



1. a. Does the proposed insured have any life insurance or annuity contract(s) currently active with our company or any other company? Yes No
(If Yes, and if required by state regulation, any Replacement Comparison, Notice or Statement must accompany this application.)
- b. Will any annuity or life insurance presently or recently in force be replaced or changed by this policy applied for?..... Yes No
if 1b is answered "yes", please complete the following questions:
 - i. What is the primary reason for the replacement? _____
 - ii. Are you the writing producer on the current policy?..... Yes No
 - iii. When was the current policy issued? _____
 - iv. With what underwriting classification was the current policy issued? _____
 - v. What are the current/proposed annualized premiums? _____
 - vi. What are the current/proposed death benefit amounts? _____
 - vii. What are the remaining surrender charges on the current policy? _____
 - viii. Have you discussed/described the surrender charges and surrender charge period regarding the proposed policy?..... Yes No
 - ix. If values from an existing annuity contract are being used to pay premiums on the proposed policy, how has the original objective of the annuity contract changed? _____
 - x. If values from an existing annuity contract are being used to pay premiums on the proposed policy, have any tax implications been explained to the customer? Yes No
 - xi. 1035 Exchange (attach required forms) External Internal _____

2. a. How long have you known the proposed insured? _____
- b. Is the proposed insured a relative of or does proposed insured have a business relationship with the producer?..... Yes No
If Yes, explain _____
- c. Did the producer personally see all the persons to be covered and were answers recorded exactly as given?..... Yes No
If No, explain and arrange for additional evidence of insurability _____
- d. I personally viewed all driver's licenses or other government issued photo identification documents..... Yes No
3. Is proposed insured(s) a U.S. citizen? Yes No If no, how long in U.S.? _____ Type of Visa? _____
4. Was any other person present to answer questions? Yes No If yes, who and why _____
5. Does proposed insured and owner speak and understand English? Yes No

6. a. If proposed insured is a minor dependent, complete for all brothers and sisters:

Age	Sex	Amount of Life Insurance in Force

Age	Sex	Amount of Life Insurance in Force

b. Amount of life insurance in force on each supporting parent or legal guardian \$ _____

7. Medical requirements arranged Paramedical Exam EKG Blood Analysis Physician's Exam Date Scheduled _____

Check here if the exam has already been done. Name & Phone # of vendor _____

8. If Married:

a. Spouse's name _____ b. Spouse's occupation _____

c. Amount of life insurance in force on spouse \$ _____ d. Spouse's annual earned income \$ _____

9. a. Purpose of insurance Business Personal Estate

(If multi-purpose, give percentage of face or split the amount by purpose in remarks section below.)

b. If business: Deferred Comp Buy/Sell Split Dollar Key Person Premium Financing Mortgage Financing

Business net annual income \$ _____ Business net worth \$ _____

Proposed insured's business life insurance in force \$ _____ % of ownership _____

Business life insurance issued or applied for on other owners, officers, partners or key person(s):

Name and Title	% of Business Owned	Insurance Company	Amount in Force



10. Additional Alternate policy: Amount \$ _____ Plan _____

11. Remarks _____

PRODUCER'S CERTIFICATION

I certify that:

- I saw and know the proposed insured(s) to be the person(s) described in this application;
- I reviewed the appropriate documents, and have truly and accurately recorded the information supplied by the applicant;
- I know of no condition affecting the eligibility or insurability of the applicant not fully set forth in the application;
- I have made no declaration, representation, or waiver regarding coverage or the provisions or terms of the application or policy;
- Other than policy-related information, I have given the proposed insured or owner(s) nothing of value in connection with this application or policy;
- I am licensed in the state in which this application was completed;
- I have delivered all required notices and disclosures and fully complied with all privacy and replacement regulations;
- Only company approved sales materials were used and copies of such materials were left with the client and retained in my files;
- I assume full responsibility for the delivery of the policy and the submission of the first premium.

Agency No. _____ Agency Name _____

List of all producers (please print)	Producer code #	Commission share

Signed at _____ Signed (writing producer) **X** _____ Date _____

Phone # _____ E-Mail _____ Fax # _____

Preferred mode of communication? Phone E-Mail Fax



INSTRUCTIONS

- Please print clearly with black ink. No felt tip pens.
 - Corrections should be initialed and dated by proposed insured/owner. Do not use white out.
 - The insured's full name should be shown in Question 1 and signed identically on page 5.
 - If the owner is a trust or business please include full title and name of trust or business.
Ex: Paula Smith, Trustee Paula Smith, President
 Paula Smith Irrev Trust date 1-2-98 Paula's Shoe Store, Inc.
- Make sure that you have the complete name and date of trust and if it is revocable or irrevocable.
- List all owners' tax IDs on page 1. If all owners' tax IDs are not included, we will require completed W-9 before issue.
 - Proposed insureds age 15 and over are required to sign the application.
 - When insuring the life of children under the age of 15 a parent's signature is required even if they are not the owner of the policy.
 - Submit all pages of the application even if information is not required.
 - For Independent Choices, only the 5 YR Index and 5 YR Fixed-Term interest crediting strategies are available.
 - Explain the terms of the Company's Conditional Life Insurance Agreement prior to accepting any settlement with the application.
 - Leave the completed Conditional Life Insurance Agreement with the applicant if money is taken.
 - Explain the Disclosure Notice and leave it with the Proposed Insured.
 - Two applications need to be completed for joint life products—one for each insured.
 - If required, send in complete illustration signed by owner and agent. Make sure the application and the illustration match.
 - When submitting an application you must include a) a fully completed illustration including both the applicant's and your signatures; or b), a completed certification stating that no illustration was presented at application; or c) an electronic illustration certification stating that an illustration was shown on a computer but that no hard copy was printed or presented to the applicant. Do not mark, highlight or write on the illustration.
If this application is completed for an indexed product in the states listed, you must provide a signed illustration with the application. A certification of non-illustration or electronic illustration only is not allowed: Arkansas, Connecticut, North Dakota, Oklahoma, South Dakota, Wyoming.
If the application is completed for an indexed product for the following states, the Applicant must initial or sign the Indexed Acknowledgments as indicated: Connecticut, Massachusetts, South Carolina, and Texas.
 - Complete the Pre-Authorized Check Information if requesting billing mode of PAC.
 - Review the application prior to mailing to the Company to make certain it is complete and accurate. Include a cover memo with special instructions if needed.
 - For faster service, fax the application to the number listed below. Please retain original, do not mail.

SPECIAL INSTRUCTIONS TO THE NEW BUSINESS STAFF:

Application for Life Insurance



**Aviva Life and
Annuity Company**
Home Office: West Des Moines, IA
Mailing Address:
P.O. Box 1555
Des Moines, IA 50306-1555
Fax: 1-800/531-0038





Application for Insurance

AGENT CODE # _____

(In this application, "Company" refers to the insurance company named above.)

APPLICANT INFORMATION

1. PROPOSED INSURED

Name (First, Middle, Last) _____ Is Insured also the Owner? Yes No
 Address _____ E-Mail: _____
 City _____ Home Ph. (____) _____ Bus. Ph. (____) _____
 State _____ Zip _____ Gender M F Maiden Name _____
 Birth Date _____ Birth State _____ Social Security Number _____
 Marital Status Married Single Divorced or Separated Widow or Widower U.S. Citizen? Yes No Permanent Resident? Yes No
 Driver's License # _____ State _____ Issue Date _____ Expiry Date _____
 Or, if you do not have a driver's license, other government issued photo ID: Document Type _____
 Document # _____ Where Issued _____ Issue Date _____ Expiry Date _____
 Employer _____ How Long? _____ Occupation/Duties _____
 Annual earned income \$ _____ Annual unearned income \$ _____ Net worth \$ _____
 If multiple life product, (2nd app required for multiple life)
 Joint Insured Names: (1st): _____ (2nd): _____

2. OWNER (If different from Proposed Insured) Individual Business Trust (date of trust) _____

Name (Owner, Business or Trustee) _____ Birth Date _____
 If trust, name of trust _____
 Address _____ City _____ State _____ Zip _____
 Relationship to Proposed Insured _____ Social Security # or Taxpayer ID # _____
 Owner's or Trustee's personal driver's license # or other government issued photo ID document, or corporate license:
 Document Type _____ Document # _____ Where Issued _____ Issue Date _____ Expiry Date _____
Contingent Owner (If none specified, policy provisions will apply.) _____
 Driver's License # or other government issued photo ID document:
 Document Type _____ Document # _____ Where Issued _____ Issue Date _____ Expiry Date _____
 Mail notices to Insured Owner Other (specify) _____

Other Notice Address _____ City _____ State _____ Zip _____

Tax Qualification Type Qualified Plan: Non-Qualified Plan: Neither
 Type: Profit Sharing Plan Type: Welfare Benefit Plan:
 401(k) single employer
 412(i) multiple employer
 Other Defined Benefit VEBA
 Deferred Comp
 Split Dollar
 Executive Bonus
 Other _____

3. PRIMARY BENEFICIARY(IES) - Applies to primary insured only. (If trust, complete name and date of trust.)
 (If necessary, use an additional page for additional details, signature of owner & date.)

Print Full Name _____ Birth Date _____ Relationship _____ Percentage _____ Social Security # or Taxpayer ID # _____

4. CONTINGENT BENEFICIARY(IES)

Print Full Name _____ Birth Date _____ Relationship _____ Percentage _____ Social Security # or Taxpayer ID # _____



POLICY INFORMATION

5. **PRIMARY INSURED** Nonsmoker/Nontobacco Smoker/Tobacco
 Base Plan _____ Amt. of Ins. \$ _____
 Additional Coverage _____ Amt. of Ins. \$ _____ Premium \$ _____
 Additional Coverage _____ Amt. of Ins. \$ _____ Premium \$ _____
Riders (Complete Supplemental Application if applicable)
 Waiver Type _____ Other Riders (Type/Amount): _____
 Spouse Rider \$ _____ Child Rider \$ _____
6. **UL Death Benefit Option:** Level Increasing Death Benefit Return of Premium Rider
 Premium Direction/Interest Crediting Strategy: 1 Year Point-to-Point _____% 2 Year Point-to-Point _____% 1 Year Monthly Average _____%
 1 Year Monthly Cap _____% 1 Year Average Multiple Index _____% 5 Year Fixed Term _____% 1 Year Fixed Term _____% _____%
 Levelized Strategy Transfer Yes No
7. **WHOLE LIFE** APL (if applicable) Yes No Direct Recognition (if available) Yes No

PREMIUM INFORMATION

8. **PREMIUM** Planned Premium \$ _____ Additional Premium (Lump Sum) \$ _____
 Billing Frequency Annual Semi-Annual Quarterly PAC (Complete Authorization) Other _____
 Govt. Allotment (if available) Group Bill Group Bill # _____
 Has the premium for the policy applied for been given to the agent? Yes No Amount \$ _____
 How Paid? Check Other (specify) _____

Additional Policy Specifications

Policy Date (optional) _____ Other _____

9. **Are you financing or refinancing a mortgage and/or a home equity loan or contemplating the use of any kind of mortgage financing strategy in connection with the purchase of or the payment of premiums on the life insurance policy?** Yes No
 (If yes, please review and acknowledge by signing the Mortgage Financing Disclosure Statement.)
10. **Will you borrow money to pay the premiums for this policy or have someone else pay these premiums for you, in return for you assigning part of or all of the policy values to someone else?** Yes No (If yes, please review and acknowledge by signing the Premium Financing Applicant Acknowledgement and Disclosure Statement.)

NON-MEDICAL INFORMATION

11. **INSURANCE IN FORCE ON PROPOSED INSURED**
 a. Are any life insurance or annuity contracts in force? Yes No
 If yes, complete section below. (Attach separate sheet if necessary)

Company	Amount	WP ?	Personal/Business	Year Issued	Replacing ?	Amount ADB

- b. Will any annuity or life insurance presently or recently in force be replaced or changed by this policy applied for? Yes No
 c. Have you ever been declined, rated, or had coverage modified or withdrawn, or reinstatement declined by any insurance company? Yes No
 d. Within the last year, has any other life, health or long term care insurance been issued or applied for, or is any to be applied for? .. Yes No

12. OTHER NON-MEDICAL INFORMATION

- a. Do you use any form of tobacco or nicotine based products? Yes No
 If no, have you used any form of tobacco or nicotine based products in the last 5 years? Yes No
 If yes, when did you last use tobacco or nicotine based products? _____ Type _____ Quantity _____
- b. Have you engaged in the last 3 years, or do you intend within the next 12 months to engage:
 1. In any aviation activity other than as a passenger? Yes No
 2. In ballooning, gliding, boat or vehicle racing, mountain or rock climbing, parachuting, sky diving, underwater diving or any other hazardous sport or activity? Yes No
- c. Within the last 5 years, have you filed for bankruptcy (personal or business)? Yes No
 d. Within the last 5 years, have you been charged with reckless driving, driving under the influence of alcohol or drugs, or 2 or more moving violations, or had your driver's license revoked or suspended, or received a warning letter? Yes No
 e. Have you been arrested for an illegal activity, acquired a criminal record, or are you currently on probation, parole, or under investigation? Yes No
 f. Are you a member of or do you contemplate joining one of the Armed Forces or an active or reserve military unit? Yes No
 g. Have you in the past 2 years traveled or do you intend to travel or live outside the United States or Canada? Yes No
 h. Is any proposed insured, owner or beneficiary a resident or citizen of or an entity organized under the laws of a country other than the U.S.? Yes No
 i. Do you intend to sell or transfer all or any portion of this policy to another person, any group of investors or other entity? Yes No



Give complete details of any YES answers to questions 11 and 12. (If necessary, use an additional page for additional details, signed by the applicant and dated.) _____

13. PHYSICIAN INFORMATION

- a. Name, address and phone # of your doctor(s) or health care provider(s): _____
- b. When did you last consult a doctor and why? _____
- c. What medication(s) (prescribed or over the counter) are you now taking? (If none, so state) _____

MEDICAL INFORMATION If medical exam is required, questions 14-17 do not need to be completed.

14. PROPOSED INSURED

- a. Height in shoes _____ feet _____ inches Weight in clothes _____ pounds
- b. Have you gained or lost more than 10 pounds in the last year? Yes No
- c. Are you now under observation or treatment? Yes No
- d. Have you ever been diagnosed by a medical professional as having or been treated for AIDS or ARC (AIDS-related complex)? . . Yes No
- e. Have you ever tested positive for HIV antibodies as part of a test for obtaining insurance? Yes No
- f. Have you ever requested or received a benefit, military deferment, discharge or rejection, payment or pension because of a disability, injury, or sickness? Yes No

15. IN THE PAST 10 YEARS, HAVE YOU BEEN DIAGNOSED OR TREATED BY A MEMBER OF THE MEDICAL PROFESSION FOR:

- a. Disease of the heart or circulatory system, including high blood pressure, heart attack, coronary artery disease, or chest pain? . . Yes No
- b. Heart murmur, rhythm abnormality, heart catheterization, echocardiogram or an exercise treadmill test? Yes No
- c. Cancer, tumors, lymphoma, leukemia, or any growths, lesions, polyps? Yes No
- d. Diabetes, thyroid, glandular or endocrinal disorder? Yes No
- e. Respiratory disorders including asthma, chronic bronchitis, emphysema, pneumonia, shortness of breath, or abnormal chest x-ray? Yes No
- f. Disorder of the stomach, liver, pancreas or intestinal tract, including ulcerative colitis, Crohn's disease, or cirrhosis? Yes No
- g. Disorder of the kidneys, prostate, bladder, reproductive organs, sexually transmitted diseases, sugar, albumin or blood in urine? . . Yes No
- h. Stroke, transient ischemic attack (TIA), Parkinson's, multiple sclerosis, seizures, epilepsy, chronic headaches, memory changes or fainting? Yes No
- i. Anxiety, depression, attempted suicide, attention deficit disorder or psychosis, mental or nervous system disorder? Yes No
- j. Anemia, hepatitis, or any blood disorder (except HIV status)? Yes No
- k. Chronic back pain, arthritis, loss of limb, paralysis, muscle weakness or disease? Yes No

16. WITHIN THE LAST FIVE YEARS, OTHER THAN AS NOTED ABOVE, HAVE YOU:

- a. Seen a doctor, health care provider, counselor, therapist, or had any illness, injury, surgery, diagnostic test or treatment, or been advised to have any diagnostic test, surgery or treatment not yet completed? Yes No
- b. Been a patient of a clinic or hospital emergency room, or had any diagnostic test that was not normal? Yes No
- c. Used any drug, narcotic or controlled substance not prescribed by a physician, or been arrested, counseled, treated, or participated in a support group because of alcohol, controlled substance or drug use? Yes No
- d. Do you currently use alcoholic beverages? Yes No
If yes, what is the average number of drinks per day? 2 or less 3-5 6 or more.

17. FAMILY HISTORY

- a. Is there a family history of diabetes, cancer, heart disease, mental illness, or any hereditary disorders? Yes No
- b. Family information (natural parents, brothers, sisters):

Family Member	Age if Living	Age at Death	Cause of Death
Father			
Brother(s)			

Family Member	Age if Living	Age at Death	Cause of Death
Mother			
Sister(s)			

Give complete details of any YES answers to questions 14 through 17. (If necessary, use an additional page for additional details, signed by the applicant & dated.)

Question Number	Date	Details, Include Diagnosis, Treatment, Duration, Result	Name, Address and Phone Number of Doctor / Medical Facility

For your protection, California law requires the following statement to appear on this application. Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.



TAXPAYER IDENTIFICATION

Instructions (Section references are to the Internal Revenue Code.)

Use this form to report the taxpayer identification number (TIN) of the **policy owner**.

Payors must generally withhold a specified percentage of taxable interest, dividend, and certain other payments if you fail to furnish payors with the correct taxpayer identification number (this is referred to as backup withholding). For most individual taxpayers, the taxpayer identification number is the social security number.

To prevent backup withholding on these payments, be sure to notify payors of the correct taxpayer identification number and properly certify that you are not subject to backup withholding under Section 3406(a)(1)(C).

Use this area to certify that the taxpayer identification number you are giving the payor is correct and that you are not subject to backup withholding.

Backup Withholding - You are subject to backup withholding if:

- (1) You fail to furnish your taxpayer identification number to the payor; OR
- (2) The Internal Revenue Service (IRS) notifies the payor that you furnished an incorrect taxpayer identification number; OR
- (3) You are notified that you are subject to backup withholding [under Section 3406(a)(1)(C)]; OR
- (4) For an interest or dividend account opened after December 31, 1983, you fail to certify to the payor that you are not subject to backup withholding under (3) above, or fail to certify your taxpayer identification number.

Payees Exempt From Backup Withholding - Certain payees, such as corporations, government agencies, etc. may be exempt from backup withholding.

What Number to Give the Payor - Give the social security number or employer identification number of the record owner of the account. If the account belongs to you as an individual, give your social security number. If the account is owned by a corporation, give the employer identification number of the corporation.

Obtaining a Number - If you don't have a taxpayer identification number or you don't know your number, obtain **Form SS-5**, Application for a Social Security Number Card, or **Form SS-4**, Application for Employer Identification Number, at the local office of the Social Security Administration or the Internal Revenue Service and apply for a number. Write "applied for" in place of your number. When you get a number, submit a new Form W-9 to the payor.

AGREEMENTS AND REPRESENTATIONS

It is hereby represented that the answers and statements on the application(s) and any Supplements required are complete, true and correctly recorded. Information not recorded on the application(s) and any Supplements will not be treated as known to the Company. A copy of the application(s) and any Supplements shall be a part of the policy, and it is agreed that the policy and copy of the application(s) and any Supplements constitute the entire contract. No changes will be made unless the owner agrees and the change is authorized in writing by an officer of the Company.

If a Conditional Life Insurance Agreement was delivered in consideration of the payment of the first premium and is in effect, its terms will apply. Otherwise the policy will take effect and coverage will begin on the issue date specified in the policy if the full first premium is paid, the Proposed Insured(s) is (are) living, and the answers and statements in the application(s) and any Supplements continue to be complete and true at the time of delivery of the policy.

Under penalties of perjury, I certify that (1) the social security or federal tax identification number shown on page 1 of this application for me as the owner of this policy is my correct taxpayer identification number, AND (2) I am a U.S. person (including a U.S. resident alien), AND (3) I am not subject to backup withholding because (a) I am exempt from backup withholding, or (b) I have not been notified by the IRS that I am subject to backup withholding as a result of failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding. NOTE: You must cross out item 3 in the above certification if you have been notified by the IRS that you are currently subject to backup withholding. The IRS does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

IMPORTANT INFORMATION ABOUT THE USA PATRIOT ACT

To help fight the funding of terrorism and money-laundering activities, the U.S. government has passed the USA PATRIOT Act, which requires financial institutions to obtain, verify and record information that identifies persons who engage in certain transactions with or through a financial institution, including insurance companies. This means that the Company will need to verify the **name, residential or street address (no P.O. Boxes), date of birth and social security number, drivers license and/or other identification information of all policy owners as may be required by law.**



AUTHORIZATION AND ACKNOWLEDGMENT

This authorization complies with the HIPAA Privacy Rule. I understand that if I refuse to sign this authorization, the Company may not be able to process my application for life insurance. I acknowledge that I have the right to request and receive a copy of this authorization.

Personal Health Information

I authorize any licensed physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, health care provider, health plan, insurer, and/or any other entity subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that has provided treatment, service, payment, or coverage to me within the past 10 years to disclose my entire medical record and any other protected health information concerning me to the Company, its agents, employees, representatives, insurance support organizations, and reinsurers ("the Company"). Protected health information includes but is not limited to: hospital records, treatment records/office notes, consultation reports, workers' compensation information, diagnosis, prescriptions, and test results. It also includes information concerning the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases, and information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any licensed physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, health care provider, health plan, insurer, and/or other entity subject to HIPAA to release and disclose such information without restriction.

I understand that, unless prohibited by state and/or federal law, the protected health information is to be disclosed under this authorization so that the Company may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have, have applied for, or may in the future apply for with the Company. I understand any information disclosed under this authorization may no longer be covered by federal rules governing privacy and confidentiality of health information and may be subject to re-disclosure.

Personal Private Information

I understand that an investigative consumer report may be prepared in connection with this application. I authorize any consumer reporting organization or employer having non-medical information about me to release such information to the Company, its reinsurers, or its authorized representatives. I authorize the Company to prepare an investigative consumer report. I understand that I may request to be personally interviewed if an investigative consumer report is prepared in connection with this application and not to have personal information disclosed for marketing purposes. Any information obtained will not be released by the Company, its reinsurers, or representatives to any person or organization except to reinsuring companies, the Medical Information Bureau, or other persons or organizations performing business or legal services in connection with my application, claim, as may be permitted or required by law, or as I may further authorize.

Limitations, Revocation and Rights

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization at any time. The request for revocation must be in writing and sent to the attention of the Underwriting Department of the Company. I understand that a revocation is not effective to the extent that the Company has already relied on this authorization or to the extent that the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. Such revocation shall not apply to any use or disclosure of my protected health information specifically allowed without authorization by HIPAA and no action relating to this authorization shall be construed as creating any restriction on the uses that HIPAA allows without my authorization.

SIGNATURES

I have reviewed and understand the information contained above in the "Taxpayer Identification," "Agreements and Representations," including reviewing the answers and statements on the application(s) and any Supplements for accuracy, "Important Information About the USA Patriot Act," and "Authorization and Acknowledgment" sections, and further acknowledge receipt of the Disclosure Notice to Proposed Insured.

I understand, acknowledge and agree that the Agent has no authority to make any promise, representation or waiver regarding coverage or the terms of the policy. I also understand, acknowledge and agree that the Agent has no authority to provide any legal or tax advice on behalf of the Company. If any such legal or tax advice has been given, I understand, acknowledge and agree it has been done without Company authority and has not been given on behalf of the Company. I understand, acknowledge and agree that I am responsible for obtaining independent legal or tax advice with respect to any such matters. I understand, acknowledge and agree that all premium payments after the first are to be provided directly to the Company and that the Agent has no authority to receive, transmit, sign, endorse, deposit or process any subsequent payments made on the policy.

Signed / Dated at _____
City, State

X _____
Signature of Owner/Proposed Insured
(or signature of Insured's Personal Representative*)

On _____
Date

X _____
Signature of Owner if Other than Proposed Insured

X _____
Signature of Licensed Agent

Parent/Guardian or Witness (if required)

If Owner is a corporation, business firm or trust, give full name and
an Authorized person must sign and provide title

*If you are the Proposed Insured's Personal Representative, describe the scope and/or basis of your authority to act on the Proposed Insured's behalf:





Conditional Life Insurance Agreement

(In this receipt, "Company" refers to the insurance company named above.)

ADDITIONS, DELETIONS, OR OTHER ALTERATIONS TO THIS AGREEMENT ARE STRICTLY PROHIBITED.

Insurance applied for on the application is provided by this form from the START DATE to the STOP DATE, as defined below. However, NO INSURANCE is provided unless ALL the CONDITIONS AND LIMITATIONS of this Agreement are met. If not met, the Company's liability under this Agreement is limited to a refund of the total premium received.

DO NOT COLLECT CASH IF DEATH BENEFIT AMOUNT APPLIED FOR EXCEEDS \$3,000,000.

CONDITIONS AND LIMITATIONS

1. It is a condition precedent that the proposed insured be insurable on the START DATE. This means "insurable" under our rules and limits.
2. There is no insurance before the START DATE.
3. There is no insurance after the STOP DATE.
4. There is no insurance if any material misrepresentation exists on the application or supplements.
5. This form is void if any check or draft is not valid.
6. There is no insurance if less than a full month premium is paid.
7. Life Insurance limits are the lesser of:
 - a. \$500,000 or the amount on page 2 of the application, if the proposed insured is insurable at the rate applied for or better; or
 - b. \$100,000 or the amount on page 2 of the application, if the proposed insured is insurable, but at a higher rate than applied for.
8. If the proposed insured dies by suicide, the Company's liability under this Agreement is limited to a refund of the payment received.

START DATE

START DATE means the later of:

1. completion of all parts of the application and supplements thereto; OR
2. the date any medical exam or other required medical studies or tests are completed.

STOP DATE

STOP DATE means the earliest of:

1. the date a non-acceptance notice is mailed by the Company; OR
2. the day before the policy date; OR
3. 60 days after the START DATE.

RECEIVED from _____ Payment in the Amount of \$ _____
ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE COMPANY. DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE PAYEE BLANK. ALL PREMIUMS AFTER THE FIRST ARE TO BE PROVIDED DIRECTLY TO THE COMPANY.

The Proposed Insured is _____ Signature of Owner _____

Signed at _____
City State Date Signature of Agent

PLEASE RETURN ONE COPY TO HOME OFFICE WITH CHECK





Conditional Life Insurance Agreement

(In this receipt, "Company" refers to the insurance company named above.)

ADDITIONS, DELETIONS, OR OTHER ALTERATIONS TO THIS AGREEMENT ARE STRICTLY PROHIBITED.

Insurance applied for on the application is provided by this form from the START DATE to the STOP DATE, as defined below. However, NO INSURANCE is provided unless ALL the CONDITIONS AND LIMITATIONS of this Agreement are met. If not met, the Company's liability under this Agreement is limited to a refund of the total premium received.

DO NOT COLLECT CASH IF DEATH BENEFIT AMOUNT APPLIED FOR EXCEEDS \$3,000,000.

CONDITIONS AND LIMITATIONS

1. It is a condition precedent that the proposed insured be insurable on the START DATE. This means "insurable" under our rules and limits.
2. There is no insurance before the START DATE.
3. There is no insurance after the STOP DATE.
4. There is no insurance if any material misrepresentation exists on the application or supplements.
5. This form is void if any check or draft is not valid.
6. There is no insurance if less than a full month premium is paid.
7. Life Insurance limits are the lesser of:
 - a. \$500,000 or the amount on page 2 of the application, if the proposed insured is insurable at the rate applied for or better; or
 - b. \$100,000 or the amount on page 2 of the application, if the proposed insured is insurable, but at a higher rate than applied for.
8. If the proposed insured dies by suicide, the Company's liability under this Agreement is limited to a refund of the payment received.

START DATE

START DATE means the later of:

1. completion of all parts of the application and supplements thereto; OR
2. the date any medical exam or other required medical studies or tests are completed.

STOP DATE

STOP DATE means the earliest of:

1. the date a non-acceptance notice is mailed by the Company; OR
2. the day before the policy date; OR
3. 60 days after the START DATE.

RECEIVED from _____ Payment in the Amount of \$ _____

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE COMPANY. DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE PAYEE BLANK. ALL PREMIUMS AFTER THE FIRST ARE TO BE PROVIDED DIRECTLY TO THE COMPANY.

The Proposed Insured is _____ Signature of Owner _____

Signed at _____
City State Date Signature of Agent

PLEASE RETURN ONE COPY TO HOME OFFICE WITH CHECK



Aviva Life and Annuity Company
Home Office: West Des Moines, IA
Mailing Address:
P.O. Box 4905
Des Moines, IA 50306-4905
Fax: 1-800/531-0038



Disclosure Notice to Proposed Insured

In this Disclosure, "Company" refers to the insurance company named above.
In this Disclosure, "You" and "Your" mean the Proposed Insured.

MEDICAL INFORMATION BUREAU (MIB)

Information regarding Your insurability will be treated as confidential. The Company or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau (MIB), a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. If You apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from You, MIB will arrange disclosure of any information it may have in Your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642) if you are interested in such a disclosure. If you question the accuracy of information in MIB's file, you may contact the MIB information office in writing at 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734 and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act.

The Company or its reinsurers may also release information in its file to insurance support organizations, or to other insurance companies to whom You may apply for life or health insurance or to whom a claim for benefits may be submitted. Insurance support organizations include any person or entity that assembles or collects information about individuals primarily for the purpose of providing such information to an insurance company.

INVESTIGATIVE CONSUMER REPORT

In addition to requesting a report from MIB, as a part of the Company's underwriting process the Company may request an investigative consumer information report to confirm and supplement the information on Your application about Your general health, employment and occupation, finances, smoking habits, and hazardous activities. Such a report may also cover Your mode of living, except as may be related directly or indirectly to Your sexual orientation, but including alcohol and drug use, general reputation, and driving record. Some of this information may be obtained through personal interviews with You or Your family, friends, associates, or others with whom You are acquainted. If a consumer information report is requested, You may request to be personally interviewed if You can be contacted during normal business hours. An interview is normally conducted, but You are entitled to make a specific request. You may submit a written request asking to be notified if an investigative consumer report has been prepared. You may also request information on what organization prepared such a report and how to contact that organization.

The Company keeps such information reports confidential and uses them only to evaluate and underwrite Your application. You have a right under the Fair Credit Reporting Act to make a written request to inspect and obtain a copy of a consumer information report. If the Company requests a report and the report has an adverse effect on Your insurability, the Company will notify You in writing and give You the name and address of the reporting company.

USA PATRIOT ACT

To help fight the funding of terrorism and money-laundering activities, the U.S. government has passed the USA PATRIOT Act, which requires financial institutions to obtain, verify and record information that identifies persons who engage in certain transactions with or through such financial institutions, including insurance companies.

This means that the Company will need to verify the **name, residential or street address (no P.O. Boxes), date of birth and social security number or other tax identification number, and other information as deemed necessary, of all policy owners.**

INFORMATION PRACTICES

Personal information the Company obtains during the underwriting process is private and confidential, and the Company will not disclose it to other persons or organizations without Your written authorization except to the extent necessary to conduct the Company's business, or as permitted or required by law. The Company reserves the right to disclose medical information to a medical professional of Your choice and the right to arrange for an insurance support organization to disclose information on the Company's behalf.

Personal information that may be collected includes mental and physical health conditions, medical history, medical treatment, and information about Your general character, habits, hobbies or avocations, finances, employment, occupation, reputation, or marital



status. The information may be collected for the Company by the Company's employees, the Agent, and insurance support organizations that assemble information or prepare investigative consumer reports about You. Information may be collected from personal interviews or by telephone calls with You or Your family, neighbors, friends, business associates, and employers, also from public records, court documents, insurance support organizations and other insurance companies or insurance institutions. If there is a need to contact You by phone, a specially trained representative will call to verify or to ask for additional information relating to the underwriting of Your application.

DISCLOSURE OF INFORMATION AND RIGHT OF ACCESS TO INFORMATION

The Company may disclose personal information about You without prior authorization under certain circumstances. For instance, disclosure may be made to persons or organizations to allow such persons or organizations to perform a business, professional, or insurance function for the Company, or an insurance support organization, or to provide information to determine eligibility for insurance benefits or detect fraud, misrepresentation, or material non-disclosure. The Company may give information to accounting firms performing audits, governmental agencies reviewing Company practices, or attorneys hired to protect the Company's legal interest.

Information may be disclosed to reinsurance companies or another insurance company to which You have applied for coverage or benefits. Information may be furnished to agents to aid them in providing adequate service to a policyowner. Other disclosures may be made as permitted or required by law. The Company may also disclose information to medical professionals where required by law for the purpose of informing You of a medical problem of which You may not be aware or to persons or organizations for the purpose of conducting research including actuarial, marketing, and underwriting studies. This may include various insurance industry groups which conduct studies about risk experience or medical backgrounds of insured lives. No medical record information or personal information relating to Your character, personal habits, mode of living, or general reputation will be released to anyone who receives personal information for purposes of marketing a product or service.

Upon Your written request, the Company will inform You of all persons or entities to whom the Company, the Agent, or any insurance support organization has released Your personal information during the 2 years prior to Your request.

You have a right of access to Your personal information that the Company has collected, and a right to know from what sources it was collected. You may submit a written request to the Company that includes Your full name, address, and policy number and reasonably describes the information desired. The Company will mail the information to You or You may review such personal information in person at one of the Company's offices. The Company will inform You of the nature and substance of the information within 30 days from receipt of the request. The Company will identify sources of information such as hospitals, clinics, doctors, or insurance support organizations. The Company will not identify sources of information where such information was obtained from individuals such as friends or neighbors. The Company will not provide access to information obtained in connection with or in anticipation of a claim for policy benefits, or as part of a civil or criminal proceeding.

You may request that the Company correct, amend, or delete personal information in whole or in part by making written request to the Company. Within 30 days from receipt of the request, the Company will inform You that the Company has either changed such information or the Company will communicate the reasons for not changing such information. If the Company does not make the requested change(s), You may then submit a written statement to the Company setting forth Your opinion regarding the information and/or the reasons why You disagree with the Company's position. All written communications will become part of the policy file.

In any case, the Company will provide either the corrected personal information, or Your request and statement, to all insurance support organizations with whom the Company has shared such information during the previous 7 years. The Company will also notify any specific persons or entities that You direct the Company to inform, who may have received such information during the previous 2 years.



Electronic Funds Transfer (EFT) Authorization For Direct Payments (ACH Debits)
 Pre-Authorized Check (PAC) Authorization Form
 Life Contracts Only



Aviva Life and Annuity Company
 7700 Mills Civic Parkway
 West Des Moines, IA 50266-3862
 Life Customer Contact Center – Tel: 800 800 9882 Fax: 800 531 0038
 Annuity Customer Contact Center – Tel: 888 266 8489 Fax: 866 709 3922

Aviva Life and Annuity Company of New York
 Home Office: Melville, NY
 Tel: 800 252 4467

www.avivausa.com

1. INFORMATION ABOUT YOU

First Name		Middle Initial	Last Name	
Contract Number				
Date of Birth (mm/dd/yy) / /		Social Security Number (Last 4 digits only) X X X - X X -		Contact Telephone Number
Street Address			Email Address	
City		State	Zip	Address Change Requested: <input type="checkbox"/>

* For your protection, confirmation of your address change will be sent to you prior to processing this request.

INSTRUCTIONS

Use this form to transfer funds systematically from your bank into your Aviva Life Contract.

2. PREMIUM PAYOR Print Name as Shown on Financial Institution Records.

Financial Institution	Name	
Address	Phone Number	

3. BANK INFORMATION

I (we) hereby authorize Aviva to initiate debit entries as follows:

Account Name (as it appears on the account)	Bank Name
---	-----------

Routing Number (Bottom left of check)

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------

Account Number (Bottom center of check)

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------

Type of account: Checking - Please attach a voided check for the listed account.
 Savings - Please attach a deposit slip for the listed account.

If you are unsure about the correct way to complete the form, please reference the following sample check information.

Name of Account → Joe Smith
 123 Any Street
 Any City, US 12345
 Date 1234

Bank Name → ABC Bank
 PO Box 111
 Any City, US 11111

Pay to the order of _____ \$ _____ Dollars

Memo _____

↑ :107198557: ↑ 1111111 ↑ 1234
 Transit /ABA No. Checking Account Number Check Number

VOID



Electronic Funds Transfer (EFT) Authorization For Direct Payments (ACH Debits)
 Pre-Authorized Check (PAC) Authorization Form
 Life Contracts Only

www.avivausa.com



4. YOUR DIRECT PAYMENT OPTIONS

Please select one option: The EFT Direct Payment (PAC) will be the same as the policy date unless otherwise indicated.

First Request for EFT Direct Payment (PAC): A check with receipt of funds is needed for initial premium payments. First or initial premiums cannot be drawn automatically.

Add to Existing EFT (PAC) under Policy Number:

Premium Payment Amount: \$ Loan Payment Amount: \$

Frequency: Direct Payments are done on a monthly basis.

Please start my withdrawals on: / / (mm/dd/yyyy) Please indicate day, 1st - 28th.

The date of transfer is the date the funds are removed from your account, not the date they are posted into your contract. Please allow 2-3 business days for funds to transfer. Due to the pre-note process at your bank, it may take 10-14 days to setup the first transfer of funds. If changes are requested, please allow 15 days for processing.

5. YOUR CONFIRMATION

I acknowledge that:

- 1) This request is to remain in full force and effect until Aviva has received notification of termination in such time and in such manner as to afford Aviva and the Depository a reasonable opportunity to act on the notification.
- 2) My financial institution shall be fully protected in honoring any such debit entry and may at any time cease its participation in and compliance with this request and authorization by giving thirty (30) days written notice to me and Aviva.
- 3) If any debit is dishonored, whether with or without cause and whether intentionally or inadvertently, Aviva shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.
- 4) If the payment is not honored by my financial institution, this agreement and future EFT transactions may be terminated by Aviva, at which time repayment notices will be sent directly to my address of record.
- 5) I understand this form is a bank authorization only and there will be no charge to my account until and unless a policy of insurance is issued by Aviva.
- 6) I understand that completion of this form DOES NOT provide coverage under a Conditional Life Insurance Agreement.

Signature of Premium Payor	Date
Additional signature if account requires	Date
Signature of Owner if other than Premium Payor	Date

If you are signing on behalf of the owner, please print your name and provide your signature below and check one of boxes to indicate the capacity in which you are signing. Please provide documentation with the request to verify your authorization to act on behalf of the owner.

Conservator Guardian Power of Attorney

Signature	Date
Print Name	Title

We appreciate your business and are committed to providing you with accurate and caring service. If you have any questions or need additional information, please contact your Insurance Professional or our Customer Contact Center.





Aviva Life and Annuity Company
7700 Mills Civic Parkway
West Des Moines, IA 50266-3862
1-800/800-9882

Electronic Signature Disclosure

I understand that all documents related to my application for a life insurance or annuity contract (the "Record") have been completed with an insurance producer of the Company by answering questions on the application and related forms as they appear on the computer screen. I understand that I will be able to review the completed Record related to my application for insurance in its entirety on the computer screen.

I understand that by clicking on the "I Accept; Proceed to Sign" button, I agree to electronically sign an electronic Record of the completed documents and I am signifying my intent to use an electronic signature to be legally bound by the terms of the applicable Record. I further understand and agree that my electronic signature has the same legal, contractual and binding effect that my written signature would have as if I physically signed a paper Record. I understand that after electronically signing the Record I consent to having the Record sent electronically to the Company for review and processing. The definition of Record includes, without limitation, insurance policy or contract applications, notices, disclosures, and authorizations.

I understand that by clicking on the "I Accept; Proceed to Sign" button, I agree that all data related to the Record will be electronically captured to create an electronic application. The electronic application will be accessed only through the Company's secure website or via a Company licensed secured desktop software version residing on the licensed insurance producer's computer. If accessed via the Company's secure website, all data, programs and security are behind a firewall in the Company's computer System. If accessed via the Company licensed secured desktop software version residing on the licensed insurance producer's computer, said software is password protected and all data is encrypted. The electronic signature is encrypted and illegible without the password-protected application. The Company's software is specifically designed to prevent tampering or alteration of the data or copying or reuse of any part of the signature files. If the Company's software detects any changes to the data, it automatically deletes the signatures from the documents. The Company will prepare a paper application from the electronic data and the paper application, along with the e-signatures printed in the designated signature blocks, will be inserted into the policy or contract.

After your policy has been issued, the electronic signatures will be purged from the application file and stored in a protected database in our back office server. The proprietary image format in the protected database does not allow the signatures to be used again.



Aviva Life and
Annuity Company
800/800-9882
P.O. Box 1555
Des Moines, IA 50306-1555

Authorization for Release of Personal Health Information

Any alteration of this form will not be accepted.

This authorization complies with the HIPAA Privacy Rule

Name of Proposed Insured _____ Birth Date _____ / _____ / _____
month day year

I authorize any physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, health care provider, health plan, insurer, and/or any other entity subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that has provided treatment, service, payment, or coverage to me within the past 10 years to disclose my entire medical record and any other protected health information concerning me to the Company, its agents, employees, representatives, insurance support organizations, and reinsurers ("the Company"). Protected health information includes but is not limited to: hospital records, treatment records/office notes, consultation reports, workers' compensation information, diagnosis, prescriptions, and test results. It also includes information concerning the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases, and information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, health care provider, health plan, insurer, and/or other entity subject to HIPAA to release and disclose such information without restriction.

I understand that, unless prohibited by state and/or federal law, the protected health information is to be disclosed under this authorization so that the Company may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have, have applied for, or may in the future apply for with the Company. I understand any information disclosed under this authorization may no longer be covered by federal rules governing privacy and confidentiality of health information and may be subject to redisclosure.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization at any time. The request for revocation must be in writing and sent to the attention of the Underwriting Department of the Company at the address listed above. I understand that a revocation is not effective to the extent that the Company has already relied on this authorization or to the extent that the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. Such revocation shall not apply to any use or disclosure of my protected health information specifically allowed without authorization by HIPAA and no action relating to this authorization shall be construed as creating any restriction on the uses that HIPAA allows without my authorization.

I understand that if I refuse to sign this authorization, the Company may not be able to process my application for life insurance. I acknowledge that I have received a copy of this authorization.

Signature of Proposed Insured or Personal Representative

Date

If you are the Personal Representative of the Proposed Insured, describe the scope and/or basis of your authority to act on the Insured's behalf: _____





Aviva Life and Annuity Company
P.O. Box 1555
Des Moines, IA 50306-1555

NOTICE AND CONSENT FOR HIV-RELATED TESTING

To evaluate your insurability, the company named above (the Company) may request that you provide a specimen for testing and analysis to determine the presence of human immunodeficiency virus (HIV) antibodies. By signing and dating this form you agree that this test may be done and that underwriting decisions will be based on the test result. A series of three tests will be performed by a licensed laboratory through a medically accepted procedure.

If an HIV Antibody Screen is performed, it will be performed only by a certified laboratory and according to the following medical protocol:

1. An initial ELISA test will be done.
 - a) If the initial ELISA test is reactive or indeterminant, it will be repeated.
 - b) If the initial ELISA test is nonreactive, a negative finding will be reported to the Company.
2. If the second ELISA test is also reactive or indeterminant, a Western Blot test will be performed to confirm the results of the two ELISA tests.
 - a) If the second ELISA test is nonreactive, a third ELISA test will be performed. If the third ELISA test is reactive or indeterminant, a Western Blot test will be performed to confirm the previous results. If the third ELISA test is nonreactive, a negative result will be reported to the Company.
3. Only if at least two ELISA tests and a Western Blot test are all reactive or indeterminant will the result be reported as such. All other results will be reported as negative to the Company.

Meaning of Positive Test Result

The test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus. A positive test result does not mean that you have AIDS but that you are at significantly increased risk of developing problems with your immune system. The test for HIV antibodies is very sensitive. Errors are rare, but they do occur. Your private physician, a public health clinic, or an AIDS information organization in your city might provide you with further information on the medical implications of a positive test.

Positive HIV antibody test results will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged or that other policy changes may be necessary.

Confidentiality of Test Results

All test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed as required by law or to employees of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer or to other persons or organizations performing business or legal services for the Insurer. The results may

be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover results of tests for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular person.

Notification of Test Result

If your test results are negative, no routine notification will be sent to you. If your test results are reported as being reactive or indeterminant, you are entitled to that information if you so desire. Because a trained person should deliver that information so that you can understand clearly what the test result means, please list your private physician below so that the Company can have him or her tell you the test result and explain its meaning. In the event the test is other than nonreactive and you are denied coverage because of that fact and you request the reason for the denial, the insurer may require you to name a physician at that time in order to receive the information.

Consent

I have read and I understand this Notice and Consent for HIV-Related Testing. I voluntarily consent to provide a specimen, the testing of that specimen, and the disclosure of the test results as described above. I have read the information on this form about what a test result means and understand that I should contact a local AIDS service group or my private physician for further information and counseling if the test result is positive.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original. This consent shall be valid for 90 days from the date below.

Name and address of physician for reporting a possible positive test result:

Signature of Proposed Insured or Parent/Guardian

Date Signed: _____

HIV INFORMATION

What Is AIDS?

Acquired immune deficiency syndrome (AIDS) is a serious condition that affects the body's ability to fight infection. A diagnosis of AIDS is made when a person develops a life-threatening illness not usually found in a person with a normal ability to fight infection. The two diseases most often found in AIDS patients are a lung infection called *Pneumocystis carinii* pneumonia and a rare form of cancer called Kaposi's sarcoma. It is these diseases, not the AIDS virus itself, that can lead to death.

What Causes AIDS?

Researchers have discovered the cause of AIDS—a virus that is called either HTLV-III or LAV. This virus changes the structure of the cell it attacks. Infection with the virus can lead to AIDS or to a less severe condition known as AIDS-related complex (ARC). Some of those persons infected with the virus will develop symptoms of AIDS or ARC. Other people who carry the virus may remain in apparent good health. These carriers can transmit the virus during sexual contact, or an infected mother can transmit the virus to her infant before, during, or after birth (probably through breast milk).

What Are the Symptoms?

Most individuals infected with the AIDS virus have no symptoms and feel well. Some develop symptoms that may include:

- Fever, including "night sweats."
- Weight loss for no apparent reason.
- Swollen lymph glands in the neck, underarm or groin area.
- Fatigue or tiredness.
- Diarrhea.
- White spots or unusual blemishes in the mouth.

These symptoms are also symptoms of many other illnesses. They may be symptoms of AIDS only if they are unexplained by other illness.

How Is the AIDS Virus Spread?

The AIDS virus is spread by sexual contact, needle sharing, or rarely through transfused blood or its components. Multiple sexual partners, either homosexual or heterosexual, and sharing needles by drug users increase the risk of infection with the virus.

Is There a Test for AIDS?

There is an AIDS virus antibody test that detects antibodies to the AIDS virus that causes the disease. The body produces antibodies that try to get rid of bacteria, viruses, or anything else that is not supposed to be in the bloodstream. The test tells if someone has been infected with the AIDS virus. Most people with AIDS have a positive test and some people with a positive test will develop AIDS. The test does not tell who will develop AIDS.

What Does a Positive Test Mean?

It means that a person has been infected with the AIDS virus. Some of these people will develop AIDS. Others who have the virus may stay well, without any symptoms, but can transmit the virus to others.

Where Can I Get Tested?

The test is available at a variety of test sites. It is also available through private doctors and clinics. Information about where to get the test is available from state or local health departments, sexually transmitted disease clinics, doctors' offices, local American Red Cross chapters, and community blood services. Anyone planning to take the test should get advice before the test and understand what the results may indicate. It is important to have counseling after the test.

What Should I Do If I have a Positive Test?

- Have a regular medical checkup and get counseling.
- Do not donate blood, sperm, or organs.
- Do not share drugs with others, and avoid exchanging body fluids during sexual activity (a condom should be used). Avoid oral-genital contact and intimate kissing.
- Do not share toothbrushes, razors, or anything that could be contaminated with blood.
- Consider postponing pregnancy.

Further information about AIDS can be obtained from your Red Cross chapter, local or state health department, other community agencies, or the Public Health Service Hotline. The Hotline number is 1-800-342-AIDS. Below are some of the counselling resources available in California:

San Francisco
AIDS Foundation
25 Van Ness Avenue
Suite 660
San Francisco, CA 94102
(415) 864-5855

Sacramento AIDS Foundation
1900 K Street
Suite 201
Sacramento, CA 95814
(916) 448-2437

Central Valley
AIDS Team
P.O. Box 4640
Fresno, CA 93744
(209) 264-2436

AIDS Project
Los Angeles
3670 Wilshire Blvd.
Suite 300
Los Angeles, CA 90010
(213) 380-2000

San Diego AIDS Project
3777 Fourth Avenue
San Diego, CA 92103
(619) 543-0300

AIDS Project—East Bay
400 40th Street
Suite 20
Oakland, CA 94609
(415) 420-8181

AIDS Project
595 Millich Drive
Suite 104
Campbell, CA 95008
(408) 370-3272

AIDS Services
Foundation of Orange County
1685-A Babcock Street
Costa Mesa, CA 92627
(714) 646-0411



Aviva Life and Annuity Company
P.O. Box 1555
Des Moines, IA 50306-1555

Policy Illustration Certification

(In this certification, "Company" refers to the insurance company named above.)

This is to certify that either:

1. No illustration was provided to the applicant by the agent or authorized representative of the Company in the solicitation of the application for insurance; or
2. The policy for which the applicant has applied is other than as illustrated and shown to the applicant by the agent or authorized representative of the Company.

The applicant acknowledges that an illustration conforming to the policy as issued will be provided no later than at the time of policy delivery if,

1. no illustration was provided at the time of application, or
2. the illustration provided did not conform to the application submitted, or
3. the issued policy is other than as applied for.

Agent's Signature

Applicant's Signature

Date Signed



Aviva Life and Annuity Company
P.O. Box 1555
Des Moines, IA 50306-1555

Computer Screen Illustration Certification

I certify that I displayed a computer screen illustration for _____ that complies with state requirements and for which no hard copy was furnished. The illustration was based on the following personal and policy information:

- 1. Gender Male Female
- 2. Age _____
- 3. Underwriting or Rating Class Nonsmoker Smoker Preferred Other _____
- 4. Type of Policy Universal Life Whole Life Term Life
- 5. Name of Plan _____
- 6a. Planned Premium Amount _____
- 6b. Planned Mode Annual Semiannual Quarterly Monthly ACP
- 7a. Initial Death Benefit _____
- 7b. Death Benefit Option Level Increasing

Agent Date

I acknowledge that I viewed a computer screen illustration based on the information as stated above. No hard copy of the illustration was furnished. I understand that I will receive an illustration conforming to the policy as issued no later than at the time the policy is delivered.

Applicant Date





Aviva Life and
Annuity Company
800/800-9882
P.O. Box 1555
Des Moines, IA 50306-1555

*No Lapse Guarantee
Rider Disclosure For
Equity Indexed
Universal Life Policies*

This policy is guaranteed to stay in force as long as you have paid the required minimum premiums. This guarantee could be provided by a separate policy (such as a term policy). However, the **nonforfeiture benefits (such as a cash surrender value) in this policy may be significantly less** valuable than those provided by the separate policy. So, if you fail to pay a premium within a specified period of time from its due date or otherwise cause this policy to terminate early, the benefits paid to you upon termination could be much less than would customarily be paid if provided by the separate policy.

If you choose the No-Lapse Guarantee Rider benefit, it is guaranteed to stay in force as long as on any monthly due after the shortest Minimum Premium Period, the No Lapse Guarantee Value minus any outstanding policy loan is greater than zero even if the net cash value of the policy is insufficient to cover the monthly deduction.

When considering the purchase of this rider, you should consider the value to you of higher nonforfeiture benefits versus the level of premiums required to keep the rider coverage in force.

TO BE PRESENTED TO THE POLICYOWNER AT THE TIME OF APPLICATION



Aviva Life and
Annuity Company
800/800-9882
P.O. Box 1555
Des Moines, IA 50306-1555

*No Lapse Guarantee
Rider Disclosure For
Universal Life Policies*

This policy is guaranteed to stay in force as long as you have paid the required minimum premiums. This guarantee could be provided by a separate policy (such as a term policy). However, the **nonforfeiture benefits (such as a cash surrender value) in this policy may be significantly less** valuable than those provided by the separate policy. So, if you fail to pay a premium within a specified period of time from its due date or otherwise cause this policy to terminate early, the benefits paid to you upon termination could be much less than would customarily be paid if provided by the separate policy.

If you choose the No-Lapse Guarantee Rider benefit, it is guaranteed to stay in force as long as on any monthly anniversary after the Basic No-Lapse Guarantee Period, the value of the NLG Account Value minus any outstanding loan is greater than zero, then the policy will not enter the grace period even if the Surrender Value is insufficient to cover the monthly deduction.

When considering the purchase of this rider, you should consider the value to you of higher nonforfeiture benefits versus the level of premiums required to keep the rider coverage in force.

TO BE PRESENTED TO THE POLICYOWNER AT THE TIME OF APPLICATION

