

**LIFE INSURANCE APPLICATION**

100 Quentin Roosevelt Boulevard, Garden City, NY 11530
Internet address: www.wpenn.com

INSTRUCTIONS

As the Agent, you are responsible for completing the necessary forms required to process and underwrite this application. All forms must be completed in full and must be legible. Please follow these instructions carefully.

DO

- Print application in black ink.
- Verify identification of Proposed Insured.
- Obtain all of the necessary signatures.
- Give the Notice to Proposed Insured to your client.
- Have the Proposed Insured/Owner initial all changes. The Proposed Insured must initial all changes to questions involving insurability. Change an answer by putting a line through the incorrect answer and inserting the correct information.
- Complete Part 2, Medical History, if the Proposed Insured is to be considered without paramedical exam, if an exam on another company's form is being used or if an abbreviated exam will be done.
- Complete section K, Part 1 on all business cases and if required on non-business cases.
- Complete and obtain signature on Consent for HIV Testing Form for each Proposed Insured.
- If you accept payment with the application:
 - Complete the Temporary Insurance Application section of the Temporary Insurance Application and Agreement (TIAA), making sure that all questions are answered. If any are answered Yes, do not accept money.
 - Remit an amount equal to the first modal premium.
 - Explain the terms and conditions of the TIAA to the Owner and Proposed Insured and have them sign it.
 - Complete and sign the Licensed Insurance Agent's Statement on the TIAA.
 - Send the TIAA with the application, give the Owner a copy.
 - All checks collected must be made payable to William Penn Life Insurance Company of New York.
- If applicable, complete and obtain signature(s) on the Payment Options form.
- Complete and sign the Agent's Report on page 11. Please be sure to enter all agent information and your William Penn agent number.

DO NOT

- Do not accept money on applications now applied for or pending with William Penn Life Insurance Company of New York totaling over \$1,000,000.
- Do not accept any payment if any question on the Temporary Insurance Application and Agreement is answered Yes or left blank.
- Do not accept cash or cash equivalents (money order, cashiers check) or "starter" checks.
- Do not accept money if the Proposed Insured is over age nearest 70.
- Do not use pencil or correction fluid.



NOTICE TO PROPOSED INSURED

(Please give to the Proposed Insured)

Thank you for applying to William Penn Life Insurance Company of New York. The soliciting insurance broker (broker) should be able to answer any questions you may have. This broker is an independent broker, not an employee of William Penn Life Insurance Company of New York, and is not authorized to make or modify contracts or to waive any requirements or any information that we may request.

Underwriting

Once we receive your application, we will begin an evaluation process called underwriting to determine whether you are eligible for insurance and, if so, the rate you should pay for that insurance. We may find that we are unable to give you the insurance you have applied for or that we are able to give it to you only on a modified basis or at a rate greater than our lowest rate.

Your application will be our primary source of information; therefore, it must be true, complete and accurate. You must inform us of a change to any answer in any part of your application before accepting delivery of a policy; in fact, you agree to do so when you sign your application. We may seek information from other sources to help us evaluate the information you give us on your application.

Contestability

We strongly urge you to review the completed application closely for accuracy. A claim may be denied, the policy may be void or your coverage may be lost if the application is incomplete or if it contains false statements or material misrepresentations. Any policy that may be issued will indicate when and under what circumstances it may be contested. You must inform us of a change to any answer in any part of your application before accepting delivery of a policy; in fact, you agree to do so when you sign your application.

Replacement of Existing Coverage

If you intend to replace existing coverage, tell the broker of your intention and answer "Yes" to the replacement question in the application. State law may require the broker to give you information that will help you compare the policy you are applying for with the policy you intend to replace. If you are undecided about keeping existing coverage, indicating an intention to replace existing coverage may help you get the information you need to make a decision. If you do replace existing coverage, the new policy may contain new suicide and contestable periods. The following would be considered replacement: you stop paying premiums on an existing policy or surrender an existing policy before or shortly after applying to us or you borrow from an existing policy to pay premiums for the insurance for which you are applying. State law may define replacement to include other situations. Ask the broker if you are unsure.

Insurance Information Practices

We will rely primarily on information provided by you. We may supplement that information with information from other sources such as medical professionals who have treated you. In some cases, we may ask a consumer reporting agency to collect information and submit an investigative consumer report to us as explained in this Notice under Federal Fair Credit Reporting Notice. You may request to be interviewed in connection with the preparation of this report.

In certain limited situations, we are allowed by law to disclose necessary items of personal information to third parties without your specific authorization.

You have the right to be told about and receive copies of, if you wish, items of personal information about you that appear in our files, including information contained in investigative consumer reports. You also have the right to seek correction of information you believe to be inaccurate.

We will send you a more detailed explanation of our information practices if you send us a written request. You may send your request to the Director of Underwriting, William Penn Life Insurance Company of New York, 100 Quentin Roosevelt Boulevard, PO Box 519, Garden City, NY 11530.

Federal Fair Credit Reporting Notice

As part of our underwriting, we may ask that an investigative consumer report be prepared. An independent source known as a consumer reporting agency will prepare the report. The report will typically include information as to your character, general reputation, mode of living, and personal characteristics. The agency may conduct personal interviews with your family, friends, neighbors, business associates, financial sources or others with whom you are acquainted in order to get this information. If you write to us, we will tell you whether or not a report was requested. If a report was requested, we will tell you the name, address and telephone number of the agency to whom the request was made. Upon request, the agency will furnish information as to the nature and scope of its investigation. If you would like to inspect and to receive a copy of the report, you may do so by contacting the agency directly.

Continued on next page

NOTICE TO PROPOSED INSURED
(Please give to the Proposed Insured)

MIB (Medical Information Bureau) Pre-Notice Disclosure

Information regarding your insurability will be treated as confidential. William Penn Life Insurance Company of New York or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of 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 each company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734.

William Penn Life Insurance Company of New York, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

Continued from prior page

**William Penn**

Life Insurance Company of New York

...A Partnership for Life

PART 1
(Please Print)

Policy # _____

SECTION A PROPOSED INSURED

1. Full Name (Include maiden name in parentheses) _____		2. Sex <input type="checkbox"/> M <input type="checkbox"/> F	3. Date of Birth Month _____ Day _____ Year _____	4. Social Security Number _____
5. a. Home Address Street _____ City, State _____ Zip _____				5. b. How Long _____
6. Phone Numbers Home _____ Work _____		7. State/Country of Birth _____	8. U.S. Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No Visa Type _____ If No, Date of Entry into U.S. _____ Country of Citizenship _____	
9. Marital Status <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> W <input type="checkbox"/> D		10. Driver's License Number and State of Issue or State ID Number _____		
11. Occupation (Include duties) _____			12. Annual Income _____	13. Total Net Worth _____
14. a. Employer's Name and Address and Nature of Business _____				14. b. How Long Employed _____
15. Have you ever used tobacco or nicotine products in any form? <input type="checkbox"/> Yes - give details below <input type="checkbox"/> No				
Product	Date last used (month/year)	Amount / Frequency		
Cigarettes	_____	_____		
Cigars	_____	_____		
Other	_____	_____		

SECTION B BENEFICIARY (Share percentage totals must equal 100%. If necessary, use Remarks section, Question 48. If Beneficiary is a trust, check box and complete Section D.)

16. Primary				
Name	_____	Relationship	_____	% Share _____
SSN	_____	Date of Birth	_____	
Name	_____	Relationship	_____	% Share _____
SSN	_____	Date of Birth	_____	
17. Contingent				
Name	_____	Relationship	_____	% Share _____
SSN	_____	Date of Birth	_____	
Name	_____	Relationship	_____	% Share _____
SSN	_____	Date of Birth	_____	

SECTION C OWNER

18. Owner is Proposed Insured Trust (also complete Section D) Other than Proposed Insured or Trust

Complete if the Proposed Insured is not the Owner. (If contingent Owner is required, use Remarks section, Question 48).

Name _____ SSN or Tax ID # _____ Date of Birth _____

Address _____ City, State _____ Zip _____

Contact Phone # _____ Relationship to Proposed Insured _____

If Owner is a business, web site address _____ Email address _____

SECTION D TRUST INFORMATION (If trust is Beneficiary and/or Owner).

19. Exact Name of Trust _____ Trust Tax ID# _____

Current Trustee(s) _____ Date of Trust _____

PART 1 (continued)

SECTION E PAYOR

20. Send premium notices to: Insured Owner Other - If Other, complete the information below
 Name _____ Relationship to Insured/Owners _____
 Address _____
Street City State Zip
 Contact Phone # _____ Email address _____

SECTION F INSURANCE APPLIED FOR

21. Amount of Insurance \$ _____ 22. Plan of Insurance _____
 23. Death Benefit Option (if available with Plan): Level Death Benefit Increasing Death Benefit
 24. Payment method: Direct Bill Electronic Funds Transfer (EFT)
 25. Frequency of premium payment: Single Annual Semi-annual Quarterly Monthly (EFT only)
 26. Planned periodic premium for universal life product: (Provide details in Remarks section, Question 48.)
 a. 1st Year Only \$ _____ 2nd Year and Thereafter \$ _____ b. Premium For All Years \$ _____
 27. Will the premiums for this policy be loaned or otherwise financed by an individual(s) or entity other than the Proposed Insured or immediate family members of the Proposed Insured? Yes No
 If Yes, please identify all parties involved and provide copies of all financing agreements or promissory notes and all related side agreements and schedules. (Provide details in Remarks section, Question 48.)
 28. a. Date to Save Age? Yes No b. Specific Policy Date? Yes No Date _____

Additional Benefits (if available)

29. Waiver of Premium Other (description and amount) _____

SECTION G OTHER INSURANCE

30. a. **Excluding** this application, amount of insurance **currently pending** with other companies. If NONE state NONE. \$ _____
 b. Of the above pending amount in 30.a., how much do you intend to accept? \$ _____
 c. Provide information for each policy in force (except group insurance). (If necessary, use Remarks section, Question 48.)
 If NONE state NONE.

Company	Policy Number	Face Amount	Business?		Issue Date	Replacing?		Beneficiary
			Yes	No		Yes	No	
			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	

31. Have you ever had an application for life or health insurance declined, postponed, modified, rated or offered with a reduced face amount? (If Yes, provide details in Remarks section, Question 48.) Yes No

 32. Will you, or are you likely to, replace, end, or change existing insurance or annuity with any company or society with the insurance for which you are applying? (If Yes, the broker may be required to provide additional forms for your review and signature.)
 33. Are there any plans to sell or permanently assign the policy to another person or entity, life settlement provider or an investor, or will it replace a policy that has already been sold to another life settlement company or investor? (If Yes, provide details in Remarks section, Question 48.)

PART 1 (continued)

SECTION H GENERAL QUESTIONS (Explain all Yes answers in Remarks section, Question 48.)		Yes	No
34. Has any person promised or agreed to give or have they given to any party to the application, any inducement, fee or compensation as an incentive to purchase the policy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35. Has any party to the application ever sold, transferred or assigned any life insurance policy to a third party, such as a viatical settlement entity, life settlement entity, insurance company, other secondary market provider, or premium financing entity?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
36. Has any party to the application ever received inducement, fee or compensation as an incentive to purchase, sell, transfer or assign a policy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
37. In the past 5 years, have you requested or received a Worker's Compensation, Social Security, or disability income payment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
38. Have you ever been convicted of, or are you currently charged with, a felony or misdemeanor, or are you currently on parole or probation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
39. In the past 5 years, has your driver's license been suspended or revoked, or have you been convicted of 2 or more moving violations or accidents?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
40. In the past 5 years, have you been convicted of, or plead guilty or no contest to, driving while impaired, intoxicated, or under the influence of alcohol or drugs? (If Yes, complete Alcohol/Drug Usage Questionnaire.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
41. Are you a member, or do you intend to become a member, of the armed forces, including the reserves?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SECTION I OTHER ACTIVITIES		Yes	No
42. Do you hold a current pilot license, or have you in the past 5 years flown, or within the next 2 years do you intend to fly, other than as a passenger in any type of aircraft? (If Yes, complete Aviation Questionnaire.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
43. Have you in the past 2 years engaged in, or within the next 2 years do you intend to engage in, certain activities such as hang gliding, hot-air ballooning, ultra-light flying, heli-skiing, mountain, ice or rock climbing, cliff or base jumping, motor vehicle racing, motorcycle or any other motorized land or water vehicle racing, or scuba or sky diving? (If Yes, complete appropriate questionnaire.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
44. Do you intend to travel outside the U.S. or Canada, or change your country of residence in the next 12 months? (If Yes, list countries, cities, duration and purpose of travel in Remarks section, Question 48.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SECTION J PROPOSED INSURED FINANCIAL INFORMATION			
Complete this section when applying for face amount over \$1,000,000 or when the Proposed Insured is over age 65:			
45. a. What is the purpose of this insurance? (e.g. income replacement, buy-sell, keyperson, estate conservation)			

b. How was the need for the face amount determined?	_____		
c. In the last 5 years, has the Proposed Insured filed for bankruptcy or had any charge off of bad debts?	<input type="checkbox"/>	Yes	No
If Yes, type of bankruptcy and discharge date or charge off date.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

46. a. Gross annual earned income (salary, bonuses, etc. from W-2 forms)	\$	_____	
b. Gross annual unearned income (dividends, interest, rental income, etc.)	\$	_____	
c. Is the Proposed Insured self-supporting?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If No, how much insurance is in-force on the life of the person providing the support?	\$	_____	
What is that person's relationship to the Proposed Insured?	_____		

PART 1 (continued)

SECTION K BUSINESS FINANCIAL INFORMATION

Complete this section when applying for face amount over \$1,000,000 and if Beneficiary or Owner is a business:

	Current YTD	Previous Year
47. a. Assets	\$	\$
b. Liabilities	\$	\$
c. Gross Sales	\$	\$
d. Net Income after Taxes	\$	\$
e. Fair Market Value of the business	\$	\$

f. How long has the business been established? _____

g. What percentage of the business does the Proposed Insured own? _____

h. Are other partners/owners/executives being insured? (If Yes, use Remarks section, Question 48.)

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

i. In the last 5 years, has the business filed for bankruptcy or had any charge off of bad debts?

If Yes, type of bankruptcy and discharge date or charge off date. _____

j. Company web site address, if available _____

48. Remarks: Explanations and/or special requests. Use Part 1 Supplement to Application if necessary.

IN CONNECTION WITH THIS APPLICATION FOR INSURANCE, IT IS UNDERSTOOD AND AGREED THAT:

The statements contained here and in Part 2 of this application and any supplements thereto, copies of which shall be attached to and made a part of any policy to be issued, are true and correct and made to induce William Penn Life Insurance Company of New York (the Company) to issue an insurance policy. I agree to notify the Company of any changes to the statements and answers given in any part of the application before accepting delivery of any policy.

No agent or other person has power to: (a) make or modify contracts; (b) waive any Company rights or requirements; (c) waive any information the Company requests; (d) discharge any contract of insurance; or (e) bind the Company by making promises respecting benefits upon any policy to be issued.

For indeterminate premium policies: (a) the premium for the policy applied for may change after the initial guarantee period and (b) the premium then charged is not guaranteed and the Company may charge the full maximum guaranteed premium.

I agree that: **(1) I will notify the Insurer if any statement or answer given in any part of the application changes prior to policy delivery; and (2) except as provided in the Temporary Insurance Application and Agreement, if any, insurance will not begin unless all persons proposed for insurance are living and insurable as set forth in the application at the time a policy is delivered to the Owner and the first modal premium is paid.**

Changes or corrections made by the Company and noted in Part 1, Question 48 above are ratified by the Owner upon acceptance of a contract containing this application with the noted changes or corrections. In those states where written consent is required by statute or State Insurance Department regulation for amendments as to plan, amount, classification, age at issue or benefits, such changes will be made only with the Owner's written consent.

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I hereby authorize any physician, medical professional, hospital, clinic or medical care facility; pharmacy benefit manager, prescription database; any insurance or reinsurance company; any consumer reporting agency or insurance support organization; my employer; or the Medical Information Bureau (MIB), to provide the Company and its legal representatives or affiliated insurers, all information they have pertaining to: medical consultations; treatments; hospitalizations for physical and/or mental conditions, use of drugs or alcohol; drug prescriptions; or any other information pertaining to me. This information does not apply to records protected under 42 USC 290dd-2. Other information could include items such as: other insurance information; personal finances; habits; hazardous avocations; motor vehicle records; court records or foreign travel, etc.

I understand that the information obtained will be used by the Company to determine my eligibility for insurance. I authorize that any information gathered during the evaluation of my application may be disclosed to: reinsurers; the MIB; other persons or organizations performing business or legal services in connection with my application or claim; any physician designated by me; or any person or entity required to receive such information by law or as I may further consent.

I understand that this consent may be revoked at any time by sending a written request to the Director of Underwriting, William Penn Life Insurance Company of New York, 100 Quentin Roosevelt Boulevard, PO Box 519, Garden City, NY 11530.

The consent will be valid for 24 months from the date of this application. I agree that a copy of this consent will be as valid as the original. I authorize the Company to obtain an investigative consumer report on me. I understand that I may request to be interviewed for the report and receive, upon written request, a copy of such report.

If an investigative consumer report is prepared, I elect to be interviewed: Yes No

DECLARATION

I/we have carefully read the Temporary Insurance Application and Agreement (TIAA) and understand and agree to the terms thereof including the conditions under which a limited amount of insurance may become effective prior to policy delivery. I/we understand that all premium checks are to be made payable to **William Penn Life Insurance Company of New York** (payee should not be left blank); checks are not to be made payable to the agent, agency or other third party. I/we have received the Notice to Proposed Insured, which includes the Medical Information Bureau Pre-Notice Disclosure and the Federal Fair Credit Reporting Notice.

Signature of Proposed Insured Signed at _____ City/State on ____/____/____

Signature of Owner (if other than Proposed Insured) Signed at _____ City/State on ____/____/____
If Owner is a firm or corporation, include officers' title with signature

Print Owner/Officer Name and Title (if applicable)

Signature of Licensed Insurance Agent Signed at _____ City/State on ____/____/____



PART 2
Medical History

1. Name of Proposed Insured _____ Date of Birth _____
 2. Height ____ ft. ____ in. 3. Weight _____ lbs.
 If your weight has changed by over 10 lbs. in the last year, indicate amount and reason _____

PHYSICIAN INFORMATION

4. **Primary Physician**

Name _____
 Address _____
 Telephone _____ Date last seen _____
 Reason last seen and results of visit _____

5. **Physician Last Consulted**

Name _____ Specialty _____
 Address _____
 Telephone _____ Date last seen _____
 Reason last seen and results of visit _____

6. Has a parent or sibling ever been diagnosed or treated by a member of the medical profession for heart or kidney disease, stroke, diabetes, cancer, melanoma, suicide, Huntington's Disease, Sickle Cell Disease or Familial Adenomatous Polyposis (FAP)? If Yes, give details in the Family History chart below. Yes No

Family History: Include the age at onset/event for each medical condition.

	Medical Conditions	Age at Onset/Event	Age if Living	Cause of Death	Age at Death
Father					
Mother					
Brothers					
Sisters					

MEDICAL HISTORY - Provide details to Yes answers in the Remarks section. Include provider, date, symptoms, diagnosis and treatment. An additional sheet of paper may be attached if necessary.

Remarks - Explain All Yes Answers
 Enter question number before detailed response.

Questions 7-22, have you ever consulted a member of the medical profession regarding or have you been diagnosed or treated for:

7. High blood pressure, high cholesterol, abnormal electrocardiogram, chest pain, irregular heart rhythm, palpitations, heart murmur, heart attack, angina, phlebitis, peripheral vascular disease, or any other disease or disorder of the heart or blood vessels?
8. Hepatitis, ulcer, internal bleeding, colitis, acid reflux, GERD, or any other disease or disorder of the stomach, gall bladder, esophagus, liver, pancreas, spleen, intestines, colon, or rectum?
9. A disorder of your blood or immune system including anemia, blood clots, bleeding, immune deficiency, leukemia, or lymphoma (excluding HIV)?

PART 2 - Medical History (continued)

Name of Proposed Insured _____	Yes	No	Remarks - Explain All Yes Answers
10. Cancer, tumor, melanoma, or any other malignant disorder?.....	<input type="checkbox"/>	<input type="checkbox"/>	
11. Diabetes or high blood sugar or any other disease or disorder of the pituitary, thyroid, or endocrine glands?	<input type="checkbox"/>	<input type="checkbox"/>	
12. Albumin, protein, blood or sugar in the urine or any other disease or disorder of the kidney or bladder?	<input type="checkbox"/>	<input type="checkbox"/>	
13. Cyst, polyp, lump, or other growth, or any disease or disorder of the skin or lymph nodes?	<input type="checkbox"/>	<input type="checkbox"/>	
14. Any disease or disorder of the uterus, cervix, ovaries, or breasts?.....	<input type="checkbox"/>	<input type="checkbox"/>	
15. Any disease or disorder of the prostate or reproductive system?	<input type="checkbox"/>	<input type="checkbox"/>	
16. Any sexually transmitted disorders or diseases?.....	<input type="checkbox"/>	<input type="checkbox"/>	
17. Pregnancy, complications of pregnancy or infertility?	<input type="checkbox"/>	<input type="checkbox"/>	If now pregnant, what is the expected date of delivery? _____
18. Asthma, shortness of breath, chronic cough or hoarseness, bronchitis, emphysema, COPD (chronic obstructive pulmonary disease), sarcoidosis, pneumonia, TB (tuberculosis), sleep apnea, or any other disorder of the respiratory system?	<input type="checkbox"/>	<input type="checkbox"/>	
19. A disorder of the brain, spinal cord, or nervous system including chronic headaches, convulsions or loss of consciousness, seizures, tremors, paralysis, fainting, stroke, MS (multiple sclerosis), or TIA (transient ischemic attack)?.....	<input type="checkbox"/>	<input type="checkbox"/>	
20. Depression, anxiety, psychosis, suicidal thoughts or attempts of suicide, anorexia or bulimia, obsessive compulsive disorder, bipolar disorder, or other mental, nervous or emotional disorder?.....	<input type="checkbox"/>	<input type="checkbox"/>	
21. Arthritis or disorder of the bones, skin or muscles?.....	<input type="checkbox"/>	<input type="checkbox"/>	
22. Any disease or disorder of the eyes, ears, nose or throat?.....	<input type="checkbox"/>	<input type="checkbox"/>	
23. In the last 5 years , unless previously stated on this application, have you:			
a. Been treated by a member of the medical profession or at a medical facility?	<input type="checkbox"/>	<input type="checkbox"/>	
b. Had an electrocardiogram, x-ray, blood test, or other diagnostic test, excluding an HIV test?	<input type="checkbox"/>	<input type="checkbox"/>	
c. Had surgery or biopsy, or been an inpatient or outpatient in a hospital, clinic, or other medical or mental health facility?	<input type="checkbox"/>	<input type="checkbox"/>	
d. Been advised by a member of the medical profession to have surgery, medical treatment, biopsy, or diagnostic testing, excluding HIV testing, that has not yet been completed?.....	<input type="checkbox"/>	<input type="checkbox"/>	
e. Been referred to any other member of the medical profession or medical facility?	<input type="checkbox"/>	<input type="checkbox"/>	
f. Been unable to work, attend school or perform the normal activities of like age and gender, or been confined at home?	<input type="checkbox"/>	<input type="checkbox"/>	
24. a. Have you ever used amphetamines, barbiturates, cocaine, heroin, crack, marijuana, LSD, PCP, or other illegal, restricted or controlled substances, except as prescribed by a licensed physician?	<input type="checkbox"/>	<input type="checkbox"/>	
If Yes, please provide dates of use: From _____ To _____			
Name of drug used: _____			
Amount and frequency of use: _____			



100 Quentin Roosevelt Boulevard, Garden City, NY 11530

Name of Proposed Insured _____ Date of Birth _____

Notice to Proposed Insured and Owner. Payment of the Amount Remitted may only be made at the same time that both the Application - Part 1 and this TIAA are completed. If the Insurer does not respond to you within 90 days, notify the Insurer at the above address. **Make the Amount Remitted payable to William Penn Life Insurance Company of New York. Do not make it payable to the licensed insurance agent or leave the payee blank. We do not accept cash or cash equivalents (money orders, cashiers checks) or "starter" checks.**

TEMPORARY INSURANCE APPLICATION (Answer all questions.)

Insurer The Insurer is William Penn Life Insurance Company of New York.

Temporary insurance cannot begin and you should make no payment if any question below is answered "Yes" or left blank.

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1. Is the Proposed Insured less than 15 days old or more than 70 years old (age nearest birthday) on the date of this TIAA?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Does the total amount of insurance on the Proposed Insured's life now applied for or pending with William Penn Life Insurance Company of New York exceed \$1,000,000? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. In the past 90 days, has the Proposed Insured been admitted, or medically advised by a member of the medical profession to be admitted, to a hospital or other licensed health care facility, had surgery performed or recommended, or been medically advised to have any diagnostic test (excluding an AIDS-related test) that was not completed?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. In the past 5 years, has the Proposed Insured been diagnosed, treated for, or been advised by a member of the medical profession to be treated for: heart disease; stroke; cancer; alcohol or drug dependence or abuse; or insulin dependent diabetes? ... | <input type="checkbox"/> | <input type="checkbox"/> |

THIS AGREEMENT PROVIDES A LIMITED AMOUNT OF LIFE INSURANCE COVERAGE FOR A LIMITED AMOUNT OF TIME, SUBJECT TO THE TERMS AND CONDITIONS SET FORTH BELOW.

TEMPORARY INSURANCE AGREEMENT

Agreement. Subject to the terms of the policy applied for and this TIAA, the Insurer agrees to pay the Limited Amount to the beneficiaries listed in the Application - Part 1 upon receipt of due proof that the Proposed Insured died, except due to suicide, and provided all eligibility requirements and conditions for coverage under this Agreement have been met. The consideration for temporary insurance is the Temporary Insurance Application and payment of an amount equal to the first modal premium for the plan applied for or completion of the payment options form.

Limited Amount. The Limited Amount is the lesser of: (1) the amount of insurance applied for in the Application or (2) \$1,000,000 minus the amount of insurance on the Proposed Insured's life with the Insurer under any other applications for insurance now pending or other temporary insurance agreements.

Start Date. Temporary insurance equal to the Limited Amount will begin on the Start Date subject to the terms of this TIAA. The Start Date is the Date of this TIAA.

Stop Date. Temporary insurance automatically ends on the **earliest** of the following: (1) the date the Owner withdraws the application for insurance or refuses to accept any policy issued or offered; (2) the date the Insurer mails or otherwise provides notice to the Owner or his/her agent that it was unable to approve the requested coverage at the premium amount quoted and a counter offer is made by the Insurer; (3) the date the Insurer mails or otherwise provides notice to the Owner or his/her representative that it has declined or cancelled the application; (4) the date the Insurer mails or otherwise provides a premium refund to the Owner or his/her representative; (5) the date the policy is delivered to the Owner and delivery requirements have been completed.

Policy Date. The policy date of any policy issued will be the Start Date unless the policy is backdated at the Owner's request. The prepayment for this temporary insurance will be applied to the first premium due if the policy is issued.

Other Limitations. The Insurer's liability will be limited to a return of the Amount Remitted if: (1) any part of the life insurance application or this TIAA contains a misrepresentation material to the Insurer; or (2) the Proposed Insured dies by suicide.

**TEMPORARY INSURANCE APPLICATION
AND AGREEMENT (TIAA)**

(continued)

I represent that: (1) I have read and received a copy of this TIAA and agree to all of its terms and conditions; (2) I understand and agree that temporary insurance will not begin if any question in this TIAA is answered Yes or left blank and any collection of premium will not activate coverage under this agreement; (3) the answers given in this TIAA are true and correct, and I understand that, if they are false, temporary insurance may be denied or declined; (4) I understand that completing this TIAA does not guarantee that the Insurer will issue a policy on the Proposed Insured's life; (5) I understand that the licensed insurance agent is not authorized to change or waive the terms of this TIAA or to collect premium if the Proposed Insured is ineligible for coverage under this Agreement; and (6) I understand that any premium submitted with this TIAA will be refunded if the Insurer does not approve the requested coverage.

Signature of Proposed Insured_____
Date of this TIAA_____
Signature of Owner (if other than Proposed Insured)**LICENSED INSURANCE AGENT'S STATEMENT**

Amount Remitted \$ _____ Person from Whom Received _____

On the Date of this TIAA, I received the Amount Remitted in exchange for this TIAA. The TIAA bears the same date as the Application - Part 1. I agree that I am not authorized to change or waive the terms of this TIAA and represent that I have not attempted to do so. I have read and explained the terms of this TIAA to the Proposed Insured and Owner. I have left a copy with the Owner.

Signature of Licensed Insurance Agent_____
Licensed Insurance Agent Number



**TEMPORARY INSURANCE APPLICATION
AND AGREEMENT (TIAA)**

100 Quentin Roosevelt Boulevard, Garden City, NY 11530

Name of Proposed Insured _____ Date of Birth _____

Notice to Proposed Insured and Owner. Payment of the Amount Remitted may only be made at the same time that both the Application - Part 1 and this TIAA are completed. If the Insurer does not respond to you within 90 days, notify the Insurer at the above address. **Make the Amount Remitted payable to William Penn Life Insurance Company of New York. Do not make it payable to the licensed insurance agent or leave the payee blank. We do not accept cash or cash equivalents (money orders, cashiers checks) or "starter" checks.**

TEMPORARY INSURANCE APPLICATION (Answer all questions.)

Insurer The Insurer is William Penn Life Insurance Company of New York.

Temporary insurance cannot begin and you should make no payment if any question below is answered "Yes" or left blank.

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1. Is the Proposed Insured less than 15 days old or more than 70 years old (age nearest birthday) on the date of this TIAA?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Does the total amount of insurance on the Proposed Insured's life now applied for or pending with William Penn Life Insurance Company of New York exceed \$1,000,000? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. In the past 90 days, has the Proposed Insured been admitted, or medically advised by a member of the medical profession to be admitted, to a hospital or other licensed health care facility, had surgery performed or recommended, or been medically advised to have any diagnostic test (excluding an AIDS-related test) that was not completed?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. In the past 5 years, has the Proposed Insured been diagnosed, treated for, or been advised by a member of the medical profession to be treated for: heart disease; stroke; cancer; alcohol or drug dependence or abuse; or insulin dependent diabetes?... | <input type="checkbox"/> | <input type="checkbox"/> |

THIS AGREEMENT PROVIDES A LIMITED AMOUNT OF LIFE INSURANCE COVERAGE FOR A LIMITED AMOUNT OF TIME, SUBJECT TO THE TERMS AND CONDITIONS SET FORTH BELOW.

TEMPORARY INSURANCE AGREEMENT

Agreement. Subject to the terms of the policy applied for and this TIAA, the Insurer agrees to pay the Limited Amount to the beneficiaries listed in the Application - Part 1 upon receipt of due proof that the Proposed Insured died, except due to suicide, and provided all eligibility requirements and conditions for coverage under this Agreement have been met. The consideration for temporary insurance is the Temporary Insurance Application and payment of an amount equal to the first modal premium for the plan applied for or completion of the payment options form.

Limited Amount. The Limited Amount is the lesser of: (1) the amount of insurance applied for in the Application or (2) \$1,000,000 minus the amount of insurance on the Proposed Insured's life with the Insurer under any other applications for insurance now pending or other temporary insurance agreements.

Start Date. Temporary insurance equal to the Limited Amount will begin on the Start Date subject to the terms of this TIAA. The Start Date is the Date of this TIAA.

Stop Date. Temporary insurance automatically ends on the **earliest** of the following: (1) the date the Owner withdraws the application for insurance or refuses to accept any policy issued or offered; (2) the date the Insurer mails or otherwise provides notice to the Owner or his/her agent that it was unable to approve the requested coverage at the premium amount quoted and a counter offer is made by the Insurer; (3) the date the Insurer mails or otherwise provides notice to the Owner or his/her representative that it has declined or cancelled the application; (4) the date the Insurer mails or otherwise provides a premium refund to the Owner or his/her representative; (5) the date the policy is delivered to the Owner and delivery requirements have been completed.

Policy Date. The policy date of any policy issued will be the Start Date unless the policy is backdated at the Owner's request. The prepayment for this temporary insurance will be applied to the first premium due if the policy is issued.

Other Limitations. The Insurer's liability will be limited to a return of the Amount Remitted if: (1) any part of the life insurance application or this TIAA contains a misrepresentation material to the Insurer; or (2) the Proposed Insured dies by suicide.

**TEMPORARY INSURANCE APPLICATION
AND AGREEMENT (TIAA)**

(continued)

I represent that: (1) I have read and received a copy of this TIAA and agree to all of its terms and conditions; (2) I understand and agree that temporary insurance will not begin if any question in this TIAA is answered Yes or left blank and any collection of premium will not activate coverage under this agreement; (3) the answers given in this TIAA are true and correct, and I understand that, if they are false, temporary insurance may be denied or declined; (4) I understand that completing this TIAA does not guarantee that the Insurer will issue a policy on the Proposed Insured's life; (5) I understand that the licensed insurance agent is not authorized to change or waive the terms of this TIAA or to collect premium if the Proposed Insured is ineligible for coverage under this Agreement; and (6) I understand that any premium submitted with this TIAA will be refunded if the Insurer does not approve the requested coverage.

Signature of Proposed Insured

Date of this TIAA

Signature of Owner (if other than Proposed Insured)

LICENSED INSURANCE AGENT'S STATEMENT

Amount Remitted \$ _____ Person from Whom Received _____

On the Date of this TIAA, I received the Amount Remitted in exchange for this TIAA. The TIAA bears the same date as the Application - Part 1. I agree that I am not authorized to change or waive the terms of this TIAA and represent that I have not attempted to do so. I have read and explained the terms of this TIAA to the Proposed Insured and Owner. I have left a copy with the Owner.

Signature of Licensed Insurance Agent

Licensed Insurance Agent Number



William Penn

Life Insurance Company of New York

...A Partnership for Life

100 Quentin Roosevelt Boulevard
PO Box 519
Garden City, New York 11530

**INSURANCE DEPARTMENT OF THE STATE OF NEW YORK
DEFINITION OF REPLACEMENT**

IN ORDER TO DETERMINE WHETHER YOU ARE REPLACING OR OTHERWISE CHANGING THE STATUS OF EXISTING LIFE INSURANCE POLICIES OR ANNUITY CONTRACTS, AND IN ORDER TO RECEIVE THE VALUABLE INFORMATION NECESSARY TO MAKE A CAREFUL COMPARISON IF YOU ARE CONTEMPLATING REPLACEMENT, THE AGENT IS REQUIRED TO ASK YOU THE FOLLOWING QUESTIONS AND EXPLAIN ANY ITEMS THAT YOU DO NOT UNDERSTAND.

AS PART OF YOUR PURCHASE OF A NEW LIFE INSURANCE POLICY OR A NEW ANNUITY CONTRACT, HAS EXISTING COVERAGE BEEN, OR IS IT LIKELY TO BE:

- 1. LAPSED, SURRENDERED, PARTIALLY SURRENDERED, FORFEITED, ASSIGNED TO THE INSURER REPLACING THE LIFE INSURANCE POLICY OR ANNUITY CONTRACT, OR OTHERWISE TERMINATED? YES ___ NO ___
- 2. CHANGED OR MODIFIED INTO PAID-UP INSURANCE; CONTINUED AS EXTENDED TERM INSURANCE OR UNDER ANOTHER FORM OF NONFORFEITURE BENEFIT; OR OTHERWISE REDUCED IN VALUE BY THE USE OF NONFORFEITURE BENEFITS, DIVIDEND ACCUMULATIONS, DIVIDEND CASH VALUES OR OTHER CASH VALUES? YES ___ NO ___
- 3. CHANGED OR MODIFIED SO AS TO EFFECT A REDUCTION EITHER IN THE AMOUNT OF THE EXISTING LIFE INSURANCE OR ANNUITY BENEFIT OR IN THE PERIOD OF TIME THE EXISTING LIFE INSURANCE OR ANNUITY BENEFIT WILL CONTINUE IN FORCE? YES ___ NO ___
- 4. REISSUED WITH A REDUCTION IN AMOUNT SUCH THAT ANY CASH VALUES ARE RELEASED, INCLUDING ALL TRANSACTIONS WHEREIN AN AMOUNT OF DIVIDEND ACCUMULATIONS OR PAID-UP ADDITIONS IS TO BE RELEASED ON ONE OR MORE OF THE EXISTING POLICIES? YES ___ NO ___
- 5. ASSIGNED AS COLLATERAL FOR A LOAN OR MADE SUBJECT TO BORROWING OR WITHDRAWAL OF ANY PORTION OF THE LOAN VALUE, INCLUDING ALL TRANSACTIONS WHEREIN ANY AMOUNT OF DIVIDEND ACCUMULATIONS OR PAID-UP ADDITIONS IS TO BE BORROWED OR WITHDRAWN ON ONE OR MORE EXISTING POLICIES? YES ___ NO ___
- 6. CONTINUED WITH A STOPPAGE OF PREMIUM PAYMENTS OR REDUCTION IN THE AMOUNT OF PREMIUM PAID? YES ___ NO ___

IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, A REPLACEMENT AS DEFINED BY NEW YORK INSURANCE DEPARTMENT REGULATION NO. 60 HAS OCCURRED OR IS LIKELY TO OCCUR AND YOUR AGENT IS REQUIRED TO PROVIDE YOU WITH A COMPLETED DISCLOSURE STATEMENT AND THE **IMPORTANT** NOTICE REGARDING REPLACEMENT OR CHANGE OF LIFE INSURANCE POLICIES OR ANNUITY CONTRACTS.

DATE: _____ SIGNATURE OF APPLICANT: _____

DATE: _____ SIGNATURE OF APPLICANT: _____

TO THE BEST OF MY KNOWLEDGE, A REPLACEMENT IS INVOLVED IN THIS TRANSACTION:
YES ___ NO ___

DATE: _____ SIGNATURE OF AGENT OR BROKER: _____



WILLIAM PENN LIFE INSURANCE COMPANY OF NEW YORK

100 QUENTIN ROOSEVELT BOULEVARD • PO BOX 519 • GARDEN CITY, NEW YORK 11530

NOTICE AND CONSENT FOR AIDS-RELATED BLOOD TESTING

To evaluate your insurability, the Insurer named above (the Insurer) has requested that you provide a sample of your blood 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 tests will be performed by a certified laboratory through a medically accepted procedure.

Meaning of Positive Test Result

A positive test result does not mean that you have AIDS but that you are at significantly increased risk of developing AIDS. The test for HIV antibodies is very sensitive. Errors are rare, but they do occur. It is possible to test negative when you have only recently been infected with HIV. You may wish to consider further independent testing.

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

For further information about AIDS, the meaning of HIV related test results and availability and location of HIV related counseling services, you may call the New York State Department of Health's toll free AIDS hotline: 1-800-541-AIDS, or any of the other New York State HIV counseling hotlines shown below.

Albany/Northeastern NY	(518) 457-7152	Syracuse Area	(315) 428-4736
Buffalo Area	(716) 847-4520	Bronx	(212) 716-3350
Nassau County	(516) 535-2004	Brooklyn	(718) 797-9110
New Rochelle and Mid-Hudson Valley	(914) 632-4133	Queens	(718) 262-9100
Rochester Area	(716) 432-8081	Harlem	(212) 694-0884
Suffolk County	(516) 348-2999	NYC Hotline	(718) 485-8111

COLLECT CALLS ACCEPTED

After hours Hotline: 1-800-872-2777

Monday thru Friday 4 p.m. to 8 p.m.

Saturday and Sunday 10 a.m. to 6 p.m.

You should also read the information regarding AIDS on page 3 of this form very carefully.

This information has been provided by the New York State Health Department.

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 may be disclosed to employees of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer or to outside legal counsel who needs such information to effectively represent the Insurer in regard to your application. 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 by the laboratory to the Insurer as being positive, 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, you are asked to list your private physician so that the Insurer can have him or her tell you the test result and explain its meaning.

Name of physician for reporting a positive test result: _____

Address _____

If you wish the results to be mailed to some person other than yourself who is not a physician, print that person's name and address here:

If you want the results sent directly to you, sign here: _____

Positive results will be sent by registered mail for restricted delivery to the addressee.

Consent

I have read and I understand this Notice and Consent for AIDS-Related Blood Testing. AIDS-Related Blood testing means any laboratory test or series of tests for any virus, antibody, antigen or etiologic agent whatsoever thought to cause or to indicate the presence of AIDS. I voluntarily consent to the withdrawal of blood from me, the testing of that blood and the disclosure of the test results as described above.

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.

Name of Proposed Insured

Signature of Proposed Insured or Parent/Guardian

Address

Date Signed

AIDS Does not discriminate. It doesn't matter if you're

**MALE
FEMALE**

**BLACK
WHITE**

**RICH
POOR**

**GAY
STRAIGHT**

If you have sex with or share needles with an infected person, you can get AIDS. But we know how to prevent AIDS. Read the information below, and you'll know, too. Learn how to protect yourself from AIDS.

WHAT IS AIDS?

- AIDS stands for Acquired Immune Deficiency Syndrome, a disorder for which there is presently no cure.
- It is caused by a virus that many scientists call HIV (Human Immunodeficiency Virus). The virus can destroy the body's immune system, making it unable to fight off even small infections. The virus can also attack the nervous system, causing seizures, memory loss and mental disorders.
- The AIDS virus is carried in the blood, semen, vaginal fluid and other body secretions of an infected person. The virus must get into your bloodstream to cause AIDS.
- As many as 300,000 to 500,000 New Yorkers may already be infected with the AIDS virus. Most of these people don't know they're infected, because they have no symptoms.

HOW DO YOU GET AIDS?

- **By having sex with someone who has the AIDS virus.** During sex with an infected person, the virus contained in the blood, semen or other fluids can enter your body. It doesn't matter if you have sex with an infected person only once - you can still get AIDS!
- **By shooting drugs with a needle, syringe or "works" that has been used by someone who has the AIDS virus.** Invisible traces of infected blood from the last person who used the equipment could enter your body.
- A woman with the AIDS virus can give it to her unborn baby if she becomes pregnant. She is also more likely to develop AIDS if she becomes pregnant.

HOW DO YOU KNOW IF SOMEONE IS INFECTED?

- You can't tell if someone is infected with the AIDS virus just by looking at him or her.
- Most men and women infected with the virus don't know they are infected, because they have no signs or symptoms of illness. It can take several years before symptoms develop.
- Anyone who has ever shared a needle to shoot drugs could be infected. Researchers think that half of I.V. drug abusers are already infected!
- Anyone who ever had sex with a man or woman who shoots drugs could be infected.
- Anyone who has had many sexual partners could be infected - the more sexual partners, the greater the chances.
- Anyone who has had anal sex has an increased risk of being infected.
- Anyone who has a medical condition which required blood transfusions could be infected.

HOW CAN YOU STAY SAFE FROM AIDS?

- Don't have sex with anyone if you don't know his or her drug use and sexual history.
- Don't have sex with a large number of partners; this increases your risk of AIDS and other sexually transmissible diseases.
- Don't have anal sex. It can tear delicate tissues, letting infected semen or blood enter your bloodstream.
- Use a condom during sex to help keep the virus from getting into your body - unless you're **absolutely sure** your partner is not infected.
- Using a spermicide containing nonoxynol-9 along with condoms may provide further protection.
- NEVER shoot drugs.
- NEVER share a needle or other equipment to shoot drugs.
- Intravenous equipment can be sterilized by soaking it in alcohol for 10 minutes, or in one part bleach and 10 parts water for 10 minutes. Rinse thoroughly.

IS THERE A WAY TO FIND OUT IF A PERSON IS INFECTED?

- A blood test can tell if a person has been exposed to the virus. Free anonymous testing centers exist across the State. Anyone who wants a blood test can call 1-800-541-AIDS to learn more.
- Testing is recommended for anyone who has shared needles or engaged in high risk sexual activity.
- A woman who is thinking about becoming pregnant should consider being tested first if there's a chance she might have been exposed to the virus. If she is infected, she should consider postponing pregnancy to avoid giving birth to a baby infected with the virus.
- Counselors will help infected people learn how to avoid spreading the AIDS virus to others, and how to avoid further exposure to themselves.

FOR REFERRAL OR ASSISTANCE

Call the New York State AIDS Hotline toll-free: 1-800-541-AIDS or contact your nearest local AIDS program:

- | | | |
|--|---|--|
| <ul style="list-style-type: none">• Western NY AIDS Program, Inc.
(Buffalo-Niagara Falls)
(716) 847-AIDS• AIDS Rochester
(716) 232-4430• Central NY AIDS Task Force
(Syracuse area)
(315) 475-AIDS• Southern Tier AIDS Program
(Binghamton area)
(607) 723-6520 | <ul style="list-style-type: none">• AIDS Council of Northeastern NY
(Albany-Adirondacks)
(518) 445-AIDS• Mid-Hudson Valley AIDS Force
(includes Westchester
and Rockland counties)
(914) 993-0607• Long Island Association
for AIDS Care, Inc.
(Nassau and Suffolk counties)
(516) 385-AIDS | <p>IN THE NEW YORK CITY AREA:</p> <ul style="list-style-type: none">• NYC AIDS Hotline
(718) 485-8111• Haitian Coalition
(718) 855-0972• Gay Men's Health Crisis
(212) 807-6655• Hemophilia Foundation
(212) 682-5510• Children and Youth AIDS Hotline
(212) 430-3333 |
|--|---|--|

Or write to: THE AIDS INSTITUTE, New York State Health Department, Empire State Plaza, Corning Tower - Room 2580, Albany, NY 12237



William Penn

Life Insurance Company of New York

...A Partnership for Life

100 Quentin Roosevelt Boulevard
Garden City, New York 11530

ELECTRONIC FUNDS TRANSFER PAYMENT OPTIONS

Policy Owner Name _____

Policy Number _____
(leave blank if policy number not yet assigned)

Proposed Insured's Name _____

Date of Birth _____

Authorization

William Penn Life Insurance Company of New York will draft the checking account designated on this form for subsequent premiums only (unless initial premium payment is authorized by checking the box below) once the policy has been approved for issue, subject to the terms below.

- Check here to authorize William Penn Life Insurance Company of New York to draft my checking account for the initial premium payment and subsequent premium payments subject to the terms of the life insurance contract.**

I understand and agree that this authorization is subject to the following conditions:

- This authorization shall remain in effect until revoked in writing by me or the Company.
- Signing this authorization does NOT mean that coverage is effective; coverage is effective only as stated in the application or Temporary Insurance Agreement, if issued.
- Completion of this form will satisfy the requirement for payment of an amount applied for as required by the Temporary Insurance Application and Agreement.
- Use of the selected payment method does not alter any provisions of any policy issued by William Penn Life Insurance Company of New York.
- William Penn Life Insurance Company of New York will process the selected payment only when one of the following events occur: 1) William Penn Life Insurance Company of New York has approved the policy for issue and there are no documents requiring the owner's and/or insured's signature; or 2) the policy has been accepted and William Penn Life Insurance of New York has received all of the necessary documents requiring the signature of the owner/insured.
- If necessary, refunds of initial premium will be refunded by Company check.
- If the payment method selected is not honored upon presentation, no coverage will be in effect and William Penn Life Insurance Company of New York will terminate any further attempt to use this payment method.

Temporary Insurance is limited to the lesser of: (1) the amount of insurance applied for in the Application or (2) \$1,000,000 minus the amount of insurance on the Proposed Insured's life with the Insurer under any other applications for insurance now pending or other temporary insurance agreements.

Bank Account Information for Draft from Checking Accounts (checking accounts only)

Name of Financial Institution _____ City _____ State _____

ABA Routing Number _____
(routing number typically located on bottom left of check)

Account Number _____
(must include dashes and spaces as they appear in your account number)

X _____
Account Owner Signature (Must be Payor, Owner
or Proposed Insured as identified on application)

_____ Date

X _____
Proposed Insured Signature

_____ Date

X _____
Owner Signature (If other than Proposed Insured)

_____ Date



WILLIAM PENN LIFE INSURANCE COMPANY OF NEW YORK

100 QUENTIN ROOSEVELT BOULEVARD • PO BOX 519 • GARDEN CITY, NEW YORK 11530

RELEASE OF HEALTH-RELATED INFORMATION

Although the application you completed includes a disclosure authorization, as a result of recent changes in the federal **Health Insurance Portability and Accountability Act (HIPAA)**, your medical provider may ask for this HIPAA specific form.

THIS AUTHORIZATION COMPLIES WITH THE HIPAA PRIVACY RULE

Print Name of Proposed Insured / Patient

____/____/____
Date of Birth

Print Name of Person or Organization Providing Information

AUTHORIZATION

I authorize any physician, health plan, medical practitioner, medical care provider, psychologist, chiropractor, physical therapist, hospital, nursing home, mental health facility, rehabilitation or ambulatory care center, medical clinic, laboratory, pharmacy, treatment facility, or other medical or medically related facility, specifically including those persons/organizations listed above, to give or disclose my entire medical record and any other protected health information concerning me for the past 10 years to **William Penn Life Insurance Company of New York**, its agents, employees, vendors or representatives. Any and all records and information regarding diagnosis, testing, treatment, and prognosis of my physical or mental condition are to be released. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco.

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

By signing below, I terminate any agreements I have made to restrict my protected health information and I instruct any physician, health care professional, hospital, clinic, medical facility or other health care provider to release and disclose my entire medical record without restriction.

This authorization shall be valid for two (2) years after the date on which it is signed by me, and a copy of this authorization is as valid as the original.

I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to the Company at 100 Quentin Roosevelt Boulevard, Garden City, NY 11530, Attention: Privacy Official. I understand that a revocation is not effective if any of My Providers has 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. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by certain federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization, the Company may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments.

I understand and acknowledge that I will receive or have received a copy of this authorization.

Signature of Proposed Insured / Patient

Date (required)

Social Security Number of Proposed Insured

Agent or Witness Signature



100 Quentin Roosevelt Blvd.
P.O. Box 519
Garden City, NY 11530
(516) 794-3700

Privacy Policy

Our corporate policy.

Your privacy is important to us. At William Penn Life Insurance Company of New York, we understand that the information you provide to us or we collect about you is private.

This privacy policy is provided to you so that you will understand what William Penn does with the personal information you provide to us and the measures we take to protect your privacy.

Who has access to customer information?

The information that you provide to us is used for William Penn purposes only. William Penn employees and independent agents have access to your information, and are authorized to review it, only for the purposes of carrying out their official duties and responsibilities. William Penn employees and independent agents are required to keep customer information confidential.

Why does William Penn collect and maintain information?

As a regulated insurance carrier, William Penn is required by state laws and regulations to collect and maintain certain information about its customers. The information we collect also enables us to provide you with services and products that meet your individual needs and to provide you with the high level of customer care that you have come to expect from William Penn.

What type of information does William Penn collect and maintain?

William Penn collects and maintains various types of information about its customers. The types of information we collect and maintain about you may include:

- Information that you submit to us, such as your name, address, telephone number, and Social Security Number.
- Information about your transactions with William Penn, such as payment history and account balance.
- Information from non-affiliated third parties about your medical, employment and income history; your assets and liabilities; and your driving record.
- Information from consumer reporting agencies about your credit history.
- Information about you that may be derived from your visits to William Penn's website.

Does William Penn disclose customer information to, or share customer information with, outsiders?

William Penn does not disclose any non-public personal financial or any non-public personal medical information about our customers or former customers to anyone, except as permitted or required by law.

It is William Penn's current policy not to disclose customer information to, or share customer information with, other businesses for marketing purposes.

If this policy should change, William Penn will notify you by mail, and you will be given an opportunity to request that your information not be disclosed to, or shared with, other businesses for marketing purposes.

How can I contact William Penn if I have privacy questions?

If you have any questions about the privacy of your information, you can contact the Customer Service Department by:

Mail: Customer Service Department
William Penn Life Insurance Company of New York
100 Quentin Roosevelt Boulevard
P.O. Box 519
Garden City, New York 11530

or

E-mail: customerservice_william penn@LGAmerica.com

or

Phone: 1-800-346-4773