



EXPRESS ISSUE COVER SHEET
 (Please submit completed sheet with every application)

Agent Contact Information

Agent ID _____ Agent Name (Print) _____

Agent Email _____ Agent Phone _____ Agent Fax _____

Point of Sale (POS) Interview - (1-866-397-9468) - (A policy cannot be placed without a POS Interview)

Was a Point of Sale (POS) Interview completed? Yes No Date _____ Time _____

Were you present for the POSI? Yes No POSI Case # _____

If Unable to Contact the Interview Operation Center:
 Did you leave on the POS message machine at 1-866-722-0058:

	YES	NO		YES	#
Insured Name	<input type="checkbox"/>	<input type="checkbox"/>	OR	Did you ask the insured to contact	<input type="checkbox"/>
Insured Phone NO.	<input type="checkbox"/>	<input type="checkbox"/>		the interviewer at 1-866-397-9468	_____
Best time to Call	<input type="checkbox"/>	<input type="checkbox"/>		and leave your agent ID with the insured?	
Agent ID	<input type="checkbox"/>	<input type="checkbox"/>			

Initial Premium

Insured Name (Print exactly as on application) _____

Last four digits of Insured's SS# _____

Method of Initial Premium Payment Draft (Monthly EFT only) Check (Must be used for qtrly, semi-annual & annual)

If no method is selected and subsequent payments are Monthly EFT, "Draft" will be the default.

Will the check for initial premium be the account for monthly EFT? Yes No

Did you attach a void check copy (deposit slip for savings accounts) to the application? Yes No

- Want to avoid delays?**
- All alterations must be initialed by the insured
 - Make sure the application is dated, signed and witnessed
 - If Question 2 in Part A1 is "Yes", submit replacement form
 - If insured qualifies for ADBR, submit signed ADBR Acknowledgement
 - Complete all questions in the Agent's Report

Submitting Application to Monumental (Faxing is the preferred method)

If faxing, fax to 1-866-721-3097, and enter date faxed _____ **Do Not** mail originals

If mailing the application and/or check for initial premium please send with cover sheet to:

Monumental Life
Mail Stop 22
2 East Chase Street
Baltimore, MD 21202



Monumental Life Insurance Company
 Home Office: Cedar Rapids, Iowa
 Administrative Office: 2 East Chase Street/Baltimore, MD 21202

Agent ID #	State Application Taken	Policy # (H.O. Use Only)
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Part A1 - Proposed Insured						
Name (First, MI, Last)			Address, City, State, Zip Code			
SSN	Gender	D.O.B. (MM/DD/YYYY)	Age	U.S. State or Country of Birth	Phone Number ()	
1 Within the last 12 months has the Proposed Insured used tobacco products in any form? <input type="checkbox"/> Yes <input type="checkbox"/> No 2 Will any existing life (including paid-up additions), health or annuity contracts be lapsed, surrendered, or borrowed against, reissued or converted (in order to reduce amount, premium, or period of coverage including surrender options) if the proposed policy is issued? <input type="checkbox"/> Yes <input type="checkbox"/> No						

Part A2 - Owner (If Other Than Proposed Insured)					
Name (First, MI, Last)		SSN	Gender	Relationship to Insured	D.O.B. (MM/DD/YYYY)
Address, City, State, Zip Code (If different from Insured)				Are you a citizen of the U.S.? <input type="checkbox"/> Yes <input type="checkbox"/> No If not, what country?	

Part A3 - Beneficiary					
Additional Beneficiary Supplement Attached (Form # PDM-025)					
Primary Name (First, MI, Last)		SSN	Gender	Relationship to Insured	D.O.B. (MM/DD/YYYY)
Contingent Name (First, MI, Last)		SSN	Gender	Relationship to Insured	D.O.B. (MM/DD/YYYY)

Part B1 - If Any Question In This Section Is Answered "Yes", The Proposed Insured Is Not Eligible For Any Coverage.		
1	Is the Proposed Insured hospitalized, bedridden, residing in a nursing home or long term care facility, receiving hospice or home health care, confined to a wheelchair, been advised or planning to have inpatient surgery or currently waiting for an organ transplant?	Yes <input type="checkbox"/> No <input type="checkbox"/>
2	Has the Proposed Insured ever:	
	a) Been diagnosed with, been treated for or advised to receive treatment for Alzheimer's disease, senile dementia, organic brain disease, mental incapacity, Lou Gehrig's disease (ALS), Downs Syndrome, Huntington's disease, sickle cell anemia, Spina Bifida not surgically corrected, cystic fibrosis, cerebral palsy or any terminal medical condition?	<input type="checkbox"/> <input type="checkbox"/>
	b) Tested positive for the antibodies to the AIDS (HIV) virus or been medically diagnosed with or received treatment for HIV, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?.....	<input type="checkbox"/> <input type="checkbox"/>
	c) Been in a diabetic coma or had or been advised to have an amputation due to disease or disorder?	<input type="checkbox"/> <input type="checkbox"/>
3	Within the past 2 years has the Proposed Insured:	
	a) Been diagnosed with, been treated for or advised to receive treatment for cancer (other than basal cell carcinoma)?	<input type="checkbox"/> <input type="checkbox"/>
	b) Undergone testing by a medical professional for which the results have not been received?.....	<input type="checkbox"/> <input type="checkbox"/>

Part B2		
4	Has the Proposed Insured been diagnosed with, been treated for or advised to receive treatment for diabetes (other than gestational diabetes) before the age of 18?	Yes <input type="checkbox"/> No <input type="checkbox"/>
5	Within the past 4 years has the Proposed Insured been diagnosed with, been treated for or advised to receive treatment for cancer (other than basal cell carcinoma)?	<input type="checkbox"/> <input type="checkbox"/>
6	Within the past 1 year has the Proposed Insured:	
	a) Used illegal drugs or been diagnosed with, been treated for or advised to receive treatment for alcohol abuse, drug abuse or muscular dystrophy?	<input type="checkbox"/> <input type="checkbox"/>
	b) Had more than 12 seizures or been diagnosed with, been treated for or advised to receive treatment for congestive heart failure, cirrhosis, hepatitis B or C or other liver disease?.....	<input type="checkbox"/> <input type="checkbox"/>
	c) Been diagnosed with, been treated for or advised to receive treatment for heart attack, stroke (CVA), transient ischemic attack (TIA), aneurysm, angina, or had or been advised to have heart surgery of any kind including bypass surgery or pacemaker implant?.....	<input type="checkbox"/> <input type="checkbox"/>
	d) Used oxygen to assist in breathing due to a disease or disorder, received kidney dialysis or been diagnosed with, been treated for or advised to receive treatment for kidney failure due to a disease or disorder?.....	<input type="checkbox"/> <input type="checkbox"/>

- If All Questions In This Part Are Answered "No", Proceed to Part B3.
- If One Question In This Part Is Answered "Yes", The Proposed Insured Is Eligible For The Graded Death Benefit Product. Proceed to Part C1.
- If Two Or More Questions In This Part Are Answered "Yes", The Proposed Insured Is Not Eligible For Any Coverage.

Last Name and Last 4 Digits of SSN: _____

Agent's Report

I hereby certify that I personally solicited and recorded the applicant's answers contained in this application, that I have no knowledge of anything which might affect the insurability of any person proposed for insurance which is not fully set forth herein.

Is the person proposed for insurance related to you? Yes No Relationship _____

Is the policy applied for in this application intended to replace any insurance or annuity now in force? Yes No

Agent Signature _____

AGREEMENT / AUTHORIZATION

This application consists of all Parts A, B, and C, and is not a contract of insurance. A contract of insurance shall take effect only if a policy is issued on this application and the first premium is paid in full (a) during the lifetime of the Proposed Insured and (b) while there is no change in the insurability and health of the Proposed Insured from that stated in this application. It is represented that all statements and answers in this application are true, full and complete and bind all parties in interest under any policy applied for. Only an authorized officer of our Company can make void, waive or change any of the conditions or provisions of any application, policy or receipt or accept risks or pass on insurability. Acceptance of any policy issued on this application shall mean acceptance of any change, correction, addition or amendment noted by any amendments and corrections. Any change shall require the written consent of the person or persons who sign(s) this application. The Proposed Insured shall be the policyowner unless another owner is named above. **Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.**

I have received the M.I.B. Disclosure Notification, Notice to Persons Applying For Insurance, Accelerated Death Benefit Disclosure and Conditional Receipt. I hereby authorize any licensed physician, medical practitioner, or the Medical Information Bureau or other institution that has any records or knowledge of the Proposed Insured's medical history to give any such information to the life insurance company. A photocopy or facsimile of this authorization shall be made as valid as the original.

Signed at City _____ State _____

Proposed Insured Signature _____

Date _____

Owner Signature _____
(If Owner other than Insured)

Witness _____
(Agent Signature)

(Print Agent's Name and I.D. Number)

If The EFT Premium Payment Method Is Chosen, Please Tape A Voided Check In This Box.

NOTICE TO PERSONS APPLYING FOR INSURANCE

As part of the Company's procedure for processing your insurance application, an investigative consumer report may be prepared whereby information is obtained through physicians, hospitals, clinics, and other medically-related facilities, who may be contacted using your signed authorization, to obtain details of your past medical treatment.

You have the right to be interviewed as part of any investigative consumer report that may be prepared. If you desire to be interviewed, you must indicate this to the Company. You also have the right to request access to, and correction and amendment of, any personal information collected. Additionally, you are entitled to receive a description of procedures which allow access to and correction of personal information which may be obtained, the nature and scope of the investigation requested, and a description of the circumstances under which personal information may be disclosed without prior authorization. Your written request should be addressed to the Company.

MONUMENTAL LIFE INSURANCE COMPANY

Administrative Office: Two East Chase Street, Baltimore, Maryland 21202

M.I.B. DISCLOSURE NOTIFICATION

Information regarding your insurability will be treated as confidential. Monumental Life Insurance Company or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its Members. If you apply to another Bureau Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is: Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (866) 692-6901 or (TTY) (866) 346-3642.

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

CONDITIONAL RECEIPT

No coverage will be effective prior to delivery of the policy applied for unless and until all the following conditions are met:

Conditions of Coverage

1. On the Effective Date indicated below, the state of health and all factors affecting insurability of each person proposed for coverage must be stated in the application required by the Company; and,
2. An amount equal to the first full premium required is paid on the plan and any check, money order, or Authorization for Electronic Funds Transfer (EFT) given in payment is honored when first presented.

Effective Date

If both the conditions above are met, insurance in the amount applied for or \$25,000, whichever is lower, will become effective on the date the application AND the telephone interview recording the responses to the medical questions in the application are completed. If the above conditions are not met, or the application contains a material misrepresentation, or if the Proposed Insured dies by suicide, this receipt provides no coverage, and the liability of the Company is the return of the amount remitted with this receipt. Coverage which takes effect through this receipt will terminate at the EARLIEST of the following: (a) the effective date of the policy; (b) thirty (30) days after the date of the application; (c) three (3) days after the date the Company sends written notice that the receipt is terminated.

A05402

ACCELERATED DEATH BENEFIT RIDER DISCLOSURE

Receipt of the Accelerated Death Benefit may adversely affect the recipient's eligibility for Medicaid or other government benefits or entitlements. In addition, receipt of the Accelerated Death Benefit may be taxable and assistance should be sought from a personal tax advisor.

Description of Benefit: Upon receipt of proof acceptable to us of the Insured's Qualifying Event, the Owner may choose to receive the Accelerated Death Benefit while the Insured is alive and the Rider is In Force.

Qualifying Event: An event defined in the Rider, which allows for payment of the Accelerated Death Benefit.

Accelerated Death Benefit Amount: The Accelerated Death Benefit shall be equal to:

1. the Policy Death Benefit that would be In Force at the end of the 12 month period following the Acceleration Date, before deduction of any outstanding Loan Balance; less
2. a discount on the Accelerated Death Benefit calculated for the 12 month period using the current interest rate; less
3. any outstanding policy loans, including accrued interest until the end of the 12 months following the Acceleration Date less;
4. any premiums which would be required to keep the Policy In Force for the 12 month period following the Acceleration Date for the Policy Amount of Insurance reduced by an appropriate discount using the current interest rate.

Termination of Coverage: The Accelerated Death Benefit Rider will automatically terminate when the Policy to which it is attached terminates or lapses or matures or is continued under one of the nonforfeiture options; or when the Accelerated Death Benefit is paid; whichever occurs first.

Impact on the Policy's Death Benefit: The Policy to which the Rider is attached will terminate on the date the Accelerated Death Benefit is paid.

MONUMENTAL LIFE INSURANCE COMPANY

Home Office: Cedar Rapids, Iowa

Administrative Office: Two East Chase Street, Baltimore, Maryland 21202

ACCELERATED DEATH BENEFIT RIDER DISCLOSURE

Acknowledgement:

I acknowledge that I have read this disclosure and understand that if I exercise the Accelerated Death Benefit Rider Option, any beneficiary designated on the attached Policy will not receive the Death Benefit.

Date

Proposed Insured Signature

Owner's Signature (If Owner other than Insured)

Agent's Signature

SAMPLE

AGENT INSTRUCTIONS -- Complete all parts of the application before calling to complete the interview

- Call 1-866-397-9468 while you are still with the Proposed Insured
 - Interviewers are available Monday through Friday 8:00 a.m. – 11:00 p.m. CST and Saturday 9:00 a.m. – 3:00 p.m. CST.
- You will need to provide the Interviewer with:
 - The state where the application was completed
 - Your name
 - Your Monumental Life Agent ID #
 - The face amount of coverage
 - The method/mode of payment (EFT or billed quarterly, semi-annual or annual)
 - Which medical questions in Parts B1 through B4 on the application were answered "yes"
 - The # of the last medical question answered by the Proposed Insured (excluding the Nursing Home Option question).
- The Interviewer will verify with you that the correct application form was used for the state in which it was completed. The form number is on the bottom left corner of the application
- The Interviewer will then need to speak to the Proposed Insured. The Interviewer will ask the Proposed Insured:
 - Their name, date of birth, gender, social security number and phone number
 - The same medical questions that are on the application.
- If the Proposed Insured is under 18, the Interviewer will need to speak to the child's parent, grandparent or legal guardian with whom the child resides. Legal Guardian will need to submit a copy of the Guardianship papers to Monumental with the application.
- If the Proposed Insured is an adult and is unable to complete the interview, the Interviewer must speak with a legal guardian. Legal Guardian will need to submit a copy of the Guardianship papers to Monumental with the application.
- If there are any discrepancies between the 'yes' answers on the application and the 'yes' answers on the interview, the Interviewer will re-ask the Proposed Insured those questions for clarification.
 - If the discrepancies are resolved and an answer on the application needs to be corrected, the Interviewer will let you know so you may have the Proposed Insured initial the correction.
 - If the discrepancies cannot be resolved between the Interviewer and the Proposed Insured, submit the application with the discrepancies. The application will be reviewed by an underwriter.
- The Interviewer will then need to speak to you again to confirm the Plan, Rate Class and Premium. Verify this is the same Plan, Rate Class and Premium recorded on the application.
 - The Interviewer has limited knowledge regarding the Plan, Rate Class and Premium and can only provide you this information based on the information you provided at the beginning of the interview and on the answers the Proposed Insured provided to the medical questions. If you have questions regarding the Plan, Rate Class or Premium, please discuss them with your administrative office.

If the interview cannot be completed at the time of the application, you have 2 options for completing the interview:

- Provide the Customer with your Monumental Life Agent ID # and with the dedicated Monumental Life toll-free # so the Customer may call to complete the interview at their convenience.

OR

- Call the Interviewer and leave a voicemail so the Interviewer may call the Customer to complete the interview. On the voicemail, you must provide your Monumental Life Agent ID #, the customer's name and phone number, and the best time to call back.

Point of Sale Interview must be completed on all sales. Policy cannot be approved or commissions paid until all requirements have been completed.

This is for agent use only and not intended for customer use or as advertising.