades E-6 and up, if the amount applied for plus the amount of the 1st option added together do not exceed the regular published limit for that age and pay grade.
4. Cost of Living Adjustment—will not be offered.
5. Payor Benefit—Usually offered Standard.

F. Premium Mode Restriction—Government allotment is the required premium mode for E-4 and below. PAC and annual premium modes are available for paygrades E-5 and above. The premium mode for a policy to which the Term Rider is attached must be annual or PAC; it may not be government allotment.

II. MILITARY AVIATION

Special Note: All extra premiums charged for military flying will automatically be removed on the policy anniversary following the Insured's 50th birthday.

Insurance Information Practices

The Federal Fair Credit Reporting Act

The Federal Fair Credit Reporting Act (Public Law 91-508) places Federal Regulation on the reporting industry, and as a consequence directly affects the life insurance business. This law became effective on April 25, 1971, and the Federal Trade Commission is the primary enforcement agency for the government.

Sections 606 and 615 of the Act directly affect ordinary new life insurance business, and these are the only aspects that need to be covered in this manual.

what does the act require?

1. With every application for life insurance, the Company must notify the applicant that an investigative consumer report may be made, and that it will include information as to character, general reputation, personal characteristics, mode of living, and upon written request to the Home Office, the Company will provide the applicant with additional information concerning the complete nature and scope of the investigation.

2. The above requirement must be made IN WRITING and MAILED OR OTHERWISE DELIVERED to the consumer not later than three days after the date on which the report is first requested.

3. If the consumer desires additional information, then he may write directly to the Underwriting Department of the Home Office for further details as to the scope of the investigation.

4. If the Company, as a result of the information contained in a consumer report, either:

a. Declines the policy or a benefit,

b. Rates the policy or a benefit,

THEN:

The Company is required to notify the consumer of this fact, and give him the name and address of the reporting agency that furnished this information to the insurance company. The consumer then has the right to contact the inspection company directly, and find out what information is contained in the report, and if the information is incorrect, ask for a reinvestigation and/or furnish a "rebuttal," if he wishes, to the reporting agency.

insurance information and privacy acts

Several states have adopted Information and Privacy Protection Acts which also regulate information gathering practices of insurance companies.

These laws deal with several facets of the underwriting process and the collection and protection of data.

1. All applicants must be given a written description of the Company's information collection and disclosure practices.

2. The proposed insured must sign a more detailed Authorization for Release of medical and other personal information.

3. Procedures are established for permitting individuals access to information in the Company's files about them.

4. When an adverse underwriting decision is made, the Company notifies the applicant of the reasons therefor and how the applicant may obtain more information about the basis on which the action was taken.

The law contains numerous provisions protecting the privacy and confidentiality of information about an insured or applicant which is collected by the insurer or its agents. Disclosure of such information without consent is restricted to a few well defined situations. The agent is subject to the same restrictions on releasing information known to the agent about an individual which was collected or received in connection with an insurance transaction. Information reamed by an agent about an applicant or proposed insured should only be disclosed to the insurance company or to insurance support organizations who are performing a function in connection with the insurance transaction involving the individual.

how does our company comply?

1. You must deliver the "Insurance Information Practices" to the Applicant and Proposed Insured at time of application. This is the FCRA/MIB tear off form in the application. A separate "Insurance Information Practices/Authorization to Release" (Form 1453) is used with conversion applications. The form contains the MIB Notice and disclosures as required by these Privacy Acts in addition to the FCRA Notice required by Federal law. Underwriting cannot begin processing without Authorization Form 1453 being completed and signed by all persons proposed for insurance.

2. The Proposed Insured must sign "Authorization to Release Information" for release of medical and other personal information. This form is included in the application packet and must be signed at time of application. A signed Authorization is also required when evidence of insurability is needed to increase coverage or reinstate a policy. A separate Form 1453 which includes both the "Insurance Information Practices" and "Authorization" may be used for those situations.

3. Note that your signature on the application Agent's Report is confirmation that you did deliver the required FCRA and MIB Notices (Insurance Information Practices Form).

4. If the policy is issued as applied for, no further action is required on the part of the Agent or the Company.

5. If, due to information contained in a consumer report, the Company rates the policy or benefit, declines the policy or benefit, the Company must so notify the applicant of this fact and give him the name and address of the reporting agency, where he may inquire as to the content of the Inspection Report. (Note: No information contained in the report is given out by the Company to either the applicant or the Agent.)
- a. If a policy is issued, notification of the action will be mailed directly from the Home Office after the policy is mailed. It is mailed directly to the proposed Insured's home address. A copy of this letter is sent to the Agent with the policy, giving him time to notify the applicant of this fact ahead of our letter, if he wishes.
- b. If a policy is declined, notification of the adverse underwriting decision is included in the letter to the applicant explaining the declination.
6. If the Insured desires to know what information caused the Company to decline him or to issue a policy other

than applied for, he may then contact the reporting agency directly on his own, and find out what information is contained in the report. If he feels the report is incorrect, he may request a reinvestigation of the information. If the reinvestigation develops the same information, he is so notified and then permitted to present his "rebuttal" in writing to be placed with the reporting agency file for future purposes.

7. If it turns out the information in the original report was incorrect, the applicant may then request that the correct information be mailed to any life insurance company that received a report within the previous six months, so they might review this for a possible change in their decision.

If you have any questions regarding these Acts or items that require further explanation, please contact the Home Office for further details.

Some states have laws of their own which may have minor variances from the Federal Law, so procedures may vary slightly in these states.

Applications Taken By Mail Outside Your Primary License State

For ALL applications written by mail, the writing agent MUST be licensed and appointed by Lafayette Life in the applicant's state BEFORE taking the application. This also applies to situations when a current Lafayette Life policyowner, for whom you have written prior coverage, has moved to another state and you want to write additional insurance coverage or an annuity by mail to their new state.

NON-RESIDENT LICENSE – Please apply for a non-resident license through the Marketing Department to solicit applications outside your state of residence.

INSURANCE PLAN – The proposed plan, riders and benefits must be approved in the applicant's state of residence. This information can be found on Lafayette Life's Website under 'Product Information / State Approvals'.

APPLICATION FORMS AND SOLICITATION REQUIREMENTS – Refer to Lafayette Life's Website under 'Software and Forms' and choose the state where the applicant resides.

APPLICATION SIGNATURE AREA –

- (1) The applicant's city and state of residence must appear in the space marked "Signed at" and "State of". This is location of the applicant when the application forms are signed.
- (2) Also instruct the applicant to have someone witness their signature on all application and associated forms since you will not be present to witness their signature.
- (3) Please be sure to give specific instructions regarding any forms that

they need to keep for their records or other needed instructions.

APPLICATION STATEMENT OF DETAILS – On the Agent's Statement portion of the application, or on a separate memo submitted with the application, please give full details of why the application was taken by mail.

ADDITIONAL EVIDENCE REQUIREMENTS – A medical examination and urinalysis will be required for ALL adult applications taken by mail. For an application on a child, a Telecom (telephone inspection with the child's parent) will be required. The Company reserves the right to alter regular underwriting rules and the right to establish additional requirements where appropriate.

POLICY FORMS – The "issue state" will be the Policyowner's state of residence (where the policy will be delivered to the new Policyowner). The rules and regulations of the Policyowner's state of residence must be followed.

FORMS SIGNED ON DELIVERY – Please be sure to give the Policyowner complete instructions regarding any forms that are to be signed and returned. Please follow-up with them to make sure the forms are signed and that you return them to the Home Office with the policy delivery period.

Completing the Application

APPLICATION SIGNATURES, DATES AND OWNERSHIP DESIGNATION

Omission of signatures on the application and Form 1453 (authorization form) are the most common oversights which require the Underwriting Department to return applications before processing. Such omissions may render the proposed insurance contract illegal. In addition, problems with completion of the ownership block as well as failure to obtain all the appropriate signature(s) frequently cause delay in the underwriting and issuance of policies. The application form discussed herein is Form 1459. There are state variations of the application Form 1459. Please be sure you have the correct form for your state. If you have questions about whether you have the correct form, please contact the Underwriting Department.

PLACE SIGNED AND DATE

1. City, State, Day, Month and Year must be where and when application is actually completed.
2. Agent must be properly licensed at such date and place.

SIGNATURES AND COMPLETION OF OWNERSHIP BLOCK

1. Must be signed personally using full name (not initials).
2. The Agent must always sign before submitting the application to the Home Office.

The Proposed Insured must sign. A juvenile who is the Proposed Insured should only sign if that person is age 15 or older.

Note: In about half the states, a juvenile cannot own a life insurance policy, even if it is on his or her own life, unless he or she is 15 years of age or older. In some states, the juvenile must be 18 years of age or older. If you have any questions about juvenile ownership, you should contact your Underwriter before the application is taken.

4. For Spouse Insurance Rider or Payor Insurance (on Juvenile Applications):

- a. The Spouse or Payor must sign the application.
 - b. Complete the Section 'Other Persons Proposed for Insurance.'
 - c. Include the Spouse's or Payor's answers to all nonmedical questions on the application.
5. The requirements concerning the signature of the Owner, where the Insured is not the Owner, will vary depending on the nature of the insurance. For example

a. If the Owner is a natural person and is not the Proposed Insured, then the Owner as well as the Proposed Insured must sign in the spaces indicated. The Owner's name must also be printed in the space provided.

b. If the Owner is to be a corporation (as in the case of Key Person insurance), the full, legal name of the corporation is to be printed in the space provided and an authorized officer of the corporation must sign on behalf of the corporation. An example of a corporate signature block is as follows:

XYZ Corporation Print Name of Owner - Applicant, if not the Proposed Insured

By: /s Sam Smith, President
Signature of Individual Owner, Trustee, or authorized officer if Corporate Owner

The title of the authorized officer should be clearly written (no initials please - e.g., V.P., S., Pr., etc.). If the Proposed Insured is an officer of the corporation, he or she should not sign as Owner (on behalf of the corporation) and some other authorized officer should sign on behalf of the corporation. If the Proposed Insured is the only corporate officer, then he or she may sign on behalf of the corporation and the Agent must notify the Underwriter, in writing, of this fact when the application is submitted. Be sure to complete the corporate ownership block on the application.

c. If the Owner is to be a partnership, it should be so indicated on the line where the name of the partnership is listed (or where all the partners are listed) and a general partner must sign. If there is more than one general partner and the Proposed Insured is a general partner, then a general partner other than the Proposed Insured must sign on behalf of the partnership. The full name of the partnership (if it has one) or, if the partnership has no name, the names of all the partners must be listed in the Ownership section of the application.

d. If the Owner is to be a living trust, the full name of the trust (if it has one) should be set forth. If there is more than one Trustee of the trust, then all must sign, unless satisfactory, written proof is submitted with the application that one Trustee's signature is all that is required. An example of a signature block where a living trust is the Owner is as follows:

John Smith, as Trustee of the John Smith Revocable Living Trust dated 1/1/88 and executed by John Smith
Print Name of Owner - Applicant, if not the Proposed Insured
/s John Smith, Trustee
Signature of Individual Owner, Trustee, or authorized officer if Corporate Owner

/s John Smith, Trustee
Signature of Individual Owner, Trustee, or
authorized officer if Corporate Owner

Note: The designation in the ownership block should read as follows: John Smith, or his successor(s) in trust, as Trustee of the John Smith Revocable Living Trust dated 1/1/88, and executed by John Smith, including any amendments made thereto. The language concerning successors in trust and "including any amendments made thereto" should always be included. The reason for this language is twofold. First, for whatever reason, Mr. Smith may be replaced as Trustee in the future. The inclusion of the successor language will mean that a Transfer of Ownership form will not have to be executed whereby Mr. Smith transfers ownership of the policy to the new Trustee. The inclusion of the amendment language will avoid any confusion in the future if the trust is amended on a future date (such as by amendment and restatement).

- e. If the Owner is the Trustee of a pension trust, then all Trustees must sign unless one of the Company's prototype pension trusts has been utilized or unless satisfactory, written proof is submitted in connection with the application establishing that only one Trustee need sign. An example of a signature block where the Trustee of a pension trust is the Owner is as follows:

XYZ Corporation Defined Benefit Pension Trust
Print Name of Owner - Applicant, if not the Proposed
Insured

/s John Smith, Trustee
Signature of Individual Owner, Trustee, or
authorized officer if Corporate Owner

Note: The designation in the ownership block should read as follows: Trustee of the XYZ Corporation Defined Benefit Pension Trust.

- f. If the Owner is an individual other than the Insured, a contingent owner should be designated to avoid the policy being transferred automatically to the Insured upon the death of the Owner.
- g. Questions regarding completion of signature blocks and the ownership block in other situations, such as where the Owner will be a custodian pursuant to the Uniform Gifts to Minors Act or Uniform Transfers to Minors Act (whichever is appropriate in your state) should be referred to your Underwriter or to the Advanced Underwriting section of the Marketing Department.

TAXPAYER IDENTIFICATION NUMBERS

Federal law requires that the Company request certified taxpayer identification numbers (TINs) of policyowners who are to receive or be credited with taxable interest. A certified TIN is

obtained by using Internal Revenue Service (IRS) Form W-9. If a certified TIN is not furnished, the Company must withhold and pay 31% of such taxable interest to the IRS. This is called back-up withholding.

If the policy to be issued is not a Universal Life policy and the dividend option selected on the application is that dividends will accumulate at interest, the following procedures apply:

- a. The Company will not issue a policy unless a TIN for the Owner has been provided on the application. For special ownership situations, such as where the Owner will be the Trustee of a trust or a custodian pursuant to either the Uniform Gifts to Minors Act or Uniform Transfers to Minors Act, consult your Underwriter to learn the appropriate TIN to use.
- b. For the TIN to be certified, a W-9 must be completed on delivery and promptly returned to the Underwriting Department. If the completed W-9 is not promptly returned, we will contact the Owner directly.

When you receive the policy for delivery, the Underwriting Department will supply you with Form W-9 and the guidelines regarding the proper name and number to be furnished.

The above procedures will be used until our application forms are revised to include the required certification for TINs.

BENEFICIARY

The application very frequently will be the only source of beneficiary information and, thus, the beneficiary section of the application should be completed with the utmost care. Print plainly and in ink the full name of each beneficiary. The relationship of each beneficiary to the proposed Insured should be listed. The designation should be explicit so that no misunderstanding may arise as to the manner in which the applicant wishes the policy proceeds to be paid.

The beneficiary named on the application should have an insurable interest in the life of the Proposed Insured (for a further discussion of the topic of insurable interest, see the Insurable Interest provision on Page B-7). The insurable interest which the beneficiary has in the life of the Proposed Insured should be clearly set forth on the application. If the insurable interest of the beneficiary is not clear, a full, written explanation must be furnished to the Underwriter.

RELATIVES AND THE ESTATE - It is generally desirable that a close relative be named beneficiary and the Agent should urge the applicant to do so, if such a designation is appropriate in light of the purpose(s) for which the insurance is being sought.

If the applicant is not able to suggest a beneficiary, consideration should be given to naming the estate of the Insured (if the Insured is also the Owner) as the beneficiary. However, before designating the estate of the Insured as the beneficiary, the Agent should suggest, where the amount of the insurance is significant, that the Owner consult an attorney since the payment of the proceeds to the estate may have adverse tax consequences. If the estate of the Insured is the beneficiary, then the net proceeds will be paid to the personal representative of the Insured's estate (or in another appropriate manner which is permitted by the applicable state law).

If the named beneficiary is an individual, the net proceeds will be paid to that individual.

Note: Where the Owner and the Insured are not the same person, naming someone other than the Owner as primary beneficiary may result in adverse tax consequences to the Owner when the benefits are paid. Caution should be used in such cases and the Owner should seek the advice of an attorney before naming someone else as primary beneficiary.

If no named beneficiary survives the Insured, the policies from our present policy series provide that the proceeds will be paid to the Owner or, if applicable, the Owner's estate. Of course, if the Insured and the Owner are not the same person and no named beneficiary survives the Insured, we will pay the Owner (or, if the Owner did not survive the Insured, we will pay the Owner's estate).

Where the insurable interest of a beneficiary is not clear, the Company reserves the right to question any designation which appears to be improper. A Proposed Insured's fiancée may be the named beneficiary if the Proposed Insured will also be the Owner of the policy.

UNNAMED BENEFICIARIES - Beneficiaries should be designated by name and relationship to the Insured, whenever possible. The Company will not approve the issuance of a policy which names on the application the Insured's or Owner's "heirs" (because of the difficulty in determining who is to be included in that description). In such a case, an Amendment to Application will be prepared naming, if applicable, the Insured's presently living lawful children and any future lawful children of the Insured (the term "lawful children" does not include stepchildren).

If, for example, on the application the Insured's wife was named as primary beneficiary and the Insured's "heirs" were named as the sole first contingent beneficiary, then the Insured's lawful children will be named as the first contingent beneficiary on the Amendment to Application. The designation on the Amendment to Application may read as follows: Upon the death of the Insured, the net proceeds shall be paid to Mary Jones, the Insured's wife, if living, otherwise the net proceeds shall be paid in equal shares to the surviving lawful children of the Insured.

If, in the example used above, the proceeds become payable to the children (because the wife did not survive), then payment to the surviving children cannot be made until we receive proof, in

a form acceptable to the Company, to establish that we have accounted for all the surviving children. The Company may request an affidavit, if, in the Company's opinion, an affidavit is appropriate. Designating unborn children as the beneficiary may delay payment of the claim if unborn children are named as the sole or primary beneficiary and the wife of the Insured survives the Insured.

If (1) the Insured's heirs were named as the sole beneficiary on the application and (2) the Insured is presently not married and (3) the Insured has no children, then the Insured's estate will be named as the sole beneficiary on the Amendment to Application.

MINOR BENEFICIARY - If the named beneficiary is a minor, payment generally can only be made to the legally appointed guardian of the minor's estate (a court of proper jurisdiction generally makes the appointment of the guardian of a minor's estate). This should be considered when designating a minor as beneficiary.

The Owner should consider consulting with his or her attorney to determine whether a designation pursuant to the Uniform Gifts to Minors Act or Uniform Transfers to Minors Act, whichever is applicable, is appropriate. Some states, which have the Uniform Gifts to Minors Act, may not permit a beneficiary designation pursuant to the act (unless the custodian for the minor, named pursuant to the Uniform Gifts to Minors Act, is also the Owner). The Owner should carefully consider the requirements set forth and the responsibilities created under the applicable act before making a designation. In some cases, the execution of a trust (established for the benefit of the minor), with the Trustee of the trust named as beneficiary, may be the best approach in providing for a minor beneficiary. The Owner should consult his or her attorney and discuss with that attorney whether the creation of a trust would be advisable.

LAST BENEFICIARY - All policies in the current policy series provide that the Owner or the Owner's estate will be the last beneficiary when all other named beneficiaries are deceased. The Insured's estate was the last beneficiary on policy series prior to 1982.

BENEFICIARY CHANGES - See B-43.

model beneficiary designations

The following samples are provided to assist you in making beneficiary designations on applications and change of beneficiary forms. It is important that you examine the general provisions in the policy and on the change of beneficiary form to make sure that the designation is in accord with your client's wishes.

These samples, of course, do not attempt to cover every situation that may arise, but it is hoped that those provided will be helpful in the majority of cases. The Company will help you prepare various specialized beneficiary arrangements.

ONE BENEFICIARY ONLY

Primary: Mary J. Doe, wife (Never designate a married woman as Mrs. John Doe.)

THE INSURED'S ESTATE

Primary: The Insured's Estate.

TWO OR MORE BENEFICIARIES TO SHARE EQUALLY

Primary: Mary J. Doe, wife; James L. Doe, son; Helen K. Doe, daughter.

ONE PRIMARY AND ONE CONTINGENT

Primary: Mary J. Doe, wife. *Contingent:* James L. Doe, son.

ONE PRIMARY AND THE UNKNOWN CONTINGENT

Primary: Mary J. Doe, wife. *Contingent:* (If there are children of the Proposed Insured in existence and they are to be named as contingent beneficiary, their names should be set forth. On application Form 1459, the Owner may also check the box which states "All lawful children of the Proposed Insured, including any named above" to provide for future children, in addition to any named, or to provide for future children if the Proposed Insured presently has no children.)

JUVENILE

Primary: John L. Doe, father. *Contingent:* Mary J. Doe, mother.

SECOND CONTINGENT

Primary: Mary J. Doe, wife. *Contingent:* James L. Doe, son. *Second Contingent:* Ruth B. Doe, mother.

PERCENTAGES

Primary: Upon the death of the Insured, the net proceeds shall be paid as follows: 50% of the net proceeds shall be paid to Mary J. Doe, the Insured's wife, 25% of the net proceeds shall be paid to James L. Doe, the Insured's son, and 25% of the net proceeds shall be paid to Helen K. Doe, the Insured's daughter. Upon the death of any such Primary Beneficiary, his or her share shall be apportioned among the surviving Primary Beneficiaries in accordance with the ratio that each surviving beneficiary's percentage of the net proceeds bears to the total of all surviving Primary Beneficiaries' percentages of the net proceeds.

Of course, if desired, a contingent beneficiary could be set forth as well under the heading "Contingent Beneficiary."

This designation will not fit in the space allotted on Form 1459B (the application). The client can submit a signed/dated letter outlining their beneficiaries (primary/contingent, percent, name, relationship and date of birth).

Dollar amounts should not be used because the total amount of the net proceeds may not equal the amount designated as payable to all beneficiaries. Thus, a question may arise upon the death of the Insured as to how the proceeds are to be paid. For example, suppose the face amount applied for and issued on a universal life policy is \$50,000 and the Insured designates that \$25,000 is to be paid to his wife, Betty, \$15,000 is to be paid to his son, Sam, and \$10,000 is to be paid to his mother, Matilda. Let us suppose the Insured takes a partial surrender of \$10,000 and a loan of \$5,000 and that the face amount at death is \$35,000. There is nothing on our application, in the beneficiary

designation area, nor is there anything in the policy which would direct how payment would be made in such a case. We cannot automatically assume that it was the Insured's intent that his wife receive her \$25,000 share first nor can we assume that he desired a percentage breakdown based upon the amounts designated. Even if we made such an assumption, the beneficiaries may not agree with our assessment and litigation may follow. Litigation is costly for all concerned and can easily be avoided by the use of percentages.

CORPORATION

Primary: The A.B.C. Corporation, Anytown, Indiana. (Be sure to state the exact legal name of the corporation.) Normally, a contingent beneficiary would not be named.

PARTNERSHIP

Primary: The S.J.B. Company, Anytown, Indiana, a partnership consisting of John A. Smith, William P. Jones, and Henry E. Brown, or its assigns. (The designation is not frequently used. Usually, the partners will have a Buy and Sell Agreement requiring the cross purchase of insurance. In such case, one partner buys a policy on the life of another and names himself as beneficiary, and the partnership entity is not named as beneficiary. Where a partnership is named as beneficiary, be sure to inform your clients of the need to reconsider the designation should there be a change in the structure of the partnership.) If policies are cross owned, it is necessary to have contingent Owners and/or Beneficiaries.

LIVING TRUST

Primary: Upon the death of the Insured, the net proceeds shall be paid to (trustee or trustees name(s)), or his/her/their/its successor(s) in trust, as Trustee under a trust agreement dated January 1, 1988, and executed by (person who created the trust) including any amendments made thereto. Payment of the net proceeds to such Trustee shall fully and finally discharge the Company from all liability.

The client can submit a signed/dated letter outlining their beneficiaries (primary/contingent, percent, name, relationship and date of birth).

The above designation assumes that the trust did not have a particular name. **If the trust has a name**, the full name of the trust should be used (this is to avoid any confusion if there is more than one living trust in existence, especially if coincidentally more than one trust was executed on the same date).

If the trust has more than one Trustee, all Trustees must be named and their names must be connected by the word "and" and not the word "or."

TESTAMENTARY TRUST

Primary: Upon the death of Insured, the net proceeds shall be paid to the Trustee of the trust created by the Last Will and Testament of John Doe. Payment of the net proceeds to such Trustee shall fully and finally discharge the Company from all liability. If said Trustee does not submit written claim to the Company, together with a certified copy of the Will as admitted to probate, within ninety (90) days of the Insured's death, the net proceeds will be paid to the Owner, if living, or to the Owner's estate.

This designation will not fit in the beneficiary block on the application (Form 1459B). The client can submit a signed/dated letter outlining their beneficiaries (primary/contingent, percent, name, relationship and date of birth).

If the trust has a name, the name of the trust should be used. If more than one trust is created by the Last Will and Testament of the individual in question, then either the name of the trust must be used (if it has one) or the specific provision of the Will which creates the trust must be set forth (For example, "... the trust created by Article VI, paragraph One...").

PER STIRPES CONTINGENT

Primary: Upon the death of the Insured, the net proceeds shall be paid to Mary J. Doe, the Insured's wife.

Contingent: Should Mary J. Doe not survive the Insured, the net proceeds shall be paid in equal shares to James L. Doe, the Insured's son, and Helen K. Doe, the Insured's daughter, per stirpes.

This designation will not fit in the beneficiary block on the application (Form 1459). The client can submit a signed/dated letter outlining their beneficiaries (primary/contingent, percent, name, relationship and date of birth).

SPLIT-DOLLAR INSURANCE

Contact the Advanced Underwriting Department for assistance with specimen split-dollar agreements and specimen collateral assignments.

EMPLOYEE OR 3RD PARTY OWNED SPLIT-DOLLAR INSURANCE

The preferred arrangement for establishing a split-dollar plan is by using the collateral assignment approach. Where the policy will be owned by the Insured-employee or a 3rd party with a collateral assignment to the employer, the beneficiary or beneficiaries of the policy will be named by the Insured using a standard beneficiary designation. The employer will not be a beneficiary. The employer's interest in the proceeds will be governed by the collateral assignment and the split-dollar agreement.

EMPLOYER OWNED SPLIT-DOLLAR INSURANCE

Where, on the rare occasion the policy will be owned by the Insured's employer and the proceeds will be divided between the beneficiary or beneficiaries named by the Insured and the employer pursuant to a split-dollar agreement, a special beneficiary designation should be included in the application. The exact wording of the designation will depend on the details of the split-dollar agreement. A typical designation is set forth below.

Primary: On the death of the Insured, XYZ Corporation, Anytown, Indiana, its successors or assigns, shall receive that portion of the proceeds equal to the share of the premiums paid on this policy by XYZ Corporation, reduced by the amount of any indebtedness on or secured by the policy and any accrued, unpaid interest thereon. The balance of the proceeds in excess of the amount payable to XYZ Corporation, its successors or assigns, shall be paid to Jane Doe, wife of the Insured.

PENSION OR PROFIT SHARING TRUST

Primary: Trustee of the XYZ Corporation Defined Benefit Trust.

SECTION 1035 EXCHANGES

Note: The terms "existing policy," "old policy," or "policy" can refer to several policies, if applicable.

If replacement of an existing Lafayette Life policy with a new Lafayette Life policy (internal exchange) or replacement of another insurer's policy with a Lafayette Life policy (external exchange) appears to be in the best interest of the policyowner, then a Section 1035 Exchange may be appropriate. There are two reasons for such an exchange.

1. To avoid current taxable income on the gain in the old policy (this may not be completely avoided if there are loans on the policy). It is best to repay a policy loan with dividends, if any, before the exchange.
2. To carry over the cost basis of the old policy into the new policy. This may lessen any taxable gain in the future.

REQUIREMENTS FOR A 1035 EXCHANGE

1. The policyowner and the insured (or annuitant) must be the same person(s) on the new policy as on the policy exchanged.
2. The existing policy must be terminated and the surrender proceeds applied to the new policy.
3. The exchange must be for a new policy. Section 1035 is not applicable to a "rollover" of cash value from one policy to another policy which is already in force.
4. A life insurance policy can only be exchanged for another life insurance policy or for an annuity. An endowment or annuity contract can only be exchanged for an annuity contract. An exchange to a Single Premium Immediate Annuity Installment Income does not qualify for 1035.

EXCHANGE PROCEDURES:

1. INTERNAL - submit, with the application, a Form 1526, the old policy and appropriate replacement forms, if any. Don't give the applicant a Conditional Receipt.
2. EXTERNAL - For each policy being replaced, submit, with the application, applicable replacement forms, and assignment form 1542. The Home Office will handle all correspondence with the other company(ies).

The above procedures are not applicable to tax qualified policies. If an exchange of a Tax Sheltered Annuity (TSA) for another TSA is desired, please contact the Qualified Markets Department for details.

We cannot assure you or the policyowner that following the above requirements and procedures will guarantee that the exchange will qualify under Section 1035. The policyowner should contact an attorney or an accountant for specific tax advice regarding the exchange.

PREMIUM INFORMATION

CALCULATION OF PREMIUM - See Page C-2 or D-5.

MINIMUM PREMIUM - The minimum fractional premium is \$10.00 (except additions to existing PAW). See Page G-8 for minimum premiums for Flexible Premium Annuities.

CWA LIMITS - The Underwriting Department will accept cash with applications for face amounts up through \$1,000,000 (base plan plus term rider) for ages 0-70. Current insurance in force with Lafayette Life will be considered in determining the CWA limit for new business applications.

Cash (check or money order) will not be accepted with application if the amount of insurance (including term rider and previous insurance) exceeds \$1,000,000 or if applicant is age 71 or over. The Conditional Receipt may not be detached from these applications.

A refund check will be drawn immediately for the total amount of CWA received and (after attempting to call the Agent) sent directly to the applicant with a letter advising them the Conditional Receipt is void and that there is no conditional coverage if the face amount (including term rider) exceeds \$1,000,000 or for ages 71 and above. The writing Agent and General Agent will receive a copy of this letter.

All premium checks for the policy (including the check for the initial premium) should be made payable to The Lafayette Life Insurance Company and should not be made payable to the Agent.

Accidental Death Benefit will not be calculated as part of the \$500,000 total. Remember the maximum ADB coverage on any one life cannot exceed the following rules:

Age:	0-14	\$ 25,000
	15-19	50,000
	20-24	100,000
	25-64	250,000

Conditional Receipt maximum limits are \$250,000 through age 70. The new limits will be included on the next application revision. California and Pennsylvania Field Associates must and all Field Associates are urged to bring the printed limits of liability to the attention of their applicants.

Do not detach the Conditional Receipt unless ALL requirements have been met.

INITIAL HEALTH HISTORY - It is important for the Agent to always ask the nonmedical questions on applications, even when a medical will be completed. Certain insurability situations prevent acceptance of an initial premium with applications for the following:

1. Previous application declined or postponed
2. A policy offered with a rating (Table E or higher) within the past 5 years
3. Health history that may require a rating or possible postpone or decline

By asking the non-medical questions on the applications, the Agent can determine whether there may be a questionable insurability risk involved. When in doubt, contact the Underwriter to discuss the situation and to determine whether an initial premium may be collected with the application.

If the Agent feels that none of the above parameters apply to the applicant, collect the initial premium while following our Conditional Receipt Rules.

For additional information about submitting applications on applicants with questionable insurability, refer to Page B-15 on "Trial Applications."

payment of premiums

Premiums are due and payable in advance at the Home Office of the Company. However, no premium is payable whose due date occurs after the date of the Insured's death. Changes in method of payment of premium may be made by written request. Failure to pay any premium when due shall cause the policy to lapse except as provided in the policy.

GRACE PERIOD - A grace period of 31 days (61 days for Universal Life) will be allowed for the payment of every premium after the first, during which period the policy shall continue in full force. If death occurs within the grace period and before premium in default has been paid, the overdue premium will be deducted in settlement of the claim.

frequency of premium payment

Policies are issued on the basis of premiums being paid annually, semiannually, quarterly, or monthly. Monthly premiums may be on the basis of Preauthorized Withdrawal, Government Allotment, or Payroll Deduction.

CHANGE IN FREQUENCY OF PREMIUM - Changes may be made by remitting to the Company the premium for the frequency desired and by notifying the Company of the desired change. It is not necessary to return the policy to the Company.

If a change in the frequency of premium payments is desired upon delivery of the policy, the Agent should indicate the requested change on the remittance blank and remit the correct premium. If cash was remitted with application, remit the balance due for the selected method of pay. Any overpayment will be refunded by check to the Owner.

PREMIUM COLLECTION - Except for Government Allotment and Payroll Deduction premiums, the full initial premium should be collected either at the time the application is signed, giving exchange therefor the Conditional Receipt or at the time of delivery of the policy. Partial payments are accepted according to Conditional Receipt Rules (at least equal to 1/12th of the annual premium). The CWA must be at least equal to the "minimum premium" for the premium method selected. If the CWA is not sufficient, the Company will contact the Agent. There will be no conditional coverage on these applicants if the CWA is not sufficient.

PREMIUM NOTICES - A notice of each premium due on direct bill policies and loan interest due on all policies is mailed 17 days prior to the due date. The notice is a two-part, perforated form consisting of a "Notice of Premium Due" and a "Remittance Stub."

The "Notice of Premium Due" is to be retained by the policyowner as a record of payment; it also contains annual dividend information and shows any cash value increase.

PREMIUM RECEIPTS - Premium receipts will be issued only when requested by the policyowner. If the "Notice of Premium Due" is returned with the "Remittance Stub," both sections are stamped "Paid" and returned to the policyowner.

GOVERNMENT ALLOTMENTS

Applications written on military personnel or their families must be on the Government Allotment premium frequency, except for E-6 and above. For Pay Grades E-6 and above, PAC and annual premium frequencies are available.

Procedures for filing Government Allotments are:

1. The Agent takes the application and arranges for the applicant to file an allotment for the premium through the applicant's Pay Center.
 - a) Give Form 1583, Request for Allotment, to the applicant and instruct him/her to return a copy of the filed allotment form which they will receive from the Pay Center. (It is IMPORTANT that this copy be submitted to the Home Office along with the application.)
 - b) The "start" date on the allotment form indicates when the allotment is to be deducted from the allotter's pay.
2. Cash with Application may be collected, if desired. If age save is requested, sufficient premium must be collected from birthday to allotment start date. If transfer from present duty station is imminent, premiums must be made to the Home Office until the allotment can be filed and received. (Be sure to complete the Conditional Receipt attached to the application and give to the applicant when CWA is collected.)
3. When no money is collected at time of application, complete the Certificate For Conditional Insurance LL-COND and give it to the applicant. There is insurance coverage FROM THE DATE THE ALLOTMENT IS REGISTERED, providing the application can be approved as applied for and conditions on the form are met.

Upon Underwriting approval, policies will be issued as follows:

1. No money collected with application:

The application will be held pending in the Underwriting Department until the allotment is received in the Home Office. The policy will be dated the first day of the month in which the allotment is received.

2. CWA collected:

Upon Underwriting approval, a policy will be immediately issued unless the policy date is in the future. The policy will be dated according to the allotment filing form, using the first day of the month in which the allotment is to be deducted from the applicant's pay.

Note: (1) If the "start" month and filing month are the same, normally the allotment will not actually be deducted until the following month.

(2) Filing at the end of the month for a "start" date the next month will normally not be deducted until the following month.

If the policy has been issued and the allotment is not received in the Home Office when expected, the Agent will be notified to continue collecting monthly premiums until the allotment is received. Policies may NOT be returned for re-date after issue.

3. If an allotment is filed for an amount over or short of the required premium or if a rating is required, the amount of insurance will be adjusted to fit the allotment amount. The plan of insurance may need to be changed if the resulting insurance amount is under the plan minimum.

PREAUTHORIZED WITHDRAWAL PLAN (PAW)

The Preauthorized Withdrawal Plan is a method of collecting premiums by means of a monthly check or Electronic Funds Transfer Debits (EFT Debits) drawn on the checking account of the premium payor, who must be a bank depositor. This plan requires an authorization from the depositor to the bank, instructing the bank to honor monthly checks or EFT Debits drawn on the account by The Lafayette Life Insurance Company for the payment of premiums. Credit Unions are also acceptable.

USAGE OF THE PLAN - The PAW Plan may be applied to old and new policies, on one or more individuals, provided the sum of the premiums for each individual or family group is not less than \$10.00.

Debits may be drawn on other than the Insured's checking account where the premium payor is other than the Insured. (Example: A husband may own and pay premiums for insurance on the life of his wife or children, or a wife on the life of her husband, or a business partner on the life of a partner or partners.)

This plan may be used to pay monthly premiums and monthly policy loan payments of at least \$10.00 each. It cannot be used to pay premiums on the annual, semiannual or quarterly basis.

NEW POLICIES - The following requirements for starting a policy on the PAW Plan supplement those requirements outlined on the check authorization cards (Form 1004):

1. The completed authorization cards and a sample of the depositor's voided check must accompany all applications

for new business on the PAW. The voided check will provide the necessary encoding to satisfy the Federal Reserve and will also provide the placement on the check of the individual's account number with his or her bank.

2. A payment for the initial premium, or the policyowner's authorization to automatically withdraw the first premium at issue, must accompany the authorization form. If all PAW requirements aren't received by issue, the premium mode will be changed to Quarterly (Annual on UL plans). If the policy is to be backdated, the Company can automatically debit for up to four premiums. It is important for you to either collect the back premium or inform the policyowner of more than one PAW premium to be withdrawn from their checking account.

OLD POLICIES - If the plan is also to cover premiums on old policies, be sure to list the policy number and names of the Insureds on the Authorization Form. When bringing a group of policies under the plan, it may be necessary to adjust the premiums so that all policies will be paid to the same month. The Customer Service Department will furnish this information upon request.

BANK COOPERATION - Before submitting an application for the Preauthorized Withdrawal Plan, make certain that it is acceptable to the depositor's bank. Once the Plan has been established with the bank, it will not be necessary to obtain a new Authorization Card for additional policies.

PREMIUM COMPUTATION - The special monthly rate is .085 of the annual premium rounded to the nearest cent except on Universal Life, Level Paid-Up Additions Rider, and Flexible Premium Annuities. This rate is different for policies issued prior to 1-1-77. The PAW premium for Universal Life, Level Paid-Up Additions Rider and Flexible Premium Annuities is calculated as 1/12 the annual premium.

AUTHORIZATION FORM - It is very important that the authorization cards be completed carefully and accurately in every detail. Both sections of the card should be completed and signed in the manner in which the checks are to be drawn. On joint accounts, secure the signature of each depositor. List all policy numbers of the policies that are to be paid under the plan on the card.

Attach one of the payor's personal checks marked "VOID". From the information on this check the Company will fill in the necessary bank information.

DATE OF DEPOSIT - The Preauthorized Withdrawal will be generated by the Company each month on the Policy Date. If a specific deposit date is desired (e.g., in addition to an existing PAW), please indicate the requested date on Form 1004. The Deposit Date may not be later than 12 days after the Policy Date for any policy other than Universal Life. Universal Life must have a Deposit Date on the Policy Date or earlier.

REMINDER NOTICE - When a new PAW account is set up, the Company will furnish a Reminder letter. The letter is a reminder for the depositor to deduct the amount from their checking account balance each month. Future changes will be communicated by premium notice or letter.

POLICIES NOT INCLUDED - It is not necessary for an Insured or family group to have the premiums on all policies paid under the Plan. However, policies previously paid on other frequencies may be placed under the Plan to enable the policyowner to enlarge the insurance program or to continue it more conveniently.

CHANGE IN AMOUNT - Notice will be given to the Insured of any change in the amount of the Preauthorized Withdrawal.

DISCONTINUANCE - Notice of discontinuance of the Plan will be given by the Company whenever for any reason not due to an automatic policy change, the amount of the premium under the Plan becomes less than \$10.00 a month. The policyowner will be given reasonable time to correct the situation and resume payment of premiums on another frequency of payment.

The Company reserves the right to discontinue the Plan if debits are not paid upon presentation. The Company will not penalize the individual who under an unusual circumstance might have a check returned. However, to protect against abuses which might otherwise arise, three returned checks in a 12 month period will disqualify the policyowner from using the plan for the next 12 months.

PAYROLL DEDUCTION

The Payroll Deduction Program enables employees to pay premiums on life insurance or annuities by having monthly payments deducted from their wages by their employer.

This program is not suitable for all businesses. Eligible employers are those who have been in business for more than one year, and are financially stable. Businesses with transient or seasonal employees are not acceptable. Likewise, hazardous job duties may exclude an employee or the employer from consideration. (See unacceptable business list on Page B-31)

A. MINIMUM REQUIREMENTS

1. A minimum of three (3) policies and a total of at least \$30.00 in monthly deduction premiums is required to put the program in operation. If the group drops below the minimum number or premium at any time after issue, the program will be discontinued and another frequency of premium must be selected by those remaining on an individual premium paying basis.

2. Any level premium whole life or universal life insurance plan plus any supplemental benefits are available for applicant (employee), spouse, or dependent children living at home.
3. Application Form 1459.
4. Regular nonmedical rules for individuals will apply. See Payor Insurance, Page B-10.
5. Premium rates will be figured the same as PAW frequency.
6. Any policy that is back dated to save age must include CWA to cover all monthly premiums from proposed back dated policy date to the initial premium remittance date.
7. If an employee leaves the service of an employer on this program, the individual may continue the policy by paying premiums to The Lafayette Life Insurance Company on another frequency of payment.
8. If any policy is rated, the amount of insurance can be adjusted (if applicant doesn't want to pay increased premiums) to agree with the premium on authorization Form 492 provided it does not reduce the policy below the minimum amount.
9. Census Form 1551 must be completed on the business. Employee Data on the back must be submitted with each group of applications and signed by employer (Payroll Dept.).
10. Form 492 Dates (Payroll Deduction Authorization)
 - First Deduction Date must be within 31 days of 492 signature. Note: The first remittance to us must be sent within 1 month of First Deduction.

B. CWA INSTALLATION PROCEDURE

1. Collect CWA for one month's premium on all (3 or more) applications and submit to Home Office along with the applications.
2. Submit one Form 491 (Employer's Acceptance) to cover all employee-applicants, properly completed by an authorized company official.
3. Have each employee applicant complete Form 492 (Payroll Deduction Authorization) selecting the second policy month as the initial withdrawal date. Attach to each application. Fill in blank showing amount of initial payment and remit payment with application and Form 492.
4. If the terms of the Payroll Deduction Plan Conditional Insurance Agreement are met, insurance will take effect as of the date of the application, or later completed medical examination, but the policies will be dated on the date of First Deduction shown on 492 (on days 1-28 of the month) except for the following condition If there is \$1000 or more CWA on Universal Life the policy will be dated the date the CWA is received.

5. Policies will be approved as soon as possible but held together in the Home Office to be delivered in one package by the writing Agent. Commission credit will be given when policies are mailed from the Home Office.
6. If an application is Incomplete (Agent cancels, evidence not submitted, declined, or rate unacceptable), the Agent will be informed and initial premium will be refunded immediately. The remainder of policies will be issued in a regular manner. There must still be a minimum of three (3) policies at time of issue.

There will be no charge for this insurance coverage from the date of the application until the policy is issued. When the underwriting requirements have been met and the policies have been issued, the premium collected with the application will be applied to pay the premium due on the policy date.

C. C.O.D. INSTALLATION PROCEDURE

On applications sent in by the Agent without first month's premium, but to be billed later to employer after policies issued (COD), the following procedure applies:

1. All applications should be submitted at the same time.
2. Submit one Form 491 (Employer's Acceptance) to cover all employee-applicants, properly completed by an authorized company official.
3. Have each employee applicant complete Form 492 (Payroll Deduction Authorization) selecting an initial withdrawal date within 31 days. Attach to each application.
4. The first remittance must be sent to us within 1 month of the date of the first deduction listed on Form 492. Policies will be dated one month following the Date of First Deduction shown on 492.
5. Write "None" in Receipt block at bottom of Form 492.
6. The initial premium billing will be sent with the policies for the total initial premium on all issued policies.
7. If terms of the Payroll Deduction Plan Conditional Insurance Agreement are met, insurance coverage will take effect on the later of (a) the application date, ((b)) the medical examination date, (c) the date the authorization is filed with the employer or (d) the effective date requested in the application. There is no charge for insurance from this date until policy is issued. The first monthly premium is due on the policy date and will be paid from the employer's remittance.
8. Policies will be approved as soon as possible but held together in the Home Office to be delivered in one package by the writing Agent. Commission credit will be given when the first payment from the employer is received in the Home Office and the policies are issued.

9. If an application is incomplete (Agent cancels, evidence is not submitted, declined, or rate unacceptable), the Agent will be informed immediately. The remainder of policies will be issued in a regular manner. There must still be a minimum of three (3) policies at time of issue.

MONTHLY PREMIUM BILLING

Every month the Company will mail to the employer an itemized "Payroll Deduction Statement" showing the premium due for each policy. Unless there is cash with the applications, the employer should be advised to begin making payroll deductions as soon as the authorization is received so the employer will have sufficient deductions made before receipt of the Company's billing. (On CWA cases, deductions start the following month) The employer will return to the Company the monthly statement by the due date listed on the billing statement, together with a check covering the total monthly premiums due from all policies in the Program. For example, the May 15 billing should be mailed to The Lafayette Life by June 1.

D. SIMPLIFIED ISSUE

There are three products currently being offered with simplified underwriting as an enhancement to our payroll deduction market. These products are The Ultimate, Century, Vanguard, Contender and Patriot. Special rules are used with these products when simplified underwriting is desired. These rules are as follows:

1. There must be an employer-employee relationship to qualify for this program. (Please refer to the list of unacceptable occupational groups.)
2. The Agent must submit a confidential census Form 1551, on the business, completing all the questions asked on this form. The business must have been in operation at least one year. Also, the census form's reverse side must be signed by an authorized person in the employer's payroll department.
3. A minimum of three (3) policies and a total of at least \$30.00 in monthly deduction premiums is required to put the program in operation. If the group drops below the minimum number or premium at any time after issue, the program will be discontinued and the billing will automatically be changed to quarterly and be mailed directly to the insured. At least 50% of the eligible employees must be insured by Lafayette Life in order to qualify for this simplified issue program.
4. Our special simplified issue section of the 1459 app will be used for this program only.
5. To be considered for this simplified issue program, the employee must have been actively at work for at least the past 6 months (not off due to sickness or disability).
6. The available ages for simplified issue are 18 to 65.
7. The policy riders for this program are as follows:
 - a. Waiver of Premium/Monthly Deduction (WP/WMD) with a maximum issue age of 55. In a given business,

all employees must choose this rider (if they qualify). If any of the employees do not want this rider, it cannot be offered at all to that employer.

- b. The Spouse Rider (SI or SIR) will be available. The normal manual rules will apply to this rider. The spouse must sign the application if this rider is chosen.
 - c. The Children's Rider (CIR) will be available. Again, normal manual rules will apply to this rider.
 - d. Lump sum deposits are acceptable under this program with Universal Life plans.
8. The amounts of insurance coverage allowed under the Simplified Issue program are as follows:
 - a. 1. minimum amount of \$5,000 for Contender (WL-95)
 2. minimum amount \$10,000 for Universal Life except for older ages.

*Amounts of insurance purchased by \$9.00 a week maximum are less than \$10,000 face amount.

 - b. The maximum amount will be what \$9.00 per week Payroll Deduction will buy (excluding the QDF is \$468 Annual Premium). Cost of the riders can be added to the \$9.00 per week maximum.

9. There will be no substandard business issued under the simplified issue program. We will accept any case underwritten standard through Table-B as a standard issue. Any case rated above these limits will not qualify for simplified issue (This case could be resubmitted on our 1459 application as a regular payroll deduction applicant with regular evidence requirements. Normal plan amounts will be applicable).

Rated Spouse Rider - not available as simplified issue

Rated WP/WMD - Waiver will be deleted if base is standard

10. The only premium frequency available will be monthly. List billings, except initial billing will be mailed directly to the employer each month. The employer can choose any one of four billing formats; alphabetically, by Social Security Number, by employee I.D. number, or by policy number.
11. Forms needed for simplified issue will be as follows:
 - a. Application 1459 parts A and B.
 - b. Confidential Census and Employee Data Form 1551 (front and back).
 - c. Employer Acceptance, Form 491. (one per company)
 - d. Payroll Deduction Authorization, Form 492. (one per each employee)

12. CWA and COD applications will be allowed. The first month's premium will be required on all CWA cases. (Please refer to Page B-26 for conditional coverage terms. Also, please refer to GOVERNMENT ALLOTMENTS, Page B-27, No. 2 for Age-Save instructions).
13. Nonsmoker rates will be available under this program. (Please refer to page C-2 for the nonsmoker parameters involving age and amounts).
14. New employees may apply to be added to the payroll deduction plan provided that they have been actively at work with this employer for at least 6 months.
15. Policy dating will be determined by the information provided on the Payroll Deduction Authorization Form 492. (Refer to Page B-6.) Policies could be dated on any day of the month (days 1 through 28).

You may use both methods of policy underwriting, Simplified Issue Underwriting and Regular Underwriting, within the same business. Product issue limits other than the issue limits stated for The ULtimate, Vanguard, and Contender (WL-95) when used in simplified issue are the same as individual limits stated in this manual.

Any of our products, their features and available riders can be used in our payroll deduction program when you use our regular underwriting rules. These products would also be available to any employee's spouse, children or relatives. Our regular application 1459 must be used for full evidence requirements.

Our experience indicates that certain occupational groups are either subjected to job-related hazards or have a high turnover, leading to poor persistency. The following list, although not inclusive, indicates the types of businesses which are transient, seasonal or hazardous and are unacceptable to our payroll deduction program.

Agricultural Workers	Federal, State and Local
Amusement Parks	Government Employees
Bands, Musicians	Gambling Houses
Bars, Taverns, Night Clubs	Hotel and Motel Workers
Bowling Alleys	Junk Dealers
Chemical Workers	Liquor Stores
Construction Workers	Lumbermen
Convenience Stores	Merchant Marine
Dance Studios	Miners
Farms, Ranches	Movie Theaters
Fast Food Restaurants	Parking Lots
	Race Tracks

Please contact the Underwriting Department if clarification is needed on any given employer.

PREMIUM DEPOSIT FUND (PDF)

The Company will accept payment of premiums in advance, using the rate of interest currently allowed on funds left on deposit with the Company. The Company reserves the right to limit any amount it will accept as a premium deposit. The maximum deposit with earned interest cannot exceed the remaining premiums due, and in some states the maximum deposit is limited by law. The minimum amount on deposit on any new or existing policy is \$50.00.

At the policyowner's request, the Company will pay current premiums from the PDF balance. If the premium is past due and the Company is not notified differently, the amount being held in the fund, if sufficient, will automatically be used to pay the premium.

Deposits will be credited at a rate declared periodically the Company, but not less than 1% interest. Interest is subject to income taxation when credited.

The maximum premium is \$150,000 into the PDF without prior company approval.

Upon request all of a portion of the Owner's PDF balance may be withdrawn, but the Company reserves the right to allow no more than one partial withdrawal in any policy year. Any funds remaining unused upon death of the Insured will be paid in a lump sum to the named beneficiaries, if living, otherwise to the Owner or, if applicable, the Owner's estate. Any balance in the PDF on the policy's maturity date will be paid to the Owner. If there is a transfer of ownership, any balance win the fund at the time of the transfer will be paid to the previous Owner unless requested otherwise.

The use of a Premium Deposit Fund is regulated by state in some states. If a state requires that premium deposit funds be handled on a basis different from that set forth herein, then that law will be applied.

Please see SPECIAL BULLETIN 12-12 for Additional Details.

DELIVERY AND REMITTANCE

delivery of policy

All policies issued by the Company are mailed to the Agent for delivery. Any special instructions applicable to a particular policy must be observed by the Agent, as well as the instructions herein contained. Before taking the policy to the applicant, the Agent should review it carefully. If a mistake is discovered, the policy should be returned promptly to the Home Office. *Agents do not have the authority to change or alter a policy in any manner.*

DELIVERY RECEIPT - Lafayette Life requires a Policy Delivery Receipt (Form 1562) which the Agent must use to verify that delivery occurred. Occasionally, an Owner will claim, long after the policy was issued, that the policy was never delivered and will request a full refund of premiums under the policy's free look provision. Where the Agent cannot produce sufficient documentation to show that delivery actually occurred, the Company may be required to honor the Owner's request. If premiums are refunded, this will result in total reversal of all compensation received by the Agent. The Policy Delivery Receipt, if used correctly, can provide the Agent with evidence to show that delivery of the policy took place.

delivery requirements

Policy delivery must be made and requirements received in the Home Office, including any initial premium due. Policy delivery must be made and requirements (including any initial premium due) received in the Home Office within the policy delivery deadline stated in the Policy Transmittal Letter (usually 30 or 60 days from the date the policy was mailed from the Home Office).

A policy should always be delivered in person. Review it carefully with the policyowner to strengthen his/her confidence in both the Agent and the Company.

Delivery requirements are:

1. Collect the initial premium or balance due.
2. Get signatures on amendments, Policy Delivery Receipt, and other forms as instructed by the Home Office. These **MUST** be signed on delivery and a signed copy must be returned to the New Business-IPO Department.
3. Follow your state regulations, which may require a Policy Summary and Buyer's Guide or other specific state forms to be delivered with the policy.
4. If any change whatsoever has occurred in the health or occupation of the applicant, your Underwriter must be

notified immediately. Do not deliver the policy until approved by your Underwriter.

If delivery requirements have not been completed within the delivery period, the policy must be returned to the Home Office. Should circumstances warrant an extension of time the Agent must submit such a request to the New Business-IPO Department **prior** to the end of the Delivery Period. A Health Certificate or other evidence may be required.

INSPECTION RECEIPT - Whenever an applicant insists on examining a C.O.D. policy before paying the initial premium, in all cases an "Inspection Receipt" (Form 1328) must be completed and signed by the applicant. The completed form should then be sent immediately to the Home Office, Agents Accounts Section. The policy may be held by the applicant for a maximum of 14 days. Then the initial premium must be collected or the policy returned as not taken. The receipt may not be used to extend the Delivery Period.

WHEN POLICIES MUST NOT BE DELIVERED -Unless the full first premium was paid at the time the application was signed, a policy must not be delivered under any of the following circumstances:

1. If any change whatsoever has occurred in the health or occupation of the applicant since the date of his or her medical examination (or nonmedical). In such event, the policy must be returned to the Company at once with a letter of explanation.
2. If the first premium is not fully paid. Agents should endeavor to collect the premium with the application, and thus save themselves the difficulty of having to do so the business a second time.
3. If 60 days has elapsed from the date the policy was mailed from the Home Office. If delivery is not made within 60 days, the policy must be returned for cancellation or to be held by the Company pending evidence of insurability. If circumstances warrant, permission may be given to deliver a policy after the 60 day limit on securing satisfactory health certificate on the form to be furnished by the Home Office. Requests for extension must be received in the Underwriting Department prior to the end of the 60 days.

premium remittance

Initial premiums collected on delivery (C.O.D.) must be sent to the Home Office immediately. Payments collected with the application (C.W.A.) should accompany the application and be sent to the Home Office promptly. Normally, only an Owner's check is acceptable for initial premiums, reinstatements, renewals, etc. A money order or cashier's check may be used when necessary. Agent or agency checks will not be accepted.

PREMIUM REMITTANCE BLANK — All Agents' remittances to the Home Office must be accompanied by the proper remittance form. This form must be completed, giving the policy number (if any), name of Insured or applicant, premium due date and amount being remitted.

INITIAL PREMIUMS - The first premium collected upon delivery of a new policy should be forwarded to the Home Office immediately, accompanied by a completed remittance blank, Form 604, for C.O.D. business only.

Amounts due the Company must be promptly remitted to the Home Office. The Company's practice of allowing a delivery period for placing a new policy refers only to the time permitted for settlement with the proposed Insured; not for the settlement with the Company when the premium has been collected.

All checks, drafts, and money orders in connection with Company business including applicant's or policyowner's checks for payment of premiums, must be drawn payable to The Lafayette Life Insurance Company and sent to the Home Office or to the Agency office through which the Agent reports his business. No Agent has authority to cash or deposit such checks.

OTHER PREMIUMS - The Agent is not authorized to collect premiums, other than the initial premium, except where the policy is being rewritten, modified, reinstated, converted or when a later payment notice has been received and the Agent collects a premium to prevent lapse of the policy. Any collected premium, other than the initial premium, should be forwarded with a completed remittance blank, Form 604. Checks should be made payable to The Lafayette Life Insurance Company, not the Agent.

CWA AND MISCELLANEOUS PAYMENTS - Cash with applications and all other miscellaneous payments to the Company should be accompanied by a completed remittance blank, Form 604.

SEPARATE CHECKS - A separate check must be attached to each remittance blank in payment of the items listed. This will assure prompt and proper credit.

PAYMENTS SHORT - Initial premium shortages on new Ordinary and Universal Life applications of \$1.00 up to and including \$10.00 per policy will automatically be charged to your Agent's account in order that the case may be released and commissions paid more quickly. This does not apply to Government Allotment.

PREMIUMS OVER - Overpayments of one dollar (\$1.00) or more shall be refunded by a check payable to the Owner.

PREMIUM FOR ADDITION OF A BENEFIT - There is inconvenience to both the Agent and the Company when a policy benefit is being added in having to collect a small premium to pay for the additional coverage to the next premium due date. To alleviate this problem, as well as to give the Agent a little extra sales leverage, free coverage will be allowed to the next premium due date if the additional premium due for the new benefit or option is less than \$5.00.

outstanding business

The Company considers all new policies as "outstanding" until settlement for the initial premium has been made with the Company and all delivery requirements are met.

Notification will be sent to the Agent of outstanding past due business, requesting immediate settlement of the initial premium or the return of the policy for cancellation.

undelivered policies

Pages 3, 3A, and 4 of all undelivered policies must be returned to the Home Office within 60 days from the date of issue.

All commission checks due the Agent will be held up until past due outstanding business has been accounted for and either the policy returned for cancellation or a settlement received to cover the initial premium together with the completed health certificate. There will be a \$25.00 charge for any undelivered policy after 60 days. The fee also applies whenever a trial application should have been submitted, but was not.

NOT TAKEN BUSINESS - This term applies to returned policies on which the full first premium has not been paid. Any partial payments being held on deposit will be refunded to the applicant.

CANCELLED POLICIES - If the delivery requirements are met, and the applicant is not entirely satisfied or has changed his or her mind and does not want the insurance, the applicant may return the delivered policy within the “right to return” period (see B-5 and below). A statement to this effect must accompany the returned policy.

INITIAL PREMIUM REFUNDS - When a policy is returned within the “right to return” period after it has been delivered normally 20 days, a full initial premium paid will be refunded. **USE OF A POLICY DELIVERY RECEIPT IS ENCOURAGED (REQUIRED BY SOME STATES)**. When you ask the applicant to sign and date a receipt for the policy, both you and we can easily determine whether a full premium refund is required.

Additionally, when a policy is returned by the agent within 60 days after it has been mailed to the agent for delivery, without having been placed or when the applicant has changed his mind after the right to return period, but within 60 days of our issue, the Company will consider refunding the premium less the short term insurance charge for coverage from the date when the insurance took affect until the policy is returned for cancellation. The conditional receipt, if detached from the application, must also be returned with the policy. In CWA cases, insurance premiums are usually calculated from the date of the application. Premium for the term insurance period may, at the Company’s discretion, be deducted from the applicant’s premium refund or from the Agent’s account.

All refunds must be made by Company check and should not be made by the Agent.

declined or postponed policies

As soon as a case is declined or postponed, a letter will immediately be typed (postdated 2 days) and the Agent’s copy will be mailed immediately.

The applicant’s copy of the letter will be sent on the date of the letter.

If there is CWA, a refund check will be sent directly to the applicant with the Decline or Postpone Letter.

incompleted policies

- a. On any case where: (1) the Agent tells us to incomplete the application; (2) we have offered a Rated Policy and so informed the Agent in writing, but the Agent advises that the applicant desires that we close the file, or (3) neither the Agent nor the applicant responds to our offer of a Rated policy, we will issue an Incomplete Letter.

The Incomplete Letter will be dated currently for situations (1) and (2) and postdated 3 days for situation (3). The Agent’s copy will be mailed immediately to the Agent. The applicant’s copy of the letter will be mailed to the applicant on the date noted on the letter and the refund check, if any, will be mailed to the Agent

- b. Where the application is incompleted because we do not have sufficient information to underwrite the application (e.g., medical EKG, etc.), we will close the file. We will then prepare an Incomplete Letter (postdated 7 days) and mail it immediately to the Agent. The applicant’s copy of the letter will be mailed to the applicant on the date noted on the letter and the refund check, if any, will be mailed to the agent.

NOTE: On any case received where Lafayette Life, or any other company brought to our knowledge, has declined or rated Table E or above in the previous 12 months - and CWA is sent with the application, we will immediately refund the money directly to the applicant (copy to Agent) along with a letter explaining we are not on the risk unless a policy is issued and the premium paid on delivery. We will also ask for the return of the Conditional Receipt and telephone the Agent if possible, and tell him what An Underwriter will attempt to telephone the Agent promptly and we are doing.

Commissions and Agent's Reports

commissions

Agents' commissions are governed by their contracts with the Company. The Company will determine the commission on all policy changes and any new policy forms not covered by the Agent's contract with the Company.

If a question arises as to which Agent is entitled to commission on a particular case, the Company's decision shall be final. When the Company returns any premium or premiums to a policyowner, or recalls or cancels a policy, the Agent and General Agent will lose all rights to any commission or allowances on such premiums, and shall return upon the demand of the Company, any commissions and allowances that have already been paid on such premiums.

REWRITTEN BUSINESS - When a new policy is issued to take the place of a permanent ordinary plan of insurance which has lapsed or was surrendered within one year prior to the date of the new application or when the older policy is lapsed or surrendered within one year after the new application, the new policy will be treated as a "changed policy" and its first year commissions and allowances will be adjusted. (Rewritten term policies will be treated as conversions.) The commissions to be allowed will be reduced by the commission paid on the previously issued policy or policies. Different rules will apply when policies are replaced by Universal Life. These rules are found in "special bulletins" mailed periodically to the Agent.

COMMISSION ON INITIAL PREMIUMS - When cash settlement for the first premium accompanies the application and the policy is issued as applied for, the Agent's commission is credited. When cash settlement accompanies the application and the policy is not issued as applied for, commission will be allowed upon payment of the balance of the premium and receipt of any supplemental forms signed on delivery.

COMMISSION ON DEFERRED FIRST YEAR AND RENEWAL PREMIUMS - Commission is credited to the Agent's account immediately upon payment of the premium by the Policyowner.

COMMISSION ON TERM CONVERSIONS - For term policies issued before the Excel Series, full commissions are payable on term conversions after the end of the first policy year. No commissions are paid on term conversions of the Excel Term Series. For the Elite Term Series, commissions are paid on 50% of the conversion credits. Please contact Agents Accounts for details.

RENEWAL COMMISSIONS ON PREMIUMS PAID BY AUTOMATIC PREMIUM LOAN - Renewal commissions are paid on premiums paid by APL.

SPECIAL COMMISSION RULES - Commissions are paid to the Agent or Agents whose names appear on the application for the policy and not otherwise.

Regular commissions are allowed on permanent extra premiums charged for physical or occupational hazards. This also includes extra premiums for aviation coverage.

Commissions are paid on monthly deductions for Riders on Universal Life policies.

No first year commission is earned until the policy has been issued, delivered to and accepted by the Insured.

No commission is allowed on short term insurance premiums, or on temporary extra premium ratings.

No commissions shall be paid on premiums or monthly deductions waived because of disability.

Commissions will not be paid to an agent on any insurance products used to fund such agent's qualified retirement program.

If it becomes necessary for the Company to return a premium and cancel the policy for any cause, the Agent shall be required to repay the Company, on demand, any commissions, asset based compensation, service fees and all allowances including bonuses of any kind received on the premium so returned relating thereto or pertaining to the policy.

agent's reports

COMMISSION STATEMENT -The Agent is furnished monthly with an itemized statement of commissions earned for that month. First year and renewal commissions are listed separately. Also shown on the statement will be various charges and credits to the account, such as checks issued, advertising material, etc.

DAILY COMMISSION CHECKS - Effective January 1, 2003, the following field compensation program will be initiated for all terminated and active field associates:

Daily commission payments will be available for all active field associates on EFT processing. The minimum commission transaction amount will be \$100.00. In the event the commission balance is less than \$100.00, we will accumulate commissions until they exceed that amount.

Non EFT (hard check) commission transactions will be processed two times per month - the first business day of the month, and the first business day following the 15th of the month, (Active Agents only). The minimum commission transaction amount will be \$100.00. In the event the commission balance is less than \$100.00, we will accumulate commissions until they exceed that amount.

The minimum commission transaction amount for terminated agents will be \$300.00.

All agents receiving advanced commission payment must be on the EFT system. If you are not on EFT, all commissions will be paid on an as earned basis.

All commission accounts will be cleared each year on the final business day of the year.

COMMISSION INFORMATION TO GOVERNMENT—At the end of each calendar year, the Company is required to report to the Internal Revenue Service the amount of commissions and other income earned by each Agent during the year.

AGENCY BUSINESS REPORT - After the close of business on the last working day of each month, the Company will prepare and mail to each general agent an Agency Business Report. This is a comprehensive report that incorporates important statistics for each writing agent.

The report will show the current month and year-to-date accumulations of both submitted and paid policies. Also, the credits earned for the production clubs and the convention are exhibited. Information regarding policy lapses, net in force data, and persistency calculations will also be displayed.

The bonus statement is also a part of the Agency Business Report.

COMMISSIONS AND ASSET BASED COMPENSATION FOR THE MARQUIS ADVANT-EDGE 5 & 10 - The commission rates and asset based compensation percentages for the Marquis Advant-Edge 5 & 10 will be the same as our current Marquis Flex 5 & 10 products, and any such compensation shall be subject to the terms and conditions of your agent's contract; provided, however, the timing of payment and the calculation of any asset based compensation to agents shall be different than the current Marquis Flex 5 and 10 products as detailed below.

For the Marquis Advant-Edge 5, any asset based compensation on a policy is payable on the 5th policy anniversary plus 60 days and on each policy anniversary thereafter. For the Marquis Advant-Edge 10, any asset based compensation on a policy is first payable on the 5th policy anniversary and on each policy anniversary thereafter through the 9th policy anniversary. Also, for the Marquis Advant-Edge 10, any asset based compensation is payable on a policy's 10th policy anniversary plus 60 days, and on each policy anniversary thereafter.

Notwithstanding any term to the contrary regarding the calculation of asset based compensation, with respect to any asset based compensation on (a) a Marquis Advant-Edge 5 policy payable on the 5th policy anniversary plus 60 days (the "5th Policy Anniversary ABC Calculation Date"), any such asset based compensation shall be based upon and paid as a percentage of the difference of the net accumulated policy value calculated as of the 5th Policy Anniversary ABC Calculation Date less any premium credited to such policy value within the 12 months immediately preceding the 5th Policy Anniversary ABC Calculation Date, and (b) a Marquis Advant-Edge 10 policy payable on the 10th policy anniversary plus 60 days (the "10th Policy Anniversary ABC Calculation Date"), any

such asset based compensation shall be based upon and paid as a percentage of the difference of the net accumulated policy value calculated as of the 10th Policy Anniversary ABC Calculation Date less any premium credited to such policy value within the 12 months immediately preceding the 10th Policy Anniversary ABC Calculation Date. Except as otherwise set forth, any asset based compensation is calculated as of the date of the applicable policy anniversary.

This Notice shall be part of your agent's contract Schedule of Compensation / Schedule of Commissions and Service Fees. Except as specifically modified by this Notice as to the timing of payment and the calculation of any asset based compensation, all compensation on the Marquis Advant-Edge 5 & 10 shall be subject to the terms and conditions of your agent's contract as if specifically listed in your respective schedule.

INTEREST CHARGED ON INDEBTEDNESS - Any debts that you owe us shall bear interest after demand at the same interest rate as the dynamic policy loan interest rate determined by Lafayette Life from time to time on policies then being issued by Lafayette Life. The rate of interest charged shall be declared monthly without notice and shall apply thereafter until a new interest rate is declared.

This Page Intentionally Left Blank

Policy Administration

DIVIDENDS

The dividend for the first policy year is contingent upon payment of the entire premium for the second policy year. (By current company practice and subject to change, the first year's dividend will be payable upon the payment of the first modal premium of the second policy year.) Thereafter, dividends are credited on policy anniversary. The amount of dividend paid depends upon the plan of insurance, age at issue, policy duration, and other factors.

The total annual amount of dividends to be distributed to the policyowners is determined by the Company's Board of Directors. The primary consideration is to declare the largest dividend possible which is consistent with overall sound financial management, security of benefits, and progressive growth.

Universal Life policies, The One, HomeEquity Term, and Ten Year Renewable Term are participating but no dividends are anticipated. Elite Term plans are non participating.

DIVIDENDS ARE NOT GUARANTEED - State statutes and regulations are very explicit that dividends are not guaranteed, and this must be communicated to the applicant. Every dividend illustration used must be accompanied by the following wording: "Dividend illustrations are based on the Company's current scale and are neither guarantees nor estimates for future years."

DIVIDEND OPTIONS - Dividends may be applied, at the option of the policyowner, in any one of the following ways: (If no option is chosen on the application, the "automatic" option for that policy will be used.)

1. Paid in cash.
2. Applied toward the payment of premiums: **RULE** - This option is not available on Universal Life or if premiums are paid by Government Allotment or by Discounted Premium Deposit.
3. Left with the Company to accumulate at interest: **RULE** - The Owner must have certified his or her Tax Identification Number on the appropriate form in order to allow this option.
4. Used to purchase participating paid-up additions: **RULE** - This is the automatic option. This option is not available on Term policies, Universal Life, and substandard Whole Life policies above Table F or \$15 per \$1,000 flat extra. Substandard rates will be used on policies with Table ratings B and above or flat extras of \$5 and above per \$1,000 and over 5 years.
- *5. Used as a net single premium to purchase as much One Year Term Insurance as the dividend will buy (OYT).

RULES:

- a. Available on permanent whole life policies.
 - b. Minimum policy size is \$10,000.
 - c. Maximum face amount of all policies with one year term dividend options is \$1,000,000.
 - d. Not available on substandard policies, or on Qualified Simplified Issue or Qualified Guaranteed Issue.
 - e. Base policy underwriting rules apply.
- *6. Left with the Company to accumulate at interest, with One Year Term Insurance equal to the cash value as of the next policy anniversary date to be purchased from the accumulations (OYD). The owner must have certified his or her Tax Identification Number on the appropriate form in order to allow this option.

RULES:

- a. Available on permanent whole life policies.
 - b. Minimum policy size is \$10,000.
 - c. Maximum face amount of all policies with one year term dividend options is \$1,000,000.
 - d. May be included on substandard risks up to Table D.
 - e. Base policy underwriting rules apply.
 - f. The owner must have certified his or her Tax Identification Number on the appropriate form in order to allow this option.
- *7. Used to purchase One Year Term Insurance equal to the cash value as of the next policy anniversary with any excess used to reduce premiums (OYR)

RULES-Same as Option 6 and Option 2.

- *8. Used to purchase One Year Term Insurance equal to the cash value as of the next anniversary with any excess used to buy paid-up additions (OYP).

RULES-Same as Option 6. Substandard rates will be used as indicated in Option 4.

9. Applied toward the payment of premiums with any excess used to buy paid-up additions.

*not available below issue age 15.

This option is not available on Universal Life, Term policies, and substandard Whole Life policies above Table F or \$15 per \$1,000 flat extra. Substandard rates will be used on policies with Table ratings B and above or flat extras of \$5 and above per \$1,000 and over 5 years.

ADDING OPTIONS 5, 6, 7 or 8 TO EXISTING POLICIES -

- (a) Use the application 1043 approved by your state. Complete the Insured's name and entire non-medical section of the application including date and signatures. In the "Other Instructions" block on Part I of the application, insert: "Add dividend _____ - one year term for full amount of dividend to policy number _____ on _____ (Insured) _____."
- (b) Submit policy along with the application.
- (c) When a medical exam is required, you may omit the non-medical questions on the application.
- (d) Underwriting Rules for Option 5 (OYT) :
 - (i) Within two (2) years of issue, use \$150,000 nonmedical limit through age 45. All others require medical evidence at no expense to Company.
 - (ii) After two (2) years, use regular nonmedical limits. If medical evidence is required, it is at no expense to Company.
- (e) Underwriting rules for Options 6, 7, and 8:

(i) Special nonmedical limits are

AGES	BASE AMOUNT
0 - 45	\$250,000
46 - 50	100,000
51 - 55	50,000

(ii) All others require medical evidence at no expense to Company.

DELETING OPTIONS 5, 6, 7, or 8 -

- (a) Use the 1043 application approved by your state. Complete Part 1 only.
- (b) Submit policy along with the application.

CONVERSION OF OPTIONS 5, 6, 7, AND 8 - The term insurance provided by dividend options 5, 6, 7, and 8 is convertible. See Page B-45, *conversions of one year term dividend options*, for details.

ALL OTHER OPTION CHANGES - Use Policy Service Request Letter, Form 2068. Lafayette Life currently does not require evidence of insurability to change to option 4 for future dividends.

Transfer of dividend accumulations to paid-up additions

EVIDENCE OF INSURABILITY REQUIREMENTS -

The following evidence of insurability is required for the transfer of dividend accumulations to paid-up additions for all plans of insurance with paid-up additions permitted. If the paid-up additions death benefit (contact the Home Office for this quote) exceeds the dividend accumulations amount by:

- a \$2,500 or less, a statement of good health will be required from the Insured;
- b over \$2,500 but less than \$10,000, a nonmedical application should be completed;
- c \$10,000 and up, the evidence of insurability required will be the same as that required for a new policy with the exception of the inspection report.

TRANSFER APPLICATION FORM - Form 2068, "Policy Service Request Letter," should be used for requesting the transfer of dividend accumulations to paid-up additions.

ONE YEAR TERM INSURANCE# PURCHASED BY DIVIDENDS*
PREMIUMS PER \$1,000

ATT'D AGE	MALE	FEMALE	UNISEX	ATT'D AGE	MALE	FEMALE	UNISEX
15	.78	.48	.72	55	6.03	4.03	5.63
16	.87	.51	.80	56	6.58	4.29	6.13
17	.95	.53	.87	57	7.17	4.54	6.64
18	1.00	.55	.91	58	7.80	4.79	7.19
19	1.03	.57	.94	59	8.48	5.06	7.80
20	1.05	.58	.95	60	9.24	5.39	8.47
21	1.05	.59	.95	61	10.10	5.80	9.24
22	1.03	.61	.95	62	11.06	6.32	10.11
23	1.01	.62	.93	63	12.15	6.95	11.11
24	.99	.63	.92	64	13.35	7.65	12.21
25	.96	.65	.90	65	14.64	8.41	13.39
26	.95	.66	.89	66	16.02	9.19	14.65
27	.94	.68	.89	67	17.49	9.97	15.98
28	.94	.70	.89	68	19.06	10.78	17.40
29	.95	.73	.90	69	20.80	11.67	18.97
30	.97	.76	.92	70	22.75	12.74	20.75
31	.99	.78	.95	71	24.98	14.04	22.80
32	1.03	.81	.99	72	27.55	15.66	25.17
33	1.08	.85	1.03	73	30.44	17.59	27.87
34	1.13	.89	1.08	74	33.61	19.83	30.85
35	1.20	.94	1.14	75	36.99	22.31	34.05
36	1.28	1.00	1.22	76	40.54	25.00	37.43
37	1.37	1.08	1.31	77	44.21	27.87	40.94
38	1.48	1.17	1.42	78	48.03	30.98	44.62
39	1.60	1.28	1.53	79	52.12	34.41	48.58
40	1.74	1.39	1.67	80	56.61	38.32	52.95
41	1.88	1.52	1.81	81	61.65	42.81	57.88
42	2.04	1.64	1.96	82	67.33	47.99	63.46
43	2.22	1.76	2.13	83	73.61	53.84	69.66
44	2.40	1.89	2.30	84	80.37	60.29	76.35
45	2.60	2.02	2.49	85	87.44	67.26	83.40
46	2.82	2.16	2.68	86	94.72	74.70	90.71
47	3.04	2.30	2.89	87	102.15	82.60	98.24
48	3.29	2.46	3.12	88	109.74	90.96	105.99
49	3.55	2.64	3.37	89	117.53	99.85	113.99
50	3.85	2.82	3.65	90	125.63	109.37	122.38
51	4.20	3.03	3.96	91	134.26	119.72	131.35
52	4.58	3.26	4.32	92	143.79	131.28	141.28
53	5.02	3.51	4.72	93	155.17	144.88	153.11
54	5.51	3.77	5.16	94	170.49	162.38	168.86

#The "One Year Term Insurance" dividend option, if desired, must be requested in the application or is subject to satisfactory evidence of insurability.

* Figures involving dividends or cost of term insurance are based on the current scale and are neither guarantees nor estimates for the future.

To find the amount purchased by \$1 dividend, divide 1000 by the appropriate premium above.

Example: Female Age 35

Amount purchased by \$1 dividend = $1000 / 0.94 = \$1,063.83$

Amount purchased by \$100 dividend = $100 \times (1000 / 0.94) = \$106,383$

REINSTATEMENT

notice of lapse

If a required premium is not paid, a Reinstatement Offer is mailed to the policyowner 35 days (61 days for Universal Life) after the due date. A copy is sent to the Servicing Agent.

REINSTATEMENT OFFER - For all policies except Universal Life, if the premium payment is received by the Home Office within 19 days after the end of the grace period, and provided the Insured is living at the time payment is made, the Company will waive the requirement of evidence of insurability and automatically reinstate the lapsed contract. This plan is not an extension of the grace period but a liberalized reinstatement procedure. Coverage ceases on the last day of the thirty-one (31) day grace period. For Universal Life all coverage ceases on the last day of the 61 day grace period and reinstatement after that grace period will only be considered if evidence of insurability is provided.

REINSTATEMENT APPLICATION - If the premium is not received prior to the expiration of the Reinstatement Offer (50 days after the due date for all policies except Universal Life, which is 61 days), an Application for Reinstatement, Form 80, will be needed to apply for reinstatement of the policy.

LAPSED POLICY FORM LETTER - Fifty (50) days (61 days for Universal Life) after the premium due date, providing payment has not been received, a lapse letter is mailed to the policyowner urging reinstatement. A Reinstatement packet is attached to the letter and a copy of the letter is mailed to the Servicing Agent. The Reinstatement packet includes the Application for Reinstatement, the Authorization to Release Information and any other form your state may require to apply for reinstatement of a lapsed policy.

REINSTATEMENT PROCEDURE - A lapsed policy may be reinstated upon evidence of insurability satisfactory to the Company and completion of the following requirements:

1. Forward Application for Reinstatement (Form 80) completed on all proposed insureds on the policy with completed Form 1453. Remittance should include all past-due premiums, together with interest from their due dates to the date of payment at the rate of 6% per annum for policy series 1979 and after and 5% per annum for policy series prior to 1979. For Universal Life, past due premiums do not have to be paid. However, remittance must be made of sufficient premium to keep the policy in force for the next three months.
2. Payment or reinstatement of any indebtedness to the Company at date of lapse plus interest from the date of lapse, providing that such indebtedness with interest to date of reinstatement be no greater than the loan value of the policy if so reinstated.
3. The policy is not required for reinstatement-except when some change in the policy is being requested. Reinstatement by redating is not allowed.

In accepting the settlement from the policyowner, the Agent should make no promise whatsoever concerning the possibility of reinstatement. If the premium on a lapsed policy is tendered without an application for reinstatement, the Insured is asked to complete an application at once and is notified by the Company that his remittance is being held without coverage by the Company, pending approval. In the event the Insured fails to complete an application or if reinstatement is declined, the original remittance is returned.

AGENT EFFECTING REINSTATEMENT - It is important that the name of the Agent effecting reinstatement of the policy appear as a witness on the application for reinstatement. If reinstatement is effected more than sixty (60) days after due date of the unpaid premium, the reinstating Agent is eligible to receive remaining commissions available after reinstatement.

EVIDENCE OF INSURABILITY REQUIRED - Any evidence requirements in addition to the application for reinstatement for any lapsed case should be secured from the Home Office. The Company reserves the right to require a medical examination in connection with the application for reinstatement. The expense of any medical examination required is to be borne by the Insured. When the evidence is approved and the policy is reinstated, a copy of the reinstatement application is mailed to the Owner to attach to their policy because the contestable period starts over again.

FORMS REQUIRED - Reinstatement forms furnished by the Company are to be used. Reinstatement forms are to be completed by the Insured except on Juvenile cases, in which case they should be completed by the policyowner. If the Insured is an adult and the policy is owned by another person, the form must be completed and signed by both the Insured and the Policyowner. Juvenile policies with Payor Benefit require evidence of both Insured and Payor. Be sure to complete evidence on *all persons insured* by the policy. The Authorization to Release Information (Form 1453) is also required.

DECLINED REINSTATEMENTS - If an application for reinstatement is declined, the Insured is notified of the Company's action and his remittance returned. It is sometimes possible to offer another policy on the same plan and bearing the same date but with an increase in premium due to some impairment or to a change in occupation. If so, the Insured is notified that the application for reinstatement of the policy as originally issued has been declined and the revised policy is offered. The Insured may accept the offer by returning the policy for reissue along with a remittance to pay premiums on the revised policy and a Policy Change Form (1043).

automatic premium loan provision (APL)

Our traditional Life policies include an Automatic Premium Loan Provision which is made operative only if elected by the policyowner in the application for the policy or upon subsequent written request to the Company provided no premium is in default at the time a request is made. The provision may also be revoked at any time upon written request to the Company, unless mandated by state law.

This is an important provision for the Insured, since it acts to prevent inadvertent lapse of the policy. As long as a policy is being carried under the APL provision and has sufficient loan value available, premium payments may be resumed without evidence of insurability requirements. Policies with Paid-Up Additions Riders or Single Premium Life Riders have a provision to automatically pay premiums from rider value when they are overdue. See "Automatic Surrender to Pay Premiums" on Pages C-9 and C-12.

It should be remembered that the APL provision is not applicable to term insurance or Universal Life, and should not be requested in such cases. Since the value of the policy is used to pay premiums automatically, it applies only to policies that contain a loan provision. If the APL provision has been requested, it is not necessary to again notify the Home Office that a particular premium should be paid by automatic loan.

PROCEDURE - Under this privilege, any premium not paid before the expiration of the grace period shall be treated as paid and charged automatically as a loan against the policy, provided that there is sufficient value. If such value is not sufficient to permit the overdue premium to be so charged, this privilege shall not apply and the Extended Term Provision of the policy shall be effective where applicable. The amount of any such premium loan with interest shall become a first lien upon the policy.

The first two premiums after default will be paid by APL on the payment frequency in effect. Then the balance of an annual premium will be paid by loan and the frequency will be changed to annual. When there is not enough loan value to pay a given premium, the policy will be changed to the next lower frequency.

LAPSE OF A POLICY WITH A LOAN - Interest on the loans at the rate as provided in the policy will be due and payable at the end of each policy year. Whenever the total indebtedness equals or first exceeds the full amount available as a loan, the policy will terminate but in no event until thirty-one (Universal Life is 61) days after notice has been mailed to the Owner and any assignee of record with the Company.

TO RESUME PREMIUM PAYMENTS - While the policy is being continued in force by Automatic Premium Loan Provision, the Insured may, without evidence of insurability, resume payment of premiums at any time and may repay the indebtedness at his convenience. If the policy has been put on Extended Term Insurance evidence of insurability is required, unless there is more than 5 years of term insurance remaining.

ALL BENEFITS CONTINUE - The word "Premium" as used in the APL provision includes the premiums for all additional benefits provided by riders, if any, attached to a policy. This fact points up a very definite advantage of the Automatic Premium Loan Provision over the Extended Insurance Option. Under APL all extra benefits and riders continue effective; and, if the payment of premiums is resumed prior to cancellation of the policy, none of the extra benefits or riders are lost. Under Extended Insurance nonforfeiture option, the basic policy only is continued to the

end of the period specified and then expires.

RENEWAL COMMISSIONS - See Commission section of Agents Reference Manual.

SURRENDERS

Any full or partial surrender or withdrawal may result in some taxable income to the Owner. Frequently, a withholding notice/election form must be signed.

full

If a policyowner is surrendering the policy for its cash value, a Cash Surrender Form must be sent to the Home Office. A witness to the signature is required.

Agents should discourage the surrender of a policy for several reasons; it means a loss of business to the Agent and the Company, and more importantly, a loss to the policyowner. The policyowner loses protection, is faced with an increased cost of obtaining new protection, and even the possibility of being uninsurable. Suggest a policy loan, if available, to relieve the present financial situation, which is often only temporary, and thus keep the policy in force.

partial

The owner of a Universal Life policy may surrender part of the cash value subject to the rules stated in Section D. A partial cash surrender form (Form 2068) must be sent to the Home Office. A partial surrender is not a loan, but the death benefit is decreased.

The owner of a Single Premium Life Rider or Paid-Up Additions Rider may surrender part of the rider subject to the rules and any surrender charge. A special partial cash surrender form must be sent to the Home Office. A partial surrender may also take place to pay a premium on the policy. See Pages C-9 and C-12.

withdrawals

The owner of a Flexible Premium Annuity, including the Horizon, may make a partial cash withdrawal of part of the cash value subject to the rules and any surrender charge. A partial cash withdrawal form (Form 2066) must be sent to the Home Office.

POLICY CHANGES

As the insurance needs and financial circumstances of policyowners change, the Company may be asked to reissue or change policies in various ways. These changes may be classified in general as (a) changes which are made at the request of the Insured or the Owner in accordance with policy provisions and (b) changes for which no provision has been made in the policy and which may be made only with the consent and approval of the Company. Evidence of insurability is required for changes which increase coverage. The Company reserves the right to request a medical examination.

The policy and the original application, a copy of which is attached to and made a part of the policy, constitutes the entire contract between the Insured and the Company. Only an officer of the Company has authority to modify or waive the provisions of the contract, and then only in writing. The Company shall not be bound by any promise or representation made by or to an Agent or person except as explained above.

The policy may be changed to another amount or plan of insurance not prohibited by law, subject to approval by the Company, any cost and furnishing of such requirements as the Company considers necessary.

Policy changes are often complex and cannot be determined without a careful examination of the records, the status of the policy, and the insurability status of the Insured. It is not practical to attempt to formulate rules which can be used in the field but such requests for changes should be referred to the Home Office. By addressing a letter to the Company with full particulars as to the change in the Insured's situation and insurance needs, the Company will consider changing the contract and will furnish the necessary forms and instructions for making the change. The Policy Change Application (1043) is required. *When you add a benefit or rider to a 1980 CSO traditional policy, you no longer need to return the policy to the Home Office.

REDUCTIONS IN AMOUNT - If the amount of a policy is reduced after the first policy year, no adjustment is made in premiums previously paid. If such change takes place after a policy has a cash value, a credit is allowed on that portion being dropped. A reduction in amount should be made preferably on the anniversary date. The policy cannot be reduced below the Company's minimum limit for the respective plan of insurance.

REDUCTION IN RATINGS - If a policy was rated because of some medical impairment, the Company will, at the request of the Insured or an Agent, review the case and will authorize another medical examination if it appears that the risk has improved since the policy was issued, or since the date of the last examination. The medical examination is made at the expense of the Insured and the Company will advise the type of examination required.

If a policy was rated because of occupation only and the Insured later enters and remains in some less hazardous occupation for a sufficient length of time to indicate that the change is permanent, a reduction in rating will usually be considered upon completion of the required forms. Such a reduction should be made preferably on the anniversary date. When such a change is advisable, the Company will furnish forms, figures and other information as to the procedure in completing the change. Evidence of insurability must always be submitted. The Company reserves the right to request a medical examination.

changes involving universal life
See Section D.

addition of benefits and riders

If a 10 Year Term insurance Rider was not included in the policy when originally issued, it may be added only during the first policy year, and as of the original policy date, and then only upon special consideration by the Home Office. The Home Office will advise the type of additional evidence required for consideration. Cost of Living Adjustment rider may not be added after issue. For information concerning the addition of other riders or benefits to existing policies, refer to the appropriate page in Section C or E.

changes to lower premium plans

Life policies do not provide for changes to lower premium plans, but it is the practice of the Company to make such changes provided satisfactory evidence of insurability is furnished. Change of life plans to term insurance is permitted only during the first policy year.

The policy number and issue date are not changed and the new policy will be issued on policy forms in use by the Company on the date of original issue. The premium will be according to the Company's rate in use on the date of issue for the original age of the Insured.

changes to higher premium plans

Life policies contain a policy change provision allowing the policy to be changed to any other amount or plan of insurance not prohibited by law, subject to approval by the Company, payment of any cost, and furnishing of such requirements as it shall consider necessary. Changes of life plans to higher premium plans do not require the furnishing of evidence of insurability unless the Waiver of Premium Disability Benefit is included. Since a reissuance of a policy may involve considerable calculation, the Agent should obtain the figures from the Home Office. In requesting this information, be sure to give complete information on the amount, plan and benefits.

change of name

When a female Insured, beneficiary, or policyowner marries, or divorces, she should promptly complete a Policy Service Request Letter Form 2068 (WL/UL) or 2066 (Annuity) and forward it to the Home Office. It is not necessary to send in the policy. A change of name may be requested for reasons other than divorce or marriage. In those cases, the Company may request documentation before it will record such a change on its records.

change of address

The Company should be notified immediately of any change in the address of a policyowner. Agents should use the Address Change Form 2068 (WL/UL) or 2066 (Annuity). Any change in name or address (including spelling corrections) will cause a "change of address" Policy Information Report to be sent to the Servicing Agent.

change of beneficiary

The policy gives the Owner the right to change the beneficiary. However, if the Owner has designated a beneficiary irrevocably, that beneficiary cannot be replaced unless their revocable beneficiary consents in writing. If the policy is collaterally assigned, the assignee need not sign the change of beneficiary request unless, under the terms of the assignment, the right to change the beneficiary was not retained by the assignor (the policyowner).

If the applicant does not wish to reserve the right to change the beneficiary, that fact should be indicated on the application and the beneficiary designation will be worded accordingly. Refer to "Beneficiary" (page B-22) and "Insurable Interest" (page B- for further information relating to the designation of the beneficiary at the time the insurance is purchased.

Policies in the 79 and later series, except Universal Life and certain term policies, contain a provision which permits the Owner to change the beneficiary within 60 days of the Insured's death, if the Insured was not the Owner immediately before his or her death. The Claims Department should be notified immediately whenever an Owner wishes to exercise this privilege. Because of the existence of this provision, the Claims Department must verify that the Owner does not desire to make such a change; otherwise, the death benefit cannot be paid until the 60 day period has expired.

A change of beneficiary may be made without forwarding the policy to the Home Office for endorsement (regardless of any provision in the policy to the contrary). Form 2068 (WL/UL) or 2066 (Annuity) (which contains the Policy Service Request Letter Form) is also used for simple beneficiary designations. Please refer to that part of the form entitled CHANGE OF BENEFICIARY. More complex designations (such as those naming a trust, where detailed contingencies are involved, where the beneficiaries will receive varying percentages of the net proceeds, etc.) must be completed using Form 70 MISC (with the latest revision date of 8/87). Many states require, when a change of beneficiary is made, that the full name of each beneficiary, each beneficiary's relationship to the Insured and the address for each beneficiary be provided.

Of course, even when not required, information as to the address for each beneficiary provides a starting point for the Claims Department to locate the beneficiary at the time a death claim is payable.

When a properly executed and completed beneficiary designation is received at the Home Office, it is recorded. The recorded original is placed in the policy file and the recorded copy is returned to the Agent to deliver to the policyowner (if an Agent sent it to the Company; otherwise, the recorded copy is submitted directly to the policyowner). The policyowner should be advised to place the beneficiary designation with the policy. If the change of beneficiary is accepted at the Home Office, it is effective as of the date it was signed, subject to any action taken by the Company or payment made by the Company before receipt of the designation. A change of beneficiary is also subject to the rights of any assignee of record with the Company.

SETTLEMENT OPTIONS - When settlement options are requested, other special forms are used. These designations are prepared exclusively at the Home Office. Complete information regarding the settlement option desired (or, in the case of policies without settlement options, the type of settlement desired), the names of the beneficiaries, the amount each beneficiary is to receive, etc., must be provided to the Policy Change Section of the Customer Service Department so that the designation may be prepared. We do our best to accommodate all settlement requests, but we are not able to prepare designations, in some cases, based on the settlement proposal which is submitted.

CHANGE OF BENEFICIARY FOR SPOUSE, CHILDREN AND FAMILY INSURANCE - A special form is used when a request is made to change the beneficiary under a Children's Insurance Agreement, Children's Insurance Rider, Family Insurance Agreement, Family Insurance Rider or Spouse Insurance (including the Spouse Term and Spouse Renewable Term Riders). Designations on these forms are prepared exclusively at the Home Office. Full particulars concerning the change should be submitted to the Policy Change Section of the Customer Service Department.

TERM CONVERSIONS

attained age conversions

CONVERSION PRIVILEGE - The One is convertible until the anniversary at insurance age 70. The Flex Term, TR-9 1, 10TR-89, and 10YT-92 may be converted until the

anniversary at insurance age 65. TLP08 may be converted during the initial term (but not beyond age 65). All other term policies and riders may be converted prior to the anniversary at insurance age 60 or prior to the expiry date, if earlier. The new policy will bear the date of conversion, and the premium will be for the Insured's then attained age for the policy desired. The new policy may be any form of life insurance (or a combination of permanent and term) then being issued by the Company. The amount of insurance may not exceed the amount of term insurance then in force unless a new application is completed for the additional amount. Any amount of insurance in excess of the term insurance will require Company approval. The minimum size policy is \$5,000.

CONVERSION CREDIT - All attained age conversions, to a new permanent insurance policy, are provided with a term conversion credit (for the portion being converted) equal to the sum of the premiums paid for the prior 12 months of coverage. The credit will be allowed even if only part of a policy or rider is converted. The credit does not apply for conversions during the first policy year. The credit is not allowed for conversions to Universal Life if the UL policy will have a COLA rider.

SUPPLEMENTAL BENEFITS - Conversions from term policies will automatically include Waiver of Premium Disability and Accidental Death Benefit if they are included in the original term policy. Term rider conversions will automatically include Waiver of Premium if on the original rider, but will require evidence of insurability to include Accidental Death Benefit. When converting to Universal Life, Waiver of Monthly Deduction will be included automatically if the converted policy included Waiver of Premium.

CONVERSION DURING DISABILITY - If the term coverage was issued with Waiver of Premium Disability Benefit and the Insured becomes disabled, the term premiums will be waived until the end of the conversion period at which time the policy will automatically convert to Contender (at attained age), and premiums will continue to be waived on the new Contender as long as disability continues. The One, Flex Term, TR-9 1, 10YT-92, and 10TR-89 will renew until age 65 and then automatically convert to Contender provided disability began before age 60. Other renewable coverages will renew until age 60 and then automatically convert to Contender. The term coverage may not otherwise be converted while premiums are being waived due to disability.

procedure

Requirements for converting term policies or riders are as follows:

1. Submit written application (Form 1280 (II)) along with original policy (if not a Universal Life term rider). Special forms may be required in some states.
2. Collect the initial premium for the converted policy. (Dividends from the term policy, premium refund and Conversion Credit may be applied to the initial premium.)
3. No premium for the term policy may be in arrears.
4. If new insurance is applied for, and Part 2 of the application is required to be completed, Authorization to Release Information (Form 1453) is also required.

conversions of one year term dividend options

The term insurance provided by dividend options 5, 6, 7, and 8 is convertible. However, upon conversion, neither the original nor the new policy may have a one year term dividend option. Procedure is as follows:

1. Fully complete the conversion application (Form 1280 (II)) and circle "Dividend OYT." Special forms may be required in some states.
2. Indicate the dividend option on the new policy. (Must be one of the following: cash, reduce premiums, accumulations, or paid-up additions.)
3. Complete a Policy Service Request Letter (Form 2068 (WL/UL) or 2066 (Annuity)) to change the dividend option on the original policy.
4. If any optional benefit or additional coverage is desired on the new policy, complete Part 2 of the Form 1280 (II) and Authorization to Release Information (Form 1453).

ASSIGNMENTS AND POLICY LOANS

assignments

There are two types of assignments - "Collateral," for use when a policy is used as collateral security for indebtedness; and, "Absolute." If an absolute transfer of all policy rights is desired, a Transfer of Ownership (Form 1299) should be used.

COLLATERAL ASSIGNMENT - If the Owner desires to use the policy as security for a debt owed to a creditor (the Assignee), the Owner may use our "Collateral Assignment of Policy" (Form 763) for that purpose. Under our form, the Assignee's interest must be shown at the time of the Insured's death and that portion of the net proceeds will then be paid to the Assignee. The balance of the net proceeds, if any, will then be paid by the Company to the named beneficiary or beneficiaries, if applicable. In the case of split-dollar insurance, refer to SPLIT-DOLLAR INSURANCE, Page B-25.

COMPLETION OF FORMS - The Company will, upon request, furnish its "Collateral Assignment of Policy" form. Two copies of the form will be supplied. Both copies must be signed by the Owner and any irrevocable beneficiary. The signatures of the Owner and the irrevocable beneficiary must be notarized. After the forms are fully signed, both copies should then be forwarded to the Home Office where they will be recorded. The Home Office shall retain a recorded copy in the policy file and the other recorded copy shall then be returned by the Home Office directly to the Assignee. Generally, the Assignee will hold this copy of the recorded assignment together with the policy. When the indebtedness which supports the collateral assignment has been repaid, the Owner should obtain a written release of the assignment from the Assignee. A form of release is contained on the reverse side of the Company's "Collateral Assignment of Policy" (Form 763). If another assignment form has been used, the Company has a general collateral assignment release form which it can provide.

VALIDITY - No assignment of a policy shall be binding on the Company until and unless a copy of the same shall be filed and recorded at the Home Office; however, the Company, by receiving or filing any assignment, does not assume any responsibility as to the validity or sufficiency thereof. Any assignment shall be subject to any indebtedness to the Company on account of or secured by the policy and to any unpaid premium or note given for premium, whether the same be incurred prior or subsequent to the assignment.

lost policies

If a policy is lost or destroyed, the validity of the contract is not affected. When the Home Office is notified, a Lost Policy Certificate will promptly be issued. A duplicate policy will be issued upon receipt of a lost policy form fully completed by the Owner. The lost policy form contains a release of liability under the original policy and an agreement that it will be delivered to the Company if located. A \$50.00 charge is levied to issue a duplicate policy for other than current series.

A diligent search for the policy should be made before reporting its loss. If the disadvantages arising from not having the original policy - possible delay in beneficiary changes, surrendering the policy, or settlement of death claim - are impressed upon the Owner and beneficiary, a more thorough search may result in locating the policy.

Occasionally, when lost policy forms are requested, the Company learns that the policy is neither lost nor destroyed but that it is being held by the beneficiary against the Owner's wishes. In such event, the Owner may wish to consult an attorney about recovering the policy.

policy loans

When a policy has accumulated a cash value and while it is in force, except as extended term insurance, the Owner may borrow on the sole security of the policy.

AMOUNT OF LOAN - The loan values for various policy years are shown in the policy under the table of guaranteed values. The maximum loan value except for Universal Life is the sum which, with any existing indebtedness and any premium then due and unpaid, together with interest on the total indebtedness to the next premium due date, will not exceed the tabular cash value at the next premium due date (or at the end of the current policy year for paid-up policy) together with the cash value of any paid-up additions and dividend accumulations. For Universal Life the most we can loan is the current cash value less existing indebtedness and interest to the next annual date.

LOAN APPLICATION - Except for large loans, the Company does not require loan agreement forms for cash loans. At the request of the Owner or Agent, a loan check is mailed to the Owner. The check which is endorsed by the Owner when cashing it, serves as the loan agreement. All loan checks are mailed to the policyowner. Any noncash loan, such as a loan to pay premiums (other than APL), will require the policyowner to sign the Policy Service Request Letter Form 2068 (WL/UL) or 2066 (Annuity).

In the event that control of a policy is vested in a minor, a loan may, in most jurisdictions, be made only to a duly authorized conservator or guardian of the minor's estate. In this event, certified copies of the appointment papers are required. In some cases, it may be necessary for the conservator or guardian to obtain a court order which permits the loan to be taken on the minor's behalf. If such an order is needed, a certified copy of that order must also accompany the loan request.

REPAYMENT - Failure to repay a loan does not invalidate a policy until the total indebtedness equals or exceeds the then current policy value. A grace period of thirty-one days (61 days for Universal Life) is allowed. The policyowner may repay the loan in whole or in part at any time prior to the date of the next premium due and prior to maturity of the policy.

Interest is due and payable on the next anniversary date; however, it may be paid at any other time if the loan is completely repaid.

Although payments of any amount will be accepted in the repayment of loans, the Company requests payments of at least \$10.00. Regular monthly loan payments of at least \$10.00 each may be made through Preauthorized Check or Government Allotment. The Owner may also request to be billed on a regular basis for loan repayment.

In event a payment is for the full amount of the principal of the loan, or more, but does not pay all the accrued interest to the date of payment, a small balance will remain.

POLICY LOAN INTEREST - On policies issued from 1-1-41 to 3-1-70, policy loan interest of 5% is payable in arrears. Policies issued from 3-1-70 to 12-31-78 require 6% interest in arrears. Policies issued from 1-1-79 to 12-31-88 (except for those products mentioned in the next paragraph) have an 8% variable loan interest rate in arrears. The loan interest rate on these policies may be increased or decreased by the Company but will never exceed 8%.

The Spectrum, most Econolife and Executive (VPP) policies issued after 1-1-84 and all non-Universal Life policies issued after 1-1-89 incorporate a Dynamic Policy Loan Rate, with interest charged at an annual effective rate that may change from policy year to policy year. Prior to each policy year the Company will set the loan rate to be applied to any outstanding loan during the next policy year. The maximum loan rate that may be used is the larger of 5% or the Monthly Average of the Composite Yield on Seasoned Corporate Bonds as published by Moody's Investors Service, Inc., or any successor to that Service. The Company will notify the policyowner of the interest rate when the initial policy loan is taken. It will also notify the policyowner of any subsequent change in loan interest rate. The Company will not change the loan interest rate unless the change is at least 1/2%.

All Universal Life policies will be eligible for a variable loan interest rate. This variable loan interest rate will be set by the Company periodically and published in the Monthly Interest Rate Bulletin. The maximum variable loan interest rate is 8%.

Effective August 1, 1995, for the first ten policy years, all Universal Life policy loans will be presently charged 6%; after the tenth policy year, all Universal Life loans will be presently charged 5%. Please refer to the Monthly Interest Rate Bulletin for the current policy loan interest rates which are subject to change. In addition, that portion of any cash value which is loaned will only earn 4% interest.

The Owner is billed 17 days prior to anniversary for loan interest.

Interest not paid by remittance is added to the loan if sufficient value remains.

Questions concerning policy loan interest on policies issued prior to 1-1-41 should be directed to the Home Office.

DISABILITY CLAIMS

DISABILITY WAIVER - When an Agent of the Company receives information that an Insured, who has a policy containing a WP or WMD rider, has become disabled, the Company should be informed immediately. This will then permit the Company to immediately take those steps necessary to initiate a review of the matter and determine whether or not the Insured is totally disabled, as defined in the policy. The Agent should use great caution in handling disability claims. Because of the varying nature of disability clauses issued by the Company over the years, a careful review of the requirements is recommended before claim forms are submitted. As a general rule, the disability must be total (as defined in the policy) and continue uninterrupted, for at least six months before a claim can be considered.

Disability claims are approved only by the Home Office, and Agents should guard against making any statement, written or verbal, as to the Company's liability to any disability claimant.

Notice to the Company regarding the disability of any Insured should contain the following information: Policy number, full name and address of the Insured, date Insured became unable to work (as defined in the policy), nature of disability, and name and address of Insured's Guardian (if applicable).

Upon notification of a claim, disability claim forms will be forwarded by the Home Office to the Agent, claimant, or claimant's representative. Please note the time limitations concerning notice of claim which appear in the policy. The Company does not, by simply providing claim forms, waive any provision in the policy relating to timeliness of notice of disability. No premium due more than one year prior to receipt of written notice of claim will be waived unless it is shown that such notice was given as soon as was reasonably possible.

DEATH CLAIMS

DEATH CLAIMS - The Company pays all valid claims promptly. Upon the death of the Insured, the Home Office should be notified immediately. Such notification should give the name, policy number if possible, date, place, and cause of death. It is usually sufficient to write a letter to the Home Office in such cases. So there will be no delays in settlement of death claims, each General Agent has a supply of life claim forms.

If the General Agent does not have a supply of claim forms or if it is more convenient, the Company will send claim forms to the claimant or the authorized representative of the claimant, along with instructions for completing the forms. A Physician's Statement should be furnished when the policy is still in the contestable period.

Agents will find it in their interest to assist in completing proofs of death. However, it is the duty of the beneficiary to furnish the proofs, and all actual expenses arising in connection with completing the proofs should be paid by the beneficiaries. The Agent, of course, will not make any charge for this service under any circumstances. It is usually not necessary for the beneficiary to employ anyone to assist in settlement of a claim. General instructions, covering practically all situations that occur in handling a claim, are attached to the Proof of Death forms.

It will not be necessary for the Claimant to return the policy for settlement of the claim, unless specifically requested by the Company.

Death claims are paid promptly upon receipt and approval by the Company of proof of the death of the Insured and of the interest of the claimant. Checks in settlement of death claims will be sent to the servicing Agent for delivery in every case possible so that the Agent has an opportunity to service the claim.

If a claim is to be settled under an income settlement option, an agreement setting forth the details of the income payments will be prepared for the signature of the claimant, following which a supplementary contract providing for the agreed payments will be issued. If the policyowner has not requested a special settlement, the beneficiary has the privilege of doing so. See "Settlement Options" for additional information.

Death claim payments will include a premium refund of any premiums paid for coverage beyond the date of death. If death occurs during the grace period and before the premium in default has been paid, the settlement will be reduced by the amount of premium due to date of death.

Interest on the net proceeds will be paid from the date of death to the date of settlement. As noted earlier in this Reference Manual (see TAXPAYER IDENTIFICATION NUMBERS, Page B-22), the Company must request certified taxpayer identification numbers (TINs) on IRS Form W-9. The certification is necessary to avoid imposition of back-up withholding on taxable interest payable to beneficiaries.

To avoid delays, you should have the beneficiary complete the IRS form W-9 using the appropriate Tax Identification Number at the same time the Proof of Death forms are completed. You should have a supply of these W-9 forms. If not, you can request them from the Claims Department. The completion of the IRS W-9 Form will prevent the need for Back-Up Income Tax Withholding to be withheld from the interest paid to the beneficiary on the net proceeds of the claim. The current rate for back-up withholding is 31%. Each beneficiary of the claim is to complete an IRS W-9 form.

Note (as to both death and disability claims): Several states have enacted laws and regulations concerning unfair claims settlement practices. Under these statutes, the insurer has an obligation to communicate with insureds and beneficiaries directly concerning their claims. Because of these statutes, it is important that communications with the insured or beneficiary, whichever is applicable, be documented. For this reason, letters may have to be sent directly to the insured or beneficiary. Of course, the servicing Agent will be provided with a copy of any letter submitted. It is especially important, if a claim cannot be honored, that the insurer communicate with the insured or beneficiary, in writing, and detail the reasons why the claim could not be approved, and if applicable, why the benefit could not be paid.

Most life insurance claims are paid to the beneficiary soon after Lafayette Life receives proof of death. However, life insurance claims which are presented within the contestable period (usually within 2 years of the Policy Date) must be investigated before the Company can determine whether the claim is payable or must be declined. Frequently, investigations of the insured's past medical history are time consuming. If the claim must be denied, the Company refunds all premiums paid on the policy when it denies the claim.

Some universal life policies involve large amounts of early premium payments to take advantage of the interest earning capabilities of these policies. We can use these large premium payments to aid the beneficiary in some cases.

To assist the beneficiary with some funds soon after the insured's death, we are going to begin refunding part or all of the premium payments to a universal life policy when we receive due proof of death on contestable policies, if the premium amount exceeds \$1,000 dollars. We will ask the beneficiary to sign a nonwaiver agreement so that we can continue the investigation after the payment of the premium refund.

Then, when the investigation is complete, the balance of the Death Benefit, less the premium, will be paid to the beneficiary, unless the claim must be denied.

This practice will help the beneficiary with some expenses that may surround the death of the insured and we are pleased that the larger premium payments to universal life policies make this practice helpful to the beneficiary.

In some cases, this practice may be not possible. For example, a policy owned by someone who is neither the insured nor the beneficiary presents a complication which will make an early return of premium difficult to carry out.

Partial payments under universal life policies are also made in some cases where the policy was issued, in part, as a conversion of term life insurance or a "rollover" of ordinary life insurance to a universal life insurance policy. Procedures particular to those instances are followed by the Claims Department to pay portions of the claim while the amount of the life insurance under the policy which should be contestable is being investigated. When those instances arise, the claims supervisor will assist you in getting the papers necessary to pay the noncontestable portion of the claim as quickly as possible.

HOW TO MAKE AN ELECTION UNDER THE ACCELERATED BENEFIT RIDER

In order for the Owner to elect the benefit under the ABR, an election form will be required. These forms will be provided by the Claim Department. Certain information on this form will need to be completed by the Claims Department, by the

Insured and the Owner (if different from the Insured), and the Insured's attending physician. A special disclosure form (showing the effect on the policy in the event of the election) will be prepared by the Actuarial Department. The Claims Department will send this form to the Owner along with the election form, at the time of the election.

The Claims Department will conduct a review, and may require further medical information, in order to determine if the Insured is suffering from a Terminal Illness, as defined by the rider. If the policy is still contestable at the time an election is made under the ABR, the Claims Department will conduct its normal contestable claim review before deciding if the election under the ABR can be approved.

FALSE & FRAUDULENT CLAIM PENALTY NOTICES

The Florida Legislature has passed a law making it a third degree felony for any person to knowingly, and with intent to injure, defraud or deceive any insurance company, file a statement of claim containing any false, incomplete or misleading information.

The law requires that insurers give notice of the law on all claim forms.

The notice reads: Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree.

To comply with the law, we have prepared a notice to Florida claimants which is to be affixed to all claim forms submitted in Florida. Since you have a supply of claim forms in your possession, we have included a small supply of the notices which you should staple to the claim forms before delivery to a claimant wishing to make a claim under his or her Lafayette Life policy.

If you have any questions about the notice or need any further supply of the forms, please contact the Claims Department.

Agent's Responsibilities

CONTRACT, AUTHORITY, AND CONDUCT OF BUSINESS

CONTRACTS AND LICENSES - Licensing laws vary in each state in regard to the requirements to be met before the Agent is permitted to solicit business. The Agent should become familiar with the various rules and regulations of his territory. No Agent is permitted to solicit business until he is licensed and contracted with the Company. Questions should be directed to the Licensing and Contracting section of the Marketing Department.

SOLICITATION - In states where required, an agent shall inform the prospective purchaser, prior to commencing a life insurance sales presentation, that he or she is acting as a life insurance agent and inform the prospective purchaser of the full name of the insurance company which the agent is representing to the buyer.

OUT OF STATE SOLICITATION - Taking applications by mail outside the primary state of license is permitted only when it involves a CURRENT Lafayette Life policyowner for whom the Agent has written prior coverage and who has moved out of the Agent's state of license. The Agent must contact his or her Underwriting Team to obtain the proper state forms BEFORE writing the application. A medical examination and Telecom Report will be required for all applications taken by mail.

You may apply for a non-resident license through the Marketing Department to solicit applications outside your state of residence.

AUTHORITY OF AGENTS - Agents of The Lafayette Life Insurance Company are authorized to solicit applications for insurance on such plans as are offered by the Company, to collect the initial premium on such business for prompt transmission to the Company, and to perform such other duties as the Company may from time to time require.

Agents are not authorized to accept risks of any kind; to make, modify, or discharge contracts; to extend the time for paying any premium; to waive forfeiture; to bind the Company by any statement, promise or representation; or to employ counsel to represent the Company. Nor are Agents authorized to accept payments other than for the initial premium in connection with the applications for insurance solicited by them. All matters involving legal questions or State Insurance Department matters must be referred to the Company promptly and instructions awaited.

MARKET CONDUCT - Agents of The Lafayette Life Insurance Company shall adhere to the Principles and Code of Ethical Market Conduct. Consult your Agent's Reference Manual for a complete description of Company's Principles and Code of Life Insurance Ethical Market Conduct.

POLICY DELIVERY - Agents may deliver policies only during the life and good health of the proposed Insured unless settlement of full initial premium has been made at the time of application and policy issued as applied for. Policies should always be delivered in person. Further details, see DELIVERY AND REMITTANCE, Page B-32. It is the Agent's responsibility to get any delivery requirements completed and returned to the Underwriting Department within the 60 day delivery period.

EXPENSES - The Agent is not authorized to incur any expense on behalf of the Company or of the General Agent, or to draw drafts on the Company. All expenses of Agents visiting the Home Office, unless invited by the Company at its expense, shall be borne by such visiting Agents.

ADVERTISING - Agents may not publish anything concerning the policies or business of this or any other Company, or to issue circulars of any kind, unless the proposed matter has been submitted to, approved and authorized by the Company in writing. All advertising and sales materials must be prepared by and/or approved by the Company. The Company's name may not be placed on any document in a manner suggesting that the Company is the author, unless the document has been approved in its final form by the Company. Questions should be directed to the Marketing Communications section of the Marketing Department.

TELEPHONE - Toll-free 800 numbers are provided for the Agent to contact the Home Office or request illustrations. The Home Office Directory should be used to directly dial an individual's extension number. A "hot line" number exists for leaving messages at any time. The policy numbers should be given in any telephone call about a policy.

REBATING - In most states rebating is illegal and a violation of the rebating laws will subject the offender to serious penalties. The Company does not authorize or permit any agent to pay or allow, or offer to pay or allow, directly and indirectly, a rebate of any premium, or to grant any special favor or valuable consideration on any policy of insurance, either to the Proposed Insured for such policy or to any other person.

correspondence

In all correspondence with the Home Office a separate sheet should be used for each subject.

When answering or referring to letters received from the Home Office, the individual or the department from whom they were received, the dates of the letters, and the subject should always be stated in the letter. When writing about a policy, always give the full name of the Insured and the policy number, if available. When writing about any pending application, be sure to state the full name (including first name and middle name or middle initial) of the applicant. Ask about each case on a separate sheet.

When an application is submitted on which there has been previous correspondence, be sure to mention the previous correspondence. Inter-Office Memo-Grams should be used in correspondence with the Home Office in every case possible. The handling of correspondence can be improved by stating the subject of the letter in the heading.

ONE ENVELOPE - All letters and memos to the Home Office, when properly identified, may be included in one mailing envelope.

REPLY PROMPTLY - You are asked to reply to all letters from the Home Office as quickly as possible and to make sure that

sufficient postage is attached. Insufficient postage may delay the receipt of mail in the Home Office.

CONSULT GENERAL AGENT - Before writing the Home Office for information, the General Agent should be consulted for advice and direction.

supplies

Requests for supplies should be made on the Supply Requisition Form and not as part of a letter regarding other matters. All Supply Requisitions must be accompanied by cash, check or money order when chargeable items are ordered. General Agents should request all supplies for their Agents. Supplies should not be ordered in unnecessarily large quantities and prudence should be exercised in the use of supplies.

business cards and stationery

Business cards will be furnished without charge to all General Agents and to all Agents. Imprinted letterheads and envelopes will be furnished without charge to all General Agents and to those Agents who qualified during the past year or who are currently qualified for membership in the General's Honor Guard Club. Orders for stationery are for normal business use and limited to 250 per order. Questions should be directed to the Marketing Communications section of the Marketing Department.

APPROVED COPY - Imprint copy must contain the Company name and address to qualify under the above rules. Titles used must be limited to contract titles or such other titles as may be approved by the Company. Titles such as "Estate Planner," "Estate Analyst," etc., have been interpreted as implying a legal service and are available only to those qualified to render such legal service.

Stationery and business cards imprinted with the name of the Company cannot, of course, include reference to any other service or product, such as "Mutual Funds," "Investments," etc.

Industry award titles (MDRT, NQA, NSAA) may be imprinted on Company business cards and stationery, but proof of qualifications must be provided. Industry award rules concerning publicity must be adhered to completely.

POLICY REPLACEMENTS

While policy replacement may not be in the consumer's best interest, there may be circumstances where it is appropriate for a client to consider replacement. The Lafayette Life Insurance Company is interested in the sale of new insurance but not at the expense of existing insurance. We condemn the indiscriminate use of replacement to sell new insurance.

Individual states have differing replacement regulations. It is your responsibility to understand the requirements of the state in which you do business.

For replacements, Lafayette Life's Principles and Code of Ethical Market Conduct states: "Do not replace existing life insurance policies and annuity contracts without first communicating to the customer information that he or she needs in order to ascertain whether such replacement of existing policies or contracts may or may not be in his or her best interest."

BEFORE YOU REPLACE A LAFAYETTE LIFE POLICY WITH ANOTHER COMPANY'S POLICY OR ANOTHER LAFAYETTE LIFE POLICY, YOU MUST NOTIFY US IN ADVANCE IN WRITING WITH FULL DISCLOSURE OF THE CIRCUMSTANCES. Replacement of one of our policies is subject to our advance approval.

Replacement is generally defined as any transaction in which new life insurance or a new annuity is to be purchased or changed, and as a result of such transaction an existing life insurance policy or annuity has been or is to be: as a result of such transaction an existing life insurance policy or annuity has been or is to be:

1. Lapsed, forfeited, surrendered, partially surrendered, assigned, or otherwise terminated;
2. Converted to reduced paid-up insurance, or continued as extended term insurance, or otherwise reduced in value by the use of nonforfeiture benefits or other policy values.
3. Amended so as to effect either a reduction in benefits or in the term for which coverage would otherwise remain in force or for which benefits would be paid;
4. Reissued with any reduction in cash value, or any negative alteration of the contract; or
5. Pledged as collateral or subjected to borrowing, whether in a single loan or under a schedule of borrowing over a period of time for amounts in the aggregate exceeding 25% of the loan value set forth in the policy. (Note: Percent may differ depending on state regulation.)

With respect to the #5 description of what constitutes a replacement, some states have adopted the most current (2000) version of the NAIC's Life and Annuities Replacement Model Regulation (the "2000 NAIC Replacement Model"), which does not refer to actual percentages of loan value, but instead refers to financed purchases. As a result, those states have expanded the scope of #5 to state that a replacement includes any transaction in which a new life insurance policy or a new annuity is to be purchased and that an existing life insurance policy or annuity has been or is to be "used in a finance purchase," without any reference to a % loan amount or withdrawal amount. The term "financed purchase" is defined as "the purchase of a new policy involving the actual or intended use of funds obtained by the withdrawal or surrender of, or by borrowing from values of an existing policy to pay all or part or any premium due on the new policy." Under such state laws, if a withdrawal, surrender or borrowing involving the policy values of an existing policy is used to pay premiums on a new policy owned by the same policyholder and issued by the same company within four (4) months before or thirteen (13) months after the effective date of the new policy, in any regulatory review involving such circumstances, it will be presumed that the policyholder intended to finance the purchase of the new policy with existing policy values.

Approximately half of the states have adopted, in full or in part, the 2000 NAIC Replacement Model: Alabama, Arizona, Arkansas, Colorado, Hawaii, Iowa, Kentucky, Louisiana, Maine, Maryland, Mississippi, Montana, North Carolina, New Hampshire, New Jersey, New Mexico, Ohio, Oregon, Rhode Island, South Carolina, Texas, Utah, Vermont, Virginia, West Virginia, and Wisconsin. Because of the differences in state laws, you are urged to familiarize yourself with the current replacement laws in the particular state(s) where you are licensed.

A few states have not adopted a version of the NAIC Life Insurance and Annuities Replacement Model Regulation (as of Sept 2016 - DC, and ND). In those States, for disclosure purposes Lafayette Life requires completion of WL Replacement Forms in instances of life or annuity replacement sales. In other States, for disclosure purposes, Lafayette Life also requires completion of WL Replacement Forms in a limited number of circumstances. See Page B-52 for a list of replacement forms applicable and required in your State.

When there is a possibility of replacement as defined above with either another Lafayette Life policy or another Insurer's policy, the following is required AT TIME OF APPLICATION:

1. Replacement questions on the application must be answered 'yes' as appropriate and the identified Company name(s) listed. (ALL STATES).
2. Replacement Forms: must be Signed and Dated – see Page B-52 for State required forms.
3. Product Comparison Forms: in a few states such as AR, FL, and NV, specific product comparison forms must be completed in defined circumstances (e.g. Florida annuity applicants age 65 and older). Check your state for particular requirements. In those states, comparison forms are included with the replacement forms listed on Page B-52.

Key Steps under Paragraphs 2 and 3:

- a. Get proposed policyowner's signature AT TIME OF APPLICATION.
- b. Give a copy to the proposed policyowner and keep a copy for your records.
- c. Send original signed form to the Home Office with the application.
- d. ALL replacements will follow this procedure, provided however, some states may provide limited exceptions.

In addition, if the state requires a special Replacement Form, have that form signed also and send to the Home Office with the application. Send copies of all sales material to us with the application.

The above requirements are to be completed AT TIME OF APPLICATION, EVEN WHEN AN APPLICANT IS UNDECIDED ABOUT REPLACEMENT. These requirements must be met BEFORE a policy will be issued. Most states require that we send notification of possible replacement to the potentially replaced Company within 3 - 5 days of our receiving an application that involves possible replacement and provide that company with copies of any sales material.

If you have any questions regarding the above or concerning specific state regulations, contact a New Business Underwriter.

Replacing a policy can be in the best interest of the proposed policyowner. Comparisons must be complete and factual.

Whole Life Replacement Forms

AL: EF-006
AR: EF-006
AZ: EF-006
CA: EF-008
CO: EF-006
CT: EF-006
DE: EF-014
DC: N/A
FL: EF-028 & D14-1180
GA: EF-030
HI: EF-006
ID: EF-009
IL: EF-010 and EF-011
IN: EF-012
IA: EF-006

KS: EF-026 and EF-027
Repl form not needed if existing
coverage, but not replacing

KY: EF-006 & EF-049
LA: EF-006
MA: EF-017
MD: EF-006
ME: EF-006
MI: EF-016
MN: EF-020
MO: EF-021
MS: EF-006
MT: EF-006

NC: EF-006
ND: N/A
NE: EF-006
NH: EF-006
NJ: EF-006
NM: EF-006
NV: EF-025-L
OH: EF-006
OK: EF-022
OR: EF-006
PA: EF-015
RI: EF-006
SC: EF-006
SD: EF-006
TN: EF-019
TX: EF-006
UT: EF-006
VA: EF-006
VT: EF-006
WA: EF-013
WV: EF-006
WI: EF-006
WY: EF-024

Special Notes:

***Qualified: CP, HR, & 412i types of business do not require repl notification and/or forms**

***Term Conversion's do not require repl notification and/or forms**

Checklist For Advertising Guidelines

Use the following checklist as a worksheet, when you are preparing life insurance and annuity advertisements for submission to the Marketing Department for review and approval. However, because the laws differ from state to state, and the application of those laws to various policies may differ, compliance with this checklist will not necessarily guarantee approval of the advertisement. (Please do not send us the completed Checklist.)

Identity of Company and Policies

Yes No N/A

- ☐ ☐ ☐ The full name of the Company and its address are clearly identified.
- ☐ ☐ ☐ The policies advertised are clearly identified as a life insurance or an annuity policy.
- ☐ ☐ ☐ The type of policy (e.g., whole life insurance, term life insurance, universal life insurance, deferred or immediate annuity, etc.) is identified. Any specific policy name is also accompanied by a clear description of the type of policy advertised.
- ☐ ☐ ☐ The advertisement includes the policy form number and date.
- ☐ ☐ ☐ There is no implication that the life insurance or annuity policy is an investment or savings plan.

Does the advertisement contain the following words? (If the answer to any of the following questions is "Yes", see the "Note" following this list of words.)

- ☐ ☐ ☐ - account (to refer to a policy);
- ☐ ☐ ☐ - college savings plan (Never use this term);
- ☐ ☐ ☐ - contribution(s) (as a description of a premium);
- ☐ ☐ ☐ - deposits, deposit premium, premium deposit (to refer to premiums);
- ☐ ☐ ☐ - earnings (to refer to life insurance cash values or dividends);
- ☐ ☐ ☐ - emergency account (to refer to cash values);
- ☐ ☐ ☐ - guaranteed cost (to refer to premiums);
- ☐ ☐ ☐ - guaranteed income, savings (to refer to cash values or dividends);

Yes No N/A

- ☐ ☐ ☐ - investment, investment premium (to refer to premiums); investment(s);
- ☐ ☐ ☐ - liquid (to refer to funds for which withdrawal charges may apply); liquidity account (to refer to cash values);
- ☐ ☐ ☐ - passbook savings (to refer to cash values);
- ☐ ☐ ☐ - payments (to refer to premiums);
- ☐ ☐ ☐ - private pension plan (Never use this term);
- ☐ ☐ ☐ - profit(s), profit sharing (to refer to increases in cash values);
- ☐ ☐ ☐ - savings, savings plan (to refer to cash value); savings account (to refer to cash values or premiums);
- ☐ ☐ ☐ - tax-free (without subsequent detailed description of how tax-free status is maintained);
- ☐ ☐ ☐ - tax-deferred (without subsequent detailed description of how tax status is maintained);
- ☐ ☐ ☐ - vanishing premiums (Never use this term);
- ☐ ☐ ☐ - other similar terms which have the capacity or tendency to mislead a person to believe that he or she will receive something other than a life insurance or annuity policy.

Note - if the answer concerning any of the above words is "Yes", you must be sure to explain the context of the term, make it clear that you are referring to a life insurance or annuity policy, and make sure that the life insurance or annuity features of the policy are emphasized and are of equal or greater prominence than other features.

- ☐ ☐ ☐ If the policy contains surrender charges, surrender charges are clearly identified. There is no implication that a policy can be surrendered without charge, if surrender charges apply.
- ☐ ☐ ☐ If a policy loan is mentioned, the advertisement states that interest will be charged on policy loans.
- ☐ ☐ ☐ The insurance features of the policy are mentioned with prominence at least equal to that of other policy features.

Yes No N/A ☐ ☐ ☐ If references are made to tax benefits or tax rates, a statement is included that the information presented is based on current tax laws; that the Company does not give legal or tax advice; and that the client should consult with his or her own legal or tax advisor regarding the application of the information to his or her own situation. Tax penalties on early withdrawals, loans or surrenders are clearly mentioned. ☐ ☐ ☐ No reference is made to your status as a “financial planner”, “financial consultant”, “investment advisor” or other such terms which imply that your compensation is unrelated to sales. ☐ ☐ ☐ If a non-guaranteed policy element is shown, guaranteed policy elements are shown in equal prominence. There is no implication that nonguaranteed policy elements are guaranteed. Discussions of non-guaranteed elements contain a statement that they are not guarantees or estimates of amounts to be paid in the future, and that non-guaranteed elements are subject to change. ☐ ☐ ☐ If reference is made to current policy rates (e.g. interest rates) which are greater than guaranteed policy rates, the policy rates stated are not greater than those currently applicable, and the guaranteed policy rates are set forth with equal prominence.. ☐ ☐ ☐ If reference is made to a policy loan, there is a statement which provides that a policy loan or withdrawal may reduce the death benefit or available cash value of the policy.	Yes No N/A ☐ ☐ ☐ If the amount of premiums required to be paid can change (if the Company expressly reserves the right to do so under the policy), such fact is disclosed. ☐ ☐ ☐ Comparisons are avoided between life insurance premium payments or cash values, and savings accounts or investments. If mentioned, comparisons are complete, accurate and not misleading. ☐ ☐ ☐ For an annuity advertisement, the piece does not refer to the annuity as a CD or compare a CD to an annuity or use terms that would mislead a prospective purchaser to believe that the annuity is a CD. ☐ ☐ ☐ Any reference to commercial ratings is clear in describing the scope and extent of the rating. ☐ ☐ ☐ All statistical information is recent and relevant, and the source and date are identified. ☐ ☐ ☐ There are no unfair or incomplete comparisons of policies, benefits, performance or rates of other insurers of their products; comparisons to competitors’ products are fair and complete. ☐ ☐ ☐ The advertisement does not disparage another company, agent or policy.
---	---

Advertising Guidelines for the Field and Home Office

State insurance advertising laws require a company to establish and maintain a system of control over the content, form and method of dissemination of all advertisements of its policies, and further provides that all advertisements, regardless of by whom written, shall be the responsibility of the company. The Lafayette Life's Principles and Code of Ethical Life Insurance Market Conduct provides that advertising will be clear as to purpose and honest and fair as to content. In furtherance of that principle Lafayette Life has policies and procedures for reviewing advertising and sales material prior to their use, whether generated by the Home Office or the Field. These policies and procedures are designed to reasonably assure compliance with applicable laws and regulations related to advertising and sales material, whether generated by the Home Office or the Field.

Lafayette Life requires that all proposed advertising be submitted to the Home Office, attention Vice President – Marketing Support, for review and approval prior to use, as provided in the agent's contract.

To assist the Field and the Home Office in preparing appropriate advertising (which will expedite the Company's review and approval process), the Company offers the following advertising guidelines. These advertising guidelines are based upon the NAIC Model Rules Governing the Advertising of Life Insurance, which have been enacted in approximately 29 states (as of November 2009). Similar advertising laws are in effect in the other states.

A SUMMARY OF THE NAIC MODEL RULES GOVERNING THE ADVERTISING OF LIFE INSURANCE

Although the insurance advertising laws of the 48 states in which the Company does business vary, the NAIC Model Rules Governing the Advertising of Life Insurance (April 1995) provide helpful guidance concerning advertising requirements. Nevertheless, you are urged to familiarize yourself with the specific advertising laws in the particular state(s) where you are licensed.

ADVERTISING DEFINED

"Advertisement" means material designed to create public interest in life insurance or annuities or in an insurer, or its policies or its agents; or to induce the public to purchase, increase, modify, reinstate, borrow on, surrender, replace or retain a policy (regardless of whether or not the material includes the Company name).

EXAMPLES OF ADVERTISING MATERIAL

Examples of advertising material include, but are not limited to, the following: Sales presentations; prepared sales talks;

letters of solicitation; direct mail solicitations; direct phone solicitations, both inbound and outbound; Web sites; radio, television and print advertisements; illustrations (Please note that the requirements of the NAIC Model Illustration Regulation are not addressed in these Advertising Guidelines); brochures; form letters; charts, graphs and other depictions; newsletters; training material; audio-visual materials; and business cards and stationery (see specific requirements below).

BUSINESS CARDS AND STATIONERY

Business cards will be furnished without charge to all General Agents and to all Agents. Imprinted letterheads and envelopes will be furnished without charge to all General Agents and to those Agents who qualified during the past year or who are currently qualified for membership in the General's Clubs. Questions should be directed to the Corporate Communications Department. The guidelines the Company uses for Company business cards and stationery are as follows:

- Business cards and stationery will contain the Company name and your address. Titles used will be limited to contract titles or such other titles as may be approved by the Company. Titles such as "Estate Planner," "Estate Analyst," etc., have been interpreted as implying a legal service and are available only to those qualified to render such legal service.
- Business cards and stationery will not include reference to any other service or product, such as "Mutual Funds," "Investments," etc.
- Industry award titles (MDRT, NQA, NSAA) may be imprinted on Company business cards and stationery, and **proof of qualifications must be provided**. Industry award rules concerning publicity will be adhered to completely.
- We will not allow the use of terms such as "financial planner," "investment advisor," "financial consultant," or "financial counseling" with respect to the sale of Lafayette Life policies, which imply that you are generally engaged in an advisory business in which compensation is unrelated to sales. When proposing, selling or servicing Lafayette Life policies, we expect you to use Lafayette Life business cards and stationery.

WHAT THE DEFINITION OF ADVERTISING DOES NOT INCLUDE

Generally, advertisements do not include communications which are used within an insurer's own organization and which are not intended for dissemination to the public, and communications with policyowners that do not urge policyowners to purchase, increase, modify, reinstate or retain a policy.

FORM AND CONTENT OF ADVERTISEMENTS

Advertisements shall be truthful and not misleading in fact or by implication. The form and content of an advertisement shall be sufficiently complete and clear so as to avoid deception. This is viewed from the perspective of a person of average education or intelligence within the segment of the public to which it is directed—a person who is not knowledgeable in insurance matters.

When referring to a life insurance or annuity policy, include the words “life insurance” or “annuity,” or other language clearly indicating that the concept is a life insurance or annuity policy. Also include the name or title of a particular type of life insurance or annuity policy. Prominently describe the type of policy advertised.

TERMS TO AVOID

Avoid using the terms listed below. If you do use these terms, you must explain the context, make it clear that you are referring to a life insurance or annuity policy and make sure that the life insurance or annuity features of the policy are emphasized and are of equal or greater prominence than other features.

Avoid these terms: **Account** (when referring to a policy); **college savings plan** (Never use this term); **contribution(s)** (as a description of a premium); **deposits, deposit premium, premium deposit** (to refer to premiums); **earnings** (to refer to life insurance cash values or dividends); **emergency account** (to refer to cash values); **guaranteed cost** (to refer to premiums); **guaranteed income, savings** (to refer to cash values or dividends); **investment, investment premium** (to refer to premiums); **investment(s); liquid** (to refer to funds for which withdrawal charges may apply); **liquidity account** (to refer to cash values); **passbook savings** (to refer to cash values); **payments** (to refer to premiums); **private pension plan** (Never use this term); **profit(s), profit sharing** (to refer to increases in cash values); **savings, savings plan** (to refer to cash value); **savings account** (to refer to cash values or premiums); **tax-free** (without subsequent detailed description of how tax-free status is maintained); **tax-deferred** (without subsequent detailed description of how tax-deferred status is maintained); **vanishing premiums** (Never use this term); and other similar terms which have the capacity or tendency to mislead a person to believe that he or she will receive something other than a life insurance or annuity policy.

OTHER HELPFUL TIPS

- Avoid terms such as “free,” “no cost,” “without cost,” “no additional costs,” “at no extra cost,” and absolute words such as “all” and “never.”
- Do not refer to dividends as tax-free, unless the nature of dividends as a return of premiums is indicated clearly.
- When referring to a life insurance or annuity policy, include the words “life insurance” or “annuity,” or other language clearly indicating that the concept is a life insurance or

annuity policy. Also include the name or title of a particular type of life insurance or annuity policy. Prominently describe the type of policy advertised.

- Avoid analogies between a life insurance policy’s cash values and savings accounts or other investments, and between premium payments and contributions to savings accounts or other investments. Any analogies you do make must be complete and accurate.
- Do not make unfair or incomplete comparisons of policies, benefits, dividends or rates of other insurers.
- Do not disparage other insurers, insurance producers, policies, services or methods of marketing. (Please refer to the Company’s Guidelines to Assure Compliance with Applicable Laws Fostering Fair Competition, Including a Policy to Refrain from Disparaging Competitors.)
- Clearly identify the name and address of the Company in all advertisements. If any specific individual policy is advertised, identify it either by form number or by other appropriate description.
- For individual deferred annuity products or deposit funds, any statements containing or based upon current interest rates that are greater than the guaranteed interest rates shall set forth with equal prominence statements containing or based upon the guaranteed interest rates.
- For individual deferred annuity products, which includes fixed indexed annuities, do not market them primarily as investments. Emphasize the insurance features of the annuity (e.g., as applicable, guaranteed lifetime income, other annuitization options, guaranteed minimum policy value, guaranteed minimum interest rate, death benefit) and the goal of providing retirement savings.
- In connection with sales materials for individual retirement annuities (IRA), Keogh Plans and other retirement plans, describe only special qualification requirements or limitations related to such plans.
- Do not present yourself as an “expert.” (This is not intended to preclude persons who hold some formal recognized designation from using that designation.)

BASIC SUGGESTIONS TO KEEP IN MIND WHEN DESCRIBING LIFE INSURANCE POLICIES AND ANNUITIES

- Make it clear that you are talking about a life insurance policy or annuity. Do not use terminology which would lead customers to believe that they are purchasing an investment, savings plan or some type of banking account or system that is not life insurance or an annuity.
- Emphasize the insurance features of a life insurance policy. When discussing the tax advantages or cash values, give the life insurance features equal emphasis and prominence.
- Accurately describe life insurance premium payments.

- Explain that dividends are based on several factors (the Company's earnings, mortality and expenses), and are not an investment return. Stress that neither the payment of dividends, nor the amount, is guaranteed.
- Accurately describe all features and benefits of the policy.
- Do not state or imply that the payment or amount of non-guaranteed policy elements is guaranteed. Statements based upon non-guaranteed elements of a policy shall set forth with equal prominence comparable statements containing or based upon the guaranteed elements. If an advertisement refers to any non-guaranteed policy elements, it shall also indicate the Company's right to change such elements.
- Make sure that the advertising is understandable by someone who is not knowledgeable in insurance matters.
- Use illustrations from Company approved software only, when proposing the sale of a Lafayette Life policy.

SPECIAL RULES REGARDING EQUITY INDEXED PRODUCTS

Follow all special rules published by the Company regarding the advertising and marketing of indexed products, including but not limited to the following:

- Do not market the product primarily as an investment. Emphasize the insurance features of the product.
- When selling and prospecting for an indexed annuity, emphasize the following:
 - The policy guarantees, including a guaranteed minimum interest rate and guaranteed minimum policy value, as applicable;
 - The annuitization benefits and options of the product. Point out that the death benefit in the policy is not available with non-insurance products.)
 - That the policy is designed as an appropriate planning vehicle for retirement income.
- Use only Company prepared and approved advertising. Do not create your own advertising.

REVIEW OF ADVERTISING

All proposed advertising must be submitted to the Home Office, attention Vice President – Marketing Support, for review and approval prior to use. Failure to obtain Company approval prior to the use of advertising not furnished by the Company can result in certain consequences, up to and possibly including termination of your agent's contract.

The Company has prepared a checklist for you to use as a worksheet before you submit proposed advertising to the Home Office for review and approval. (Please refer to Attachment titled, "Checklist for Advertising Material.") Although you should not send us the completed checklist, using the checklist before you submit proposed advertising is likely to reduce or minimize the number of objections to the proposed piece.

The Company reserves the right to supplement or modify these Advertising Guidelines as necessary or appropriate, to address such matters as new products or changes in the law.

These Advertising Guidelines are in addition to any other guidelines, rules or policies published by the Company concerning marketing and advertising material or other communications to the public.

The Lafayette Life Insurance Company Guidelines for the Field and the Home Office to Assure Compliance with Applicable Laws Fostering Fair Competition, Including a Policy to Refrain from Disparaging Competitors

The Company's Code of Ethical Life Insurance Market Conduct provides that it will engage in fair competition. It further provides that to maintain and enhance competition, the Company will develop policies and procedures designed to provide reasonable assurance that it maintains compliance with applicable laws fostering fair competition and that its agents and employees involved in the sales process refrain from disparaging competitor insurers.

The Company believes in maintaining ethical business practices which support and encourage the concept of fair competition. The Company has established the following guidelines in order to allow its agents and employees involved in the sales process to determine what fair competition is.

Background

"Fair Competition" can be generally defined as competition based on the elements of price, quality, and services subject to federal and state antitrust laws and state insurance laws and regulations. A focus on Fair Competition can identify certain negative practices to be eliminated, such as inappropriate replacement and bashing of competitors.

"Unfair Competition" can be generally defined as unethical, dishonest, false or fraudulent rivalry in the business of life insurance particularly related to improper practices that endeavor to substitute one insurer's products or services in the market for those of another insurer. Some Unfair Competition practices have been specifically identified and addressed in federal antitrust and trade practices law and regulation (with corresponding state laws on those same subjects) and in some states the NAIC Model Unfair Trade Practices Act (as adopted in those several states.)¹

THE NAIC MODEL UNFAIR TRADE PRACTICES ACT

Although the laws of the 48 states pertaining to unfair competition and disparaging remarks may vary, the NAIC Model Unfair Trade Practices Act, (sometimes referred to as the "NAIC Model Act"), provides helpful guidance concerning "unfair competition" and disparaging remarks under state law.

The NAIC Model Act is intended to assure appropriate market conduct in the business of insurance by addressing unfair methods of competition and unfair and deceptive acts and practices. Specifically, the NAIC Model Act defines

prohibited conduct that constitutes unfair methods of competition or unfair or deceptive acts in such areas as:

1. Misrepresentations;
2. False Information;
3. Defamation;
4. Boycott, Coercion and Intimidation;
5. False Statements and Entries;
6. Unfair Discrimination;
7. Rebates; and
8. Unfair Financial Planning Practices.

Because the insurance laws and regulations pertaining to advertising and unfair trade practices vary in the 48 states in which the Company does business, you are urged to familiarize yourself with the specific advertising and unfair trade practice laws and regulations in the particular state(s) where you are licensed.

Disparaging Competitors

It is Company policy that agents and employees involved in the sales process are prohibited from disparaging competitors. The Company prohibits any oral or written statements or representations about competitors which are untrue, or which are deceptive or misleading or otherwise unlawful.

Following is guidance on the issue of disparaging remarks:

"Disparagement" or "Disparaging" generally refers to statements, either written or verbal, which are untruthful, deceptive or misleading or otherwise unlawful with regard to competitors. Such statements are usually intended to dissuade a customer from doing business with a competitor. Under a general definition, disparaging statements may not include relevant, factually accurate information. (See Bashing.)

However, state law often establishes a higher standard than the above general definition. Under the NAIC Model Act, it is not an absolute defense to the charge of making a disparaging statement that the statement contains information which is relevant and factually accurate. Stated differently relevant and factually accurate statements can be disparaging if they are deceptive or misleading, or if they are maliciously critical of or derogatory to the financial condition of any insurer and are calculated to injure such insurer.

¹ NAIC Model Unfair Trade Practices Act (January, 1993)

“Bashing” is generally defined as behavior that occurs when, in a sales situation, a company or its representative put the primary focus on negative attributes, other than relevant and factually accurate information, of a competitor or its representatives rather than on the positive attributes of that company or its products and services. (See Disparaging.)”

The NAIC Model Rules Governing the Advertising of Life Insurance provide that “An advertisement shall not make unfair or incomplete comparisons of policies, benefits, dividends or rates of other insurers. An advertisement shall not disparage other insurers, insurance producers, policies, services or methods of marketing.”²

The NAIC Model Unfair Trade Practices Act contains several relevant provisions pertaining to the disparagement of competitors. The NAIC Model Act defines the following practices as unfair trade practices, if the practice is committed flagrantly and in conscious disregard of the Act or of any rules promulgated under the Act, or if the practice has been committed with such frequency as to indicate a general business practice to engage in that type of conduct:

- Making any statement as to the financial condition of any insurer that is misleading or is a misrepresentation;
- Making any statement which is untrue, deceptive or misleading with respect to the business of insurance or with respect to any insurer in the conduct of its insurance business; or
- Making any statement which is false, or maliciously critical of or derogatory to the financial condition of any insurer, and which is calculated to injure such insurer.

Based on complaint handling experience, we know that disparaged competitors are likely to file complaints or threaten to sue.

In conclusion, those statements which degrade, speak slightly of, or speak in negative terms about competitors, are inappropriate and are prohibited.

Examples of disparaging another insurer:

- “That company has received a lot of complaints.”
- “That company's ratings have been downgraded.”
- “That company is having financial problems.”

Other Unfair Trade Practices

The NAIC Model Unfair Trade Practices Act also defines the following additional practices as unfair trade practices in the business of insurance, if committed flagrantly and in conscious disregard of the Act or of any rules issued thereunder,

or if committed with such frequency as to indicate a general business practice to engage in that type of conduct:

- Misrepresenting the benefits, advantages, conditions or terms of any policy;
- Misrepresenting the dividends or share of surplus to be received on any policy;
- Making a false or misleading statement as to the dividends or share of surplus previously paid on any policy;
- Using any name or title of any policy or class of policies misrepresenting the true nature of such policy;
- Making a misrepresentation for the purpose of inducing or intending induce the purchase, lapse, forfeiture, exchange, conversion or surrender of any policy;
- Making a misrepresentation for the purpose of effecting a pledge or assignment of any policy or effecting a loan against any policy;
- Rebating - Except as otherwise expressly provided by law, paying, allowing, giving or offering to pay, allow or give, directly or indirectly, as an inducement to such policy, any rebate of premiums payable on the policy, or any special favor or advantage in the dividends or other benefits thereon, or any valuable consideration or inducement whatever not specified in the policy. (Please note that our agents’ contracts prohibit rebating.)
- Making false or fraudulent statements or representations on or related to an application for a policy, for the purpose of obtaining a fee, commission, money or other benefit from any person;
- Holding oneself out, directly or indirectly, to the public as a “financial planner”, “investment advisor”, “consultant”, “financial counselor”, or any other specialist engaged in the business of giving financial planning or advice relating to investments, insurance, real estate, tax matters or trust and estate matters when such person is in fact engaged only in the sale of policies. The Drafting Note accompanying this provision states that it is not intended to preclude persons who hold some form of formal recognized financial planning or consultant designation from using this designation when they are only selling insurance. The Drafting Note also states that this does not permit persons to charge an additional fee for services that are customarily associated with the solicitation, negotiation or servicing of policies. (Agents engaged in the business of financial planning and charging fees other than commissions are subject to other requirements of the Act, and to other laws, which are beyond the scope of these guidelines.)

² NAIC Models Rules Governing the Advertising of Life Insurance (April, 1995)

Avoid anti-competitive behavior in the following areas:

- unreasonable restraint of trade
- price fixing
- gathering competitive information
- conduct of meetings with competitors
- joint ventures with competitors
- tying or bundling
- exclusive dealing
- discriminatory pricing.

One purpose of these guidelines, which generally define “fair competition” and “unfair competition” and also identify certain negative practices that can be targeted for attention, is to allow agents and employees involved in the sales process to determine what fair competition is. Another purpose is to set forth the Company’s policy that agents and employees involved in the sales process are prohibited from disparaging competitors.

The Company reserves the right to supplement or modify these Guidelines as necessary or appropriate, to address matters such as new products or changes in the law.

These “Guidelines for the Field and Home Office to Assure Compliance with Applicable Laws Fostering Fair Competition, Including a Policy to Refrain from Disparaging Competitors” are in addition to any other guidelines, rules, or policies published by the Company concerning conduct in the sales process.

THE LAFAYETTE LIFE INSURANCE COMPANY'S PRINCIPLES AND CODE OF LIFE INSURANCE ETHICAL MARKET CONDUCT

The following Principles and Code of Ethical Market Conduct have been developed by the American Council of Life Insurance and endorsed by its Board of Directors. The Lafayette Life Insurance Company also endorses and subscribes to these Principles and Code and commits itself in all matters affecting the sale of individually-sold life and annuity products as follows:

PRINCIPLE 1: The Lafayette Life Insurance Company will conduct business according to high standards of honesty and fairness and will render that service to its customers which, in the same circumstances, it would apply to or demand for itself. To conduct its business according to high standards of honesty and fairness, The Lafayette Life Insurance Company will implement policies and procedures designed to provide reasonable assurance that:

A. Insofar as individual products or those marketed on an individual basis are concerned, its distributors make reasonable efforts to determine the insurable needs or financial objectives of its customers based upon relevant information obtained from the customer and enter into transactions which assist the customer in meeting his or insurable needs or financial objectives.

B. It maintains compliance with applicable laws and regulations.

C. In cooperation with consumers, regulators and others, it affirmatively seeks to improve the practices for sales and marketing of life and annuity products.

D. The Principles of Ethical Market Conduct are reflected in company policies and practices.

PRINCIPLE 2: The Lafayette Life Insurance Company will provide competent and customer-focused sales and service. To provide for competent sales and service of life and annuity products, The Lafayette Life Insurance Company will develop policies and procedures designed to provide reasonable assurance that:

A. Its distributors are of good character and business repute, and have appropriate qualifications and experience.

B. Its distributors are duly licensed or otherwise qualified under state law.

C. Its distributors and employees involved in the sales process are adequately trained, as appropriate to The Lafayette Life Insurance Company's distribution system, to focus on customers' needs and objectives.

D. Its distributors have adequate knowledge of The Lafayette Life Insurance Company's products and their operation.

E. Its distributors and employees involved in the sales process are trained, as appropriate to its distribution system, in the need to comply with applicable insurance laws and regulations and the concepts in the Principles and Code of Ethical Market Conduct.

F. Its distributors and employees involved in the sales process participate, as appropriate to The Lafayette Life Insurance Company's distribution system, in continuing education.

PRINCIPLE 3: The Lafayette Life Insurance Company will engage in active and fair competition. The Lafayette Life Insurance Company is committed to competition as the most effective and efficient means of providing products and services to customers. Competition is also the most efficient regulator of activities. To maintain and enhance competition in the marketplace for life and annuity products, The Lafayette Life Insurance Company will develop policies and procedures designed to provide reasonable assurance that:

A. It maintains compliance with applicable state and federal laws fostering fair competition.

B. Its distributors do not replace existing life insurance policies and annuity contracts without first communicating to the customer, in a manner consistent with Principle 4, information that he or she needs in order to ascertain whether such replacement of existing policies or contracts may or may not be in his or her best interest.

C. Its distributors and employees involved in the sales process refrain from disparaging competitor insurers.

PRINCIPLE 4: The Lafayette Life Insurance Company will provide advertising and sales materials that are clear as to purpose and honest and fair as to content. To provide sales and advertising materials which are clear as to purpose and honest and fair as to content, The Lafayette Life Insurance Company will develop policies and procedures designed to provide reasonable assurance that:

A. Presentation of any material designed to lead to sales or solicitation of life and annuity products is done in a manner consistent with the best interests of the customer. All such sales or solicitation communications should be based upon the principles of fair dealing and good faith, and will have a sound basis in fact.

B. Materials presented as part of a sale are comprehensible in light of the complexity of the product being sold.

C. It maintains compliance with applicable laws and regulations related to advertising, unfair trade practices, sales illustrations and other similar provisions.

D. Illustrations of premiums and considerations, costs, values and benefits are accurate and fair, and contain appropriate disclosure of amounts which are not guaranteed and those which are guaranteed in the policy or contract.

PRINCIPLE 5: The Lafayette Life Insurance Company will provide for fair and expeditious handling of customer complaints and disputes. To

resolve any complaints and disputes that may arise concerning market conduct, The Lafayette Life Insurance Company will develop policies and procedures designed to provide reasonable assurance that:

A. Complaints are identified, evaluated and handled in compliance with applicable state law and regulations related to consumer complaint handling.

B. Good faith efforts are made to resolve complaints and disputes without resorting to civil litigation.

PRINCIPLE 6: The Lafayette Life Insurance Company will maintain a system of supervision and review that is reasonably designed to achieve compliance with these Principles of Ethical Market Conduct. The Lafayette Life Insurance Company will develop or assign responsibilities designed to provide reasonable assurance, as appropriate to its distribution system, that:

A. It establishes and enforces policies and procedures reasonably designed to comply with the Principles and Code of Ethical Market Conduct.

B. There is an adequate system of supervision of the market activities of its distributors and employees involved in the sales process in order to monitor their compliance with these Principles and Code and applicable laws and regulations.

C. Compliance training sessions are conducted for employees involved in the sales process and instruction on the company's compliance requirements is made available to all distributors.

D. Policies and procedures provide for auditing and monitoring of information related to sales practices of its employees involved in the sales process and distributors.

Agent's Responsibilities

CONTRACT, AUTHORITY, AND CONDUCT OF BUSINESS

CONTRACTS AND LICENSES - No Agent is permitted to solicit business until he or she is licensed and contracted with The Lafayette Life Insurance Company (the "Company").

SOLICITATION - In states where required, an agent shall inform the prospective purchaser, prior to commencing a life insurance sales presentation, that he or she is acting as a life insurance agent and inform the prospective purchaser of the full name of the insurance company which the agent is representing to the buyer.

OUT OF STATE MAIL SOLICITATION - Taking applications by mail outside the primary state of license is permitted only when it involves a CURRENT Lafayette Life policyowner for whom the Agent has written prior coverage and who has moved out of the Agent's state life license. A medical examination and Telecom Report will be required for all applications taken by mail. For a nonresident license - contact the Marketing Department.

INTERNET ACCESS AND ELECTRONIC COMMUNICATIONS - You hereby acknowledge and agree that the Company may provide written notices and other communications electronically via e-mail or by posting to the Company website at www.LafayetteLife.com. Additionally, many Company forms are available to agents through the Company's website. Consequently, Agent's must maintain internet access and an e-mail address and immediately provide the Company with their e-mail address and notice of any changes thereto.

AUTHORITY OF AGENTS - Agents of the Company are authorized to solicit applications for insurance on such plans as are offered by the Company, to collect the initial premium on such business for prompt transmission to the Company, and to perform such other duties as the Company may from time to time require.

Agents are not authorized to accept risks of any kind; to make, modify, or discharge contracts; to extend the time for paying any premium; to waive forfeiture; to bind the Company by any statement, promise or representation; or to employ counsel to represent the Company.

MARKET CONDUCT - Agents of the Company shall adhere to the Principles and Code of Ethical Market Conduct. Consult your Agent's Reference Manual for a complete description of Company's Principles and Code of Life Insurance Ethical Market Conduct.

In the event that you receive any communication primarily expressing a grievance that pertains to a Lafayette Life policy, the Company, your conduct or the conduct of agents while assigned to you, you must immediately report and send copies of such grievance to the Home Office. You will cooperate with any Company investigation of any grievance and promptly provide any documents, explanations or statements requested.

PRIVACY POLICY - Agents of the Company shall comply with the Company's policies and practices concerning the protection of customers' nonpublic personal information (Non Public Informa-

tion) as defined in Title V of the Gramm-Leach-Bliley Act ("GLB"). Agents agree that they will use or disclose Non Public Information that they receive from or on behalf of the Company only for the purpose for which the Non Public Information was disclosed or as otherwise permitted under applicable federal or state laws or regulations. Agents shall maintain physical, electronic and procedural safeguards to protect Non Public Information. For additional information on the Company's GLB privacy policies contact The Lafayette Life Insurance Company, 400 Broadway, Cincinnati, Ohio 45202-3341.

POLICY DELIVERY - Agents may deliver policies only during the life and good health of the proposed Insured unless settlement of full initial premium has been made at the time of application and policy issued as applied for. Policies should always be delivered in person within 60 days from the date the policy was mailed from the Home Office.

ADVERTISING - Agents may not publish anything concerning the policies or business of this or any other Company, or to issue circulars of any kind, unless the proposed matter has been submitted to, approved and authorized by the Company in writing. All advertising and sales materials must be prepared by and/or approved by the Company. The Company's name may not be placed on any document in a manner suggesting that the Company is the author, unless the document has been approved in its final form by the Company.

REBATING - In most states rebating is illegal and a violation of the rebating laws. Violations will subject the offender to serious penalties. The Company does not authorize or permit any agent to pay or allow, or offer to pay or allow, directly and indirectly, a rebate of any premium, or to grant any special favor or valuable consideration on any policy of insurance, either to the Proposed Insured for such policy or to any other person.

EXPENSES - The agent is not authorized to incur any expense on behalf of the Company or of any agent to which it is assigned, or to draw drafts on the Company.

CWA LIMITS - The Underwriting Department will accept cash with applications for face amounts up through \$1,000,000 (base plan plus term rider) for ages 0-70. Current insurance in force with the Company will be considered in determining the CWA limit for new business applications. Cash (check or money order) will not be accepted with application if the amount of insurance (including term rider and previous insurance) exceeds \$1,000,000 or if applicant is age 71 or over. The Conditional Receipt may not be detached from these applications. **All premium checks** for the policy (including the check for the initial premium) should be **made payable to The Lafayette Life Insurance Company** and should not be made payable to the Agent.

CONDITIONAL RECEIPT - Maximum limits are \$250,000 through age 70. California and Pennsylvania Field Associates must and all Field Associates are urged to bring the printed limits of liability to the attention of their applicants.

REPLACEMENT - The Company is interested in the sale of new insurance but not at the expense of existing insurance.

PREMIUM REMITTANCE - Initial premiums collected on delivery must be sent to the Home Office immediately. Normally, only an owner's check is acceptable for any premium payment. A money order or Cashier's Check may be used when necessary. **Agent or Agency checks will not be accepted.**

AGENT TRAINING; FAMILIARITY WITH COMPANY PRODUCTS

Agents of The Lafayette Life Insurance Company shall be familiar with and understand, and agree to ensure that all agents and assigned agents will be familiar with and understand, the terms and conditions of the life insurance policies and annuity contracts sold by the Company and the supporting marketing literature made available by

the Company in connection with any of the life insurance policies and annuity contracts that the agent or assigned agents sell. Agents shall not recommend the purchase of any Lafayette Life product unless the Agent has adequate knowledge of the product. Agents shall comply with all state required and/or Company required training/continuing education obligations, and shall furnish to the Company upon reasonable request - documentation acceptable to the Company substantiating completion of any such training/continuing education.

SUITABILITY

Agents of the Company shall abide by all applicable state, local and federal laws, regulations and guidelines in conducting its business, including without limitation any state laws, regulations and rules applicable to suitability of the product purchased.

This summary highlights some of your key responsibilities as a Lafayette Life Agent. Consult your contract and Agent's Reference Manual for a more complete description of your responsibilities and Company rules. For purpose of this form, the term "Agent" includes the term General Agents, Agents, Independent Marketing Organizations, Marketing General Agents, Independent General Agents, and all other agents appointed by the Company.

I have read, understand and will comply with the above Responsibilities and all others set forth in my contract.

Applicant Signature: _____

Date: _____

AR
4/05