

TEXASLIFE INSURANCE
COMPANY

Since 1901 | 900 WASHINGTON | POST OFFICE BOX 830 | WACO, TEXAS 76703-0830

SOLUTIONS 121

Application/Forms Packet For: VANCE COUNTY GOVERNMENT

Marketed by: Mark III Brokerage, Inc.

**FOR USE ONLY IN
NORTH CAROLINA**

1st Deduction Date: _____ Employer: _____ Policy Number: _____

Employee (EE) Hire Date: _____ Plan: *SOLUTIONS 121*

Last Name _____ First Name _____ MI: _____ Face Amount² _____

SSN _____ Sex _____ Birth Date _____ Age¹ _____ Premium _____ \$ _____

Home Address: _____ City: _____ State: _____ Zip: _____

Phone-Day: _____ Evening: _____ Personal E-mail: _____

Tier 1 **Within the last 12 months have you used tobacco in any form?** Yes No
Are you at work on a full-time basis, performing your usual duties? Yes No

(Spouse is beneficiary unless otherwise stated here) Name: _____ Relationship: _____

On all policies I elect the Automatic Contract Loan provision to pay a premium overdue 30 days or more, if the policy has sufficient cash value.

Riders: Included in Plan Premium **Optional Riders: Additional Premium Required**
 Accidental Death⁽³⁾ Waiver Premium⁽³⁾ Child Term rider - Add to policy of: Employee Spouse
 Union Strike⁽⁴⁾ Chronic Illness Family Term Rider⁽⁴⁾ Total Premium of Optional Riders: \$ _____

Spouse (SP) Plan: *SOLUTIONS 121*

Last Name _____ First Name _____ MI: _____ Face Amount² _____

SSN _____ Sex _____ Birth Date _____ Age¹ _____ Premium _____ \$ _____

Within the last 12 months has the proposed insured age 17 or older used tobacco in any form? Yes No

(Employee is beneficiary unless otherwise stated here) Name: _____ Relationship: _____

Dependents (DEP) Plan: *SOLUTIONS 121*

(1) Last Name _____ First Name _____ MI: _____ Face Amount² _____

SSN _____ Sex _____ Birth Date _____ Age¹ _____ Premium _____ \$ _____

Within the last 12 months has the proposed insured age 17 or older used tobacco in any form? Yes No

(Employee is beneficiary unless otherwise stated here) Name: _____ Relationship: _____

(2) Last Name _____ First Name _____ MI: _____ Face Amount² _____

SSN _____ Sex _____ Birth Date _____ Age¹ _____ Premium _____ \$ _____

Within the last 12 months has the proposed insured age 17 or older used tobacco in any form? Yes No

(Employee is beneficiary unless otherwise stated here) Name: _____ Relationship: _____

(3) Last Name _____ First Name _____ MI: _____ Face Amount² _____

SSN _____ Sex _____ Birth Date _____ Age¹ _____ Premium _____ \$ _____

Within the last 12 months has the proposed insured age 17 or older used tobacco in any form? Yes No

(Employee is beneficiary unless otherwise stated here) Name: _____ Relationship: _____

Payroll is per: Weekly Bi-Weekly Semi-Monthly Monthly Skip _____ Total of all Premiums: \$ _____

Tier 2 _____ (If answered "Yes" no coverage is offered, except as available under Tier 1 Questions)

During the last 24 months has the proposed insured been treated for, been prescribed medication for, or been diagnosed by a member of the medical profession as having, any of the following: Answer(s):

(a) Cancer (excluding non-melanoma skin cancer)?	(f) Stroke or transient ischemic attack (TIA)?	Employee Yes <input type="checkbox"/> No <input type="checkbox"/>
(b) Heart attack, coronary artery or valve disease, heart failure or cardiomyopathy?	(g) Chronic kidney disease or kidney failure (excluding kidney stones)?	Spouse Yes <input type="checkbox"/> No <input type="checkbox"/>
(c) Alcohol or drug abuse?	(h) Parkinson's disease or paralysis?	Dep 1 Yes <input type="checkbox"/> No <input type="checkbox"/>
(d) Diabetes for which the recommended treatment is insulin?	(i) Cirrhosis of the liver or hepatitis (excluding Hepatitis A)?	Dep 2 Yes <input type="checkbox"/> No <input type="checkbox"/>
(e) Chronic obstructive pulmonary disease (COPD), emphysema or other chronic lung disease (excluding asthma)?	(j) Acquired Immune Deficiency Syndrome or tested positive for the Human Immunodeficiency Virus (HIV) or its antibodies?	Dep 3 Yes <input type="checkbox"/> No <input type="checkbox"/>

¹ Age on Issue Date ² or Face Amount purchased by premium shown, if less ³ Proposed insured issue ages 17-59 ⁴ EE Only

Will proposed coverage replace or change any existing insurance or annuity policy? Yes No
(if "Yes" identify and complete replacement form.) Company _____ Policy Number _____
Do you have existing insurance or annuities (including coverage with Texas Life)? Yes No If "Yes" complete the Existing
Insurance Form *even if replacement is not contemplated.*

For residents of AL, IN, LA, KS, MA, MI, MS, NC, OH, OK, OR, VA, and WA: I received a summary description of the accelerated death benefit(s) and Important Notice(s) regarding Accelerated Death Benefit Due to Terminal Illness and, if offered, Accelerated Death Benefit for Chronic Illness.

For residents of ME, NH, WA, and WI: I acknowledge receipt of a Life Insurance Buyer's Guide.

For residents of Massachusetts: I acknowledge receipt of the Disclosure Regarding Right to Notice of Adverse Underwriting Decision Form 03M019MA and the Massachusetts Electronic Signature Disclosure Form 05M117 (for applications taken with an electronic signature).

For residents of Pennsylvania: I acknowledge receipt of the Disclosure Notice for Accelerated Death Benefit Due to Terminal Illness Form 08M003PA and, if offered, the Disclosure Notice for the Accelerated Death Benefit for Chronic Illness Form 14M073PA.

REPRESENTATIONS: I represent to the best of my knowledge and belief that all statements and answers in this application are complete, true and correctly recorded, and are made as a consideration for the insurance applied for. I understand that Texas Life Insurance Company will rely on my statements and answers as being true and complete in deciding whether to issue insurance on the proposed insured. Insurance is effective under the policy only when it is delivered to the owner and the full first premium is paid in cash. Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Proposed Insured
(Owner) Signature: _____

City: _____ State: _____ Date: _____

Agent Only: To the best of my knowledge the insurance applied for is is not to replace existing insurance or annuity. I have delivered to the Proposed Insured the applicable forms and information described in Additional Statements above.

Print Enroller Name: _____ Agent #: _____

Enroller Signature: _____ Date: _____

Supplement to Application from (Employee): _____

Employee Social Security: _____ Application Date: _____

1. Within the past five years, has any proposed insured: a. been treated by a member of the medical profession, been an inpatient or outpatient at a hospital or clinic, or been advised to have a surgical operation? b. Had an X-ray, EKG, lab test, blood test, or any other medical test or study, except those related to the Human Immunodeficiency Virus (AIDS virus)? c. Used heroin, cocaine, marijuana, PCP, or any other narcotic, hallucinogenic, sedative or legally controlled substance, except as prescribed by a physician? d. Been diagnosed or treated by a member of the medical profession as having AIDS (Acquired Immune Deficiency Syndrome) or the HIV (Human Immunodeficiency Virus) infection?	Employee		Spouse		Dep(s)	
	Yes	No	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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. Within the past ten years, has any proposed insured been diagnosed with or been treated for: a. Alcohol or drug abuse, or disorder of the stomach, liver, intestines, or kidneys? b. Cancer, tumor, diabetes, or disorder of the blood? c. Asthma, lung disease, seizure, depression, or mental, psychiatric, or neurologic disorder? d. Heart or circulatory disease or abnormality, chest pain, shortness of breath, murmur, stroke, or high blood pressure?	<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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. Is any proposed insured taking any prescribed medication at regular intervals? If "Yes", indicate name of medication in Details below.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
---	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------

4. What is the height, weight, and birth state of each proposed insured?	First Name	Hgt. Wgt.	Birth State
5. Personal physician for each proposed insured (if none, enter "None") Proposed Insured Physician Address City, State			

6. Details, including date, diagnosis, type of treatment, and current condition			Name, address and phone # of physician(s)
Ques No.	Proposed Insured	Details	

REPRESENTATIONS: I represent to the best of my knowledge and belief that all statements and answers in this application are complete, true and correctly recorded, and are made as a consideration for the insurance applied for. I understand that Texas Life Insurance Company will rely on my statements and answers as being true and complete in deciding whether to issue insurance on the proposed insured(s). Insurance is effective under the policy only when it is delivered to the owner and the full first premium is paid in cash. Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

X _____ X _____
Employee (and policyowner) Signature Spouse Signature (or Child over 18) if to be insured

X _____
Enroller/Agent Signature Print Enroller/Agent Name Agt No. Date City State

TEXASLIFE INSURANCE COMPANY **EXISTING INSURANCE FORM**

I do not want this notice read aloud to me. (Applicants must initial only if they do not want the notice read aloud.)

Note: The law requires we give you the option to have this notice read to you aloud. If an agent is not present, but you would like the notice read aloud, call your agent, or call the Home Office at 1-800-283-9233, extension 6814.

Section I. Existing Insurance or Annuities

Replacement of Life Insurance or Annuities

Important Notice -- Four pages

This document must be signed by the applicant and the producer and a copy left with the applicant

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financial purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy, to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interests. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy or contract and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

- | | |
|--|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contracts? |

If you answered "No" to BOTH questions, skip Section II and complete Section III.

Section II. Replacing Existing Insurance or Annuities

If you answered YES to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured, and the contract number if available) and whether each policy will be replaced or used as a source of financing:

	Insurer Name	Policy Number	Insured/Annuitant	Replaced (R) or Financed (F)	
1.	_____	_____	_____	<input type="checkbox"/> R	<input type="checkbox"/> F
2.	_____	_____	_____	<input type="checkbox"/> R	<input type="checkbox"/> F
3.	_____	_____	_____	<input type="checkbox"/> R	<input type="checkbox"/> F

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. [If you request one, an in force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer.] Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision. The existing policy or contract is being replaced because: _____

Section III. Signatures

I certify that the responses herein are, to the best of my knowledge, accurate:

X _____
Applicant Signature and Printed Name Date

Agent Statement. I certify that in this solicitation of insurance I used only company-approved sales materials and, pursuant to Company policy and law, left with the applicant an original or copy of all sales material used in the solicitation.

X _____
Agent Signature and Printed Name Date

Continued Next Page

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

premiums

Are they affordable?

Could they change?

You're older—are premiums higher for the proposed new policy?

How long will you have to pay premiums on the new policy? On the old policy?

policy values

New policies usually take longer to build cash values and to pay dividends.

Acquisition costs for the old policy may have been paid, you will incur costs for the new one.

What surrender charges do the policies have?

What expense and sales charge will you pay on the new policy?

Does the new policy provide more insurance coverage?

insurability

If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.

You may need a medical exam for a new policy.

Claims on most new policies for up to the first two years can be denied based on inaccurate statements.

Suicide limitations may begin anew on the new coverage.

if you are keeping the old policy as well as the new policy

How are premiums for both policies being paid?

How will the premiums on your existing policy be affected?

Will a loan be deducted from death benefits?

What values from the old policy are being used to pay premiums?

if you are surrendering an annuity or interest-sensitive life product

Will you pay surrender charges on your old contract?

What are the interest rate guarantees for the new contract?

Have you compared the contract charges or other policy expenses?

other issues to consider for all replacements

What are the tax consequences of buying the new policy?

Is this a tax free exchange? (See your tax advisor.)

Is there a benefit from favorable grandfathered treatment of the old policy under the federal tax code?

Will the existing insurer be willing to modify the old policy?

How does the quality and financial stability of the new company compare to the present company?