



Application for Life Insurance

Affiliated Life Insurance Companies of GE Financial Assurance

First Colony Life Insurance Company General Electric Capital Assurance Company GE Life and Annuity Assurance Company

Please complete this application properly and ensure that you have satisfied all of our requirements. Follow the submission instructions provided through your marketing distribution channel. If special mailing envelopes have been provided, submitting the application in such an envelope will help avoid delays in processing your client's application. We sincerely appreciate your business.

LICENSED INSURANCE AGENT CHECKLIST

This checklist is not part of the application. Please remove this page before submitting the application to the Insurer.

DO

- ▶ Give the *Notice to Proposed Insured and Owner* to the Proposed Insured or Owner before completing the application.
- ▶ Make sure that the circle for the appropriate Insurer is marked in item 4.a. on Page 1.
- ▶ Ask all questions and fully and accurately record all answers given — the application will be part of any policy issued.
- ▶ Enter each beneficiary's SSN — it will help us locate the beneficiary at claim time.
- ▶ Print in dark ink.
- ▶ Obtain all the necessary signatures.
- ▶ Complete and sign the Licensed Insurance Agent's Report.
- ▶ Promptly schedule any required medical exam.
- ▶ Obtain proper identification and sufficient information about the customer and source of funds to ensure that money laundering is not involved in the transaction.
- ▶ If you accept payment with the application:
 - Accept payment only in the form of a currently dated check or money order made payable to the selected Insurer.
 - Enter the full amount accepted in Section 7.f. on Page 1.
 - Complete the Temporary Insurance Application section of the Temporary Insurance Application and Agreement (TIAA), making sure that all questions are answered "No."
 - 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.
 - Give the Owner the COPY of the TIAA. Keep the ORIGINAL with the application.
 - Promptly send the payment and the Application – Part I, including the ORIGINAL of the TIAA to the Insurer marked in item 4.a. on Page 1.
- ▶ For Term and Excess Interest Whole Life plans — explain that for premiums not paid on an annual basis at the beginning of a policy year, we adjust the annual premium by a modal factor to compensate for the lost investment earnings, additional administrative costs, and expected early lapses. These modal factors and associated APRs are available and will be provided on request.

DO NOT

- ▶ DO NOT use pencil or correction fluid.
- ▶ DO NOT attempt to waive any of our requirements or any information that we request; you do not have the authority to make or modify contracts.
- ▶ DO NOT promise or imply that we will provide insurance.
- ▶ DO NOT accept payment in the form of cash/currency or Traveler's checks.
- ▶ DO NOT accept a check or money order made payable to you or with the payee left blank.
- ▶ DO NOT do the following:
 - Do not accept payment when the amount applied for plus existing insurance with the Insurer exceeds \$1,000,000.
 - Do not accept payment if the Proposed Insured's age nearest birthday exceeds 70 years or is less than 15 days.
 - Do not accept payment if any question on the Temporary Insurance Application is answered "Yes" or left blank.



Application for Life Insurance – Part I



Affiliated Life Insurance Companies of GE Financial Assurance

First Colony Life Insurance Company (FCL) • General Electric Capital Assurance Company (GECA) • GE Life and Annuity Assurance Company (GE Life & Annuity)
700 Main Street • Lynchburg, VA 24504

1. Proposed Insured

Please print all answers.

a. Full Name (First, Middle, Last. Include maiden name in parentheses.)		b. Sex <input type="radio"/> F <input type="radio"/> M	c. Date of Birth Mo. Day Yr.	d. State of Birth	e. Social Security Number
f. Home Address (Number, Street, City, State, and Zip Code.) e-mail: _____				How Long At Address?	g. Legal Residency <input type="radio"/> U.S. <input type="radio"/> Other (Specify):
h. Driver's License Number/State	i. Marital Status <input type="radio"/> M <input type="radio"/> S <input type="radio"/> W <input type="radio"/> D	j. Home Phone Number		k. Work Phone Number	
l. Occupation (Include duties.)	m. Employer Name and Address			How Long w/ Employer?	

2. Ownership (Complete if Owner is other than Proposed Insured. If trust, give full name of trust and date of trust agreement.)

a. Owner: (Full Name and Address) e-mail: _____	b. Rel. to Prop. Ins.	c. SSN or TIN	d. Date of Birth/Trust Mo. Day Yr.
e. Owner is: <input type="radio"/> Individual <input type="radio"/> Partnership <input type="radio"/> Corporation <input type="radio"/> Trust <input type="radio"/> Other (Specify):			
f. Contingent Owner: (Full Name and Address) e-mail: _____	g. Rel. to Prop. Ins.	h. SSN or TIN	i. Date of Birth/Trust Mo. Day Yr.
j. Contingent Owner is: <input type="radio"/> Individual <input type="radio"/> Partnership <input type="radio"/> Corporation <input type="radio"/> Trust <input type="radio"/> Other (Specify):			

3. Beneficiary (If percentage shares are not given, they will be equal. Use REMARKS to name additional Beneficiaries.)

a. Primary: (Full Name and Address)	b. % Share	c. Rel. to Prop. Ins.	d. SSN or TIN	e. Date of Birth/Trust Mo. Day Yr.
f. Primary: (Full Name and Address)	g. % Share	h. Rel. to Prop. Ins.	i. SSN or TIN	j. Date of Birth/Trust Mo. Day Yr.
k. Contingent: (Full Name and Address)	l. % Share	m. Rel. to Prop. Ins.	n. SSN or TIN	o. Date of Birth/Trust Mo. Day Yr.
p. Contingent: (Full Name and Address)	q. % Share	r. Rel. to Prop. Ins.	s. SSN or TIN	t. Date of Birth/Trust Mo. Day Yr.

4. Insurer, Plan and Amount of Insurance

5. Death Benefit Option (Universal Life only)

6. Riders (If available with Plan)

a. Insurer: (Select one) <input type="radio"/> FCL <input type="radio"/> GECA <input type="radio"/> GE Life & Annuity	<input type="radio"/> Level (Specified Amount only)	<input type="radio"/> Waiver
b. Plan of Insurance:	<input type="radio"/> Increasing (Specified Amount plus cash value)	<input type="radio"/> Children's Term Ins.: Units <input type="text"/>
c. Amount of Insurance: \$	<input type="radio"/> Scheduled Increases (if available): <input type="radio"/> Simple _____% <input type="radio"/> Compound _____%	<input type="radio"/> Other (Amount and Description):

7. Premiums

a. Payment Method: <input type="radio"/> Pre-Arranged Withdrawal (PAW) <input type="radio"/> Direct Bill <input type="radio"/> Other (Specify):	c. Automatic Premium Loan: <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> (if available)
b. Payment Mode: <input type="radio"/> Monthly (PAW only) <input type="radio"/> Quarterly <input type="radio"/> Semiannual <input type="radio"/> Annual <input type="radio"/> Single	d. Send Premium Notices to: <input type="radio"/> Insured (Section 1.f.) <input type="radio"/> Owner (Section 2.a.) <input type="radio"/> Other (Specify):
e. Premium Source: <input type="radio"/> Salary <input type="radio"/> Investments <input type="radio"/> Savings <input type="radio"/> Gifts/Inheritance <input type="radio"/> Other (Specify):	f. Amount Remitted in Exchange for Temporary Insurance: \$

8. Proposed Insured's Tobacco and Nicotine Use

- a. Mark the **one** item that best describes your history of tobacco and other nicotine product use: Never Used Totally Stopped Use Now
 b. If you have "Totally Stopped," indicate number of **years** since you totally stopped and give date and reason in **REMARKS**.
 Less than 1 1 or more/less than 2 2 or more/less than 3 3 or more/less than 5 5 or more

9. Proposed Insured's Insurance Needs (Complete either the Personal or Business section. Explain "Yes" answers in REMARKS.)

- a. **Personal:** Income Replacement Debt Repayment Estate Conservation Other
1. Personal Finances: Gross Annual Income \$ Total Assets \$ Total Liabilities \$
 2. Within the past 5 years, have you filed for bankruptcy or had any judgments or liens filed against you? Yes No
- b. **Business:** Buy-Sell Key Employee Secure Credit Other
1. Business Finances: Total Assets \$ Total Liabilities \$ Net Worth \$
 2. What percentage of the business do you own? % 3. Your Gross Annual Salary (include bonus) \$
 4. Is business insurance applied for or in force on other key members of the business? (Explain either answer in **REMARKS**.) Yes No
 5. Within the past 5 years, has the business filed for bankruptcy or had any lien or judgments filed against it? Yes No

10. Proposed Insured's Existing Insurance/Replacement (Explain "Yes" answers in REMARKS.)

- a. Do you have existing life insurance or annuities? Yes No
 b. If "Yes," to Question 10.a., will the insurance applied for in this application replace, end or change any existing life insurance or annuities? Yes No
 (If "Yes," you may be required to review and sign additional forms.)
 c. If "Yes," to Question 10.a., list all existing life insurance policies and annuity contracts. For additional policies/contracts, use **REMARKS**.

Full Name of Company	To Be Replaced?	Amount	Year Issued	Beneficiary(ies)
	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/>	\$		
	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/>	\$		
	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/>	\$		
	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/>	\$		

11. Proposed Insured's History (Explain "Yes" answers in REMARKS.)

- | | | |
|--|-----------------------|-----------------------|
| | Yes | No |
| a. Do you have any other application or informal inquiry for life insurance pending in any company or society? | <input type="radio"/> | <input type="radio"/> |
| b. Have you ever had an application or reinstatement request for life or disability insurance refused, postponed, limited, withdrawn or cancelled, or have you been asked to pay a higher premium? | <input type="radio"/> | <input type="radio"/> |
| c. Have you ever been convicted of a misdemeanor or felony? | <input type="radio"/> | <input type="radio"/> |
| d. Have you ever requested or received a Worker's Compensation, Social Security or disability income payment, excluding a pregnancy-related payment? | <input type="radio"/> | <input type="radio"/> |
| e. In the past 5 years, has your driver's license been suspended or revoked? | <input type="radio"/> | <input type="radio"/> |
| f. In the past 5 years, have you been convicted of, or pled guilty or no contest to, reckless driving or driving under the influence of alcohol or drugs? | <input type="radio"/> | <input type="radio"/> |
| g. In the past 5 years have you flown, or do you intend to fly, as a pilot, student pilot, or crew member other than for a scheduled commercial airline? (If "Yes," complete Aviation Supplement.) | <input type="radio"/> | <input type="radio"/> |
| h. In the past 2 years have you engaged in, or do you intend to engage in, hang gliding, ultra-light flying, hot-air ballooning, mountain, rock, or ice climbing, motor vehicle or boat racing, or scuba or sky diving? (If "Yes," complete appropriate activities Supplement[s].) | <input type="radio"/> | <input type="radio"/> |
| i. In the next 2 years, do you intend to travel or reside outside of the U.S. for more than 4 consecutive weeks other than for vacation? (If "Yes," complete Foreign Residence/Travel Supplement.) | <input type="radio"/> | <input type="radio"/> |

12. REMARKS (For explanations and special requests. Identify applicable item number and letter. If additional space is needed, use an overflow form.)

Authorization to Collect and Disclose Information

Information Information means facts about the Proposed Insured. It includes facts about these topics: mental and physical health, including facts about communicable diseases such as HIV infection, AIDS, tuberculosis, and sexually transmitted diseases; other insurance coverage; hazardous activities; character; general reputation; mode of living; finances; vocation; and other personal traits. It does not include facts about sexual orientation. The following statements apply to Information being collected in the states named: **New Jersey** Information does not include facts about previously administered tests for HIV Antibodies, T-Cell Counts, or AIDS. **Vermont** Information does not include facts about previously administered tests for HIV Antibodies, T-Cell Counts, or AIDS. In Vermont, the Company will not forward the results of any new tests it requests to any other entity.

Source Medical physicians; chiropractors; physical therapists; psychologists; drug, alcohol, or mental health counselors; hospitals; clinics; drug or alcohol treatment or consultation facilities; nursing homes; mental health facilities; ambulatory care centers; facilities or offices staffed or run by care providers; insurers; reinsurers; MIB; consumer reporting agencies; financial sources; employers; the Social Security Administration; neighbors; friends; and relatives.

Insurer First Colony Life Insurance Company, General Electric Capital Assurance Company, and GE Life and Annuity Assurance Company

Proposed Insured The Proposed Insured is the person whose life is proposed to be insured.

Authorization The Authorization is this Authorization to Collect and Disclose Information.

MIB MIB is the medical information bureau known as MIB, Inc.

The following parties may need to collect Information in regard to proposed coverage: the Insurer and its reinsurers; MIB; consumer reporting agencies; and all persons authorized to represent these parties. Those parties that may need to collect Information may generally disclose Information to the following: other insurers to which the Proposed Insured has applied or may apply; reinsurers; MIB; or persons who perform business, professional, or insurance tasks for them. They may disclose Information as allowed or required by law. MIB and consumer reporting agencies may disclose Information only as set forth in an agreement with a member company or organization. Certain laws may pertain to some kinds of Information and may further restrict disclosure of that Information. The Insurer and its reinsurers will use Information to evaluate the application.

By signing this Application – Part I, the Proposed Insured or the person authorized to act on the Proposed Insured’s behalf: (1) authorizes each Source to give Information when this Authorization is presented; and (2) acknowledges receipt of the Notice to Proposed Insured and Owner. A copy of this Authorization will be as valid as the original. The Proposed Insured or the person authorized to act on the Proposed Insured’s behalf may revoke this Authorization by sending written notice to the Insurer. Failing to sign, changing, or revoking this Authorization will impair processing of the application; as a result, the application may be denied.

In all states except Rhode Island and Vermont, this Authorization will be valid for thirty (30) months after the date this Application – Part I is signed. In Rhode Island and Vermont, this Authorization will be valid for twenty-four (24) months after the date this Application – Part I is signed. The Proposed Insured or an authorized representative of the Proposed Insured may ask to receive a copy of this Authorization.

Representations

The application includes the Application – Parts I and II and all approved supplemental forms or amendments the Insurer specifically designates as parts of the application by attaching copies of them to any policy delivered to the Owner. No licensed insurance agent is authorized to: (a) make or modify contracts; (b) waive any Insurer rights or requirements; or (c) waive any information the Insurer requests.

I represent: (1) the statements and answers given in the application are true, complete, and correctly recorded to the best of my knowledge and belief; and (2) the insurance being applied for is suitable for the Owner’s insurance needs.

I agree that: (1) I will notify the Insurer if any statement or answer given in 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.**

State in which Owner Signed Application

State in which Policy will be Delivered

Signature of Proposed Insured

Date

Owner (if not Proposed Insured: Signature and any Title)

Signature of Licensed Insurance Agent

Signature of Licensed Insurance Agent

Licensed Insurance Agent’s Printed Name

Licensed Insurance Agent’s Printed Name

Social Security No. License No. Managing Agency/
Brokerage No.

Social Security No. License No. Managing Agency/
Brokerage No.

1. Licensed Insurance Agent's Report (Not part of the Application)

a. Full Name (Please print)	b. Agent's Company Code No.*	c. SSN or Tax ID No.	d. Phone and FAX Numbers Phone: FAX:
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e. 1. Does the proposed insured have any existing life insurance or annuity? Yes No

2. Is this insurance applied for intended to replace, end or change any existing insurance or annuity? Yes No

If "Yes," to either question, replacement forms may be required by state law. Include copies of any required forms with the application. If existing insurance may be replaced, ended or changed, attach a full explanation to the application and explain to the Owner and Proposed Insured that new suicide and contestable periods may apply.

f. If you accepted money with this application, a Temporary Insurance Application and Agreement (TIAA) is required. Was a TIAA given? Yes No

g. Has a medical or paramedical exam been scheduled? If "Yes," give date and Provider with whom scheduled. Yes No

Date (Mo. Day Yr.): _____ Provider's Name: _____

h. If Proposed Insured is married, amount of insurance on spouse. If spouse is not insured, give reason.

Amount: \$ _____ Reason: _____

i. If Proposed Insured is a minor, amount of insurance on parents and any siblings. If parents and siblings are not insured, give reason.

Father	Mother	Siblings (Name and Amount)
\$ _____	\$ _____	_____

I represent that to the best of my knowledge and belief: (1) the insurance being applied for is suitable for the Owner's insurance needs and financial objectives; (2) the information provided in this report and by the Owner and Proposed Insured in the application is complete, accurate, and correctly recorded; and (3) there is nothing adversely affecting the insurability of the Proposed Insured other than as indicated in the application. I also represent that I gave all required form(s) on or before the date the application was taken.

Signature(s) of Licensed Insurance Agent(s)

Date

2. Managing Agency/Brokerage Report (Not part of the Application)

a. Managing Agency/Brokerage Name (Please print) e-mail: _____	b. Managing Agency/Brokerage No.	c. Date
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3. Licensed Insurance Agents to Receive Commission (Please print)

Complete for each licensed agent to receive commission.

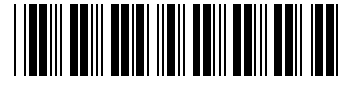
Total Commission Share(s) to equal 100%. Each licensed agent will share equally unless otherwise indicated.

a. Full Name, Address, and SSN or TIN (Please print)	e-mail: _____	b. Agent's Commission Share %	c. Agent's Company Code No.*
d. Full Name, Address, and SSN or TIN (Please print)	e-mail: _____	e. Agent's Commission Share %	f. Agent's Company Code No.*
g. Full Name, Address, and SSN or TIN (Please print)	e-mail: _____	h. Agent's Commission Share %	i. Agent's Company Code No.*
j. Full Name, Address, and SSN or TIN (Please print)	e-mail: _____	k. Agent's Commission Share %	l. Agent's Company Code No.*
m. Full Name, Address, and SSN or TIN (Please print)	e-mail: _____	n. Agent's Commission Share %	o. Agent's Company Code No.*

***The code number assigned by the Insurer selected in item 4.a. on Page 1 of the application.**



Temporary Insurance Application and Agreement (TIAA)



Affiliated Life Insurance Companies of GE Financial Assurance

First Colony Life Insurance Company (FCL) • General Electric Capital Assurance Company (GECA) • GE Life and Annuity Assurance Company (GE Life & Annuity)
700 Main Street • Lynchburg, VA 24504

Notice to Proposed Insured and Owner. Payment of the Amount Remitted may only be made at the same time that both the Application - Part I 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 the Insurer. Do not make it payable to the licensed insurance agent or leave the payee blank. Do not pay cash.**

Temporary Insurance Application (Answer all Questions.)

Insurer The Insurer designated in Section 4.a. of the Application - Part I. Yes No

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

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? Yes No
2. Is the Policy applied for a joint life insurance policy? Yes No
3. Does the total amount of insurance on the Proposed Insured's life in force with the Insurer under any policies, conditional receipts, or temporary insurance agreements exceed \$1,000,000? Yes No
4. In the past 90 days, has the Proposed Insured been admitted, or medically advised 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? Yes No
5. In the past 5 years, has the Proposed Insured had, been treated for, or been advised to be treated for, heart disease, stroke, cancer, or alcohol or drug dependence or abuse? Yes No
6. Has a medical physician diagnosed the Proposed Insured as having Hepatitis C or Acquired Immunodeficiency Syndrome (AIDS)? Yes No

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 above is answered "Yes" or left blank; (3) the answers given above are true to the best of my knowledge and belief, 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; and (5) I understand that the licensed insurance agent is not authorized to change or waive the terms of this TIAA.

Signature of Proposed Insured

Date of this TIAA

Signature of Owner (if other than Proposed Insured)

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 I upon receipt of due proof that the Proposed Insured died while temporary insurance was in effect. 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.

Limited Amount. The Limited Amount is the lesser of: (1) the Amount of Insurance applied for in the Application - Part I; and (2) \$1,000,000 minus the amount of any insurance on the Proposed Insured's life in force with the Insurer under any policies, conditional receipts, or 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 - 90 Day Maximum. Temporary insurance automatically ends on the Stop Date and the entire amount remitted will be returned without interest to or for the benefit of the Owner. The Stop Date is the earliest of the following: (1) the date the Owner withdraws the application; (2) 45 days after the Start Date if the Insurer has **not** received a properly completed and signed Application Part II – Medical History and all medical examinations and tests required by the Insurer as set forth in its Initial Submission Guidelines; (3) the date the Owner refuses to accept any policy issued or offered; (4) the date the Insurer sends notice to the Owner at the address shown in the Application - Part I that the Insurer has declined to issue insurance; and (5) 90 days after the Start Date.

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 Amount Remitted will be applied to the first modal premium for the policy. Upon policy delivery, the policy will replace this TIAA and coverage will continue under the policy without interruption.

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.

Licensed Insurance Agent's Statement

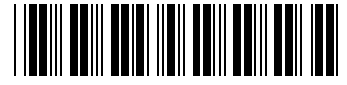
Amount Remitted \$

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 I. 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 the Copy with the Owner.



Temporary Insurance Application and Agreement (TIAA)



Affiliated Life Insurance Companies of GE Financial Assurance

First Colony Life Insurance Company (FCL) • General Electric Capital Assurance Company (GECA) • GE Life and Annuity Assurance Company (GE Life & Annuity)
700 Main Street • Lynchburg, VA 24504

Notice to Proposed Insured and Owner. Payment of the Amount Remitted may only be made at the same time that both the Application - Part I 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 the Insurer. Do not make it payable to the licensed insurance agent or leave the payee blank. Do not pay cash.**

Temporary Insurance Application (Answer all Questions.)

Insurer The Insurer designated in Section 4.a. of the Application - Part I. Yes No

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

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? Yes No
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3. Does the total amount of insurance on the Proposed Insured's life in force with the Insurer under any policies, conditional receipts, or temporary insurance agreements exceed \$1,000,000? Yes No
4. In the past 90 days, has the Proposed Insured been admitted, or medically advised 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? Yes No
5. In the past 5 years, has the Proposed Insured had, been treated for, or been advised to be treated for, heart disease, stroke, cancer, or alcohol or drug dependence or abuse? Yes No
6. Has a medical physician diagnosed the Proposed Insured as having Hepatitis C or Acquired Immunodeficiency Syndrome (AIDS)? Yes No

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 above is answered "Yes" or left blank; (3) the answers given above are true to the best of my knowledge and belief, 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; and (5) I understand that the licensed insurance agent is not authorized to change or waive the terms of this TIAA.

Signature of Proposed Insured

Date of this TIAA

Signature of Owner (if other than Proposed Insured)

Temporary Insurance Agreement

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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.

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 I. 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 the Copy with the Owner.

Signature(s) of Licensed Insurance Agent(s)
Form No. GEFA-599 (TIAA)

COPY Give to the Owner only if payment is made at the time the Application – Part I is signed.

Licensed Insurance Agent Number(s)

4/2001
Page 6

Electronic Fund Transfer Authorization (EFT)



First Colony Life Insurance Company (FCL) • General Electric Capital Assurance Company (GECA)
700 Main Street • Lynchburg, VA 24504

Instructions

- **Complete this form and attach a void check from your checking account. Keep a copy of the form for your records.**

Insurer (Select only one.) <input type="radio"/> FCL <input type="radio"/> GECA	Name of Account Owner (as shown on account)	<input type="checkbox"/> Check this box to ONLY draft for renewal premiums
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Account No.	Name of Financial Institution
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Premium Payment Frequency (check the appropriate box below)

- Monthly** (initial draft will be 2 monthly premiums) **Quarterly** **Semi-annually** **Annually**

Non-annual payment frequencies include an additional cost, and the premiums you pay each year will be higher than the annual premium paid at the beginning of the policy year.

Amount of Authorized Draft Per Frequency \$	Policy or Application Number	Insured's Name
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Authorization

As a convenience to me, I authorize the Insurer indicated above (the "Insurer") to make pre-authorized electronic fund withdrawals or other forms of pre-authorized check withdrawals from my account for my insurance premiums.

- I understand that, if a withdrawal request is not honored by the financial institution, Insurer will not consider that my premium has been paid.
- If any withdrawal request is not paid by the financial institution for any reason, Insurer may terminate this premium payment method and bill directly for premium payments.
- I may cancel this authorization at any time by giving Insurer prior written notification at the above address. Any notice hereunder shall not be deemed effective until the 15th business day after the Insurer receives notice.
- I may modify this authorization by authorizing Insurer to make preauthorized electronic fund transfers or other forms of check withdrawals from any other bank account or financial institution that I so designate either verbally, in writing or by such other methods as Insurer may permit. Any such non-written request will be confirmed by Insurer in writing.

Signature of Premium Payer (Account Owner)	Date
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Acknowledgement

- **Signing the EFT authorization does not mean that insurance is effective. Insurance is effective only as stated in (1) the application for insurance; or (2) the Temporary Insurance Application Agreement (TIAA) if one is properly issued in connection with the application.**
- The Insurer will promptly initiate payment of the initial premium only after (1) a completed and signed Application – Part 1 has been received by the Insurer and a TIAA has been properly issued, or (2) a Policy Delivery and Acknowledgement form and all requirements requested during delivery of any policy issued to the Owner are received by the Insurer and reviewed for proper dates and signatures.
- If a policy is issued, it may be issued at a premium rate different from the rate applied for. In such a case, Insurer will provide advance notice to the premium payer of the EFT premium amount before drafting future premiums if a TIAA is used. Thereafter, future premiums will be drafted on the day of the month corresponding with the policy's contract date (the date that the policy owner signs the Policy Delivery and Acknowledgment form or the date of the month that the TIAA is signed if one was submitted with the policy application).
- For coverage under the TIAA to be effective, the amount of the initial premium drafted must be equal to the first premium for the plan applied for on the payment frequency chosen or the first two if the payment frequency is monthly. (We will draft the Initial Premium once this form is received in our Home Office along with a TIAA and application).
- There is no coverage provided by Insurer if the initial premium EFT withdrawal is not honored (1) after a submission of the TIAA with the application; or (2) if no TIAA is used, after the policy is delivered and a Policy Delivery Acknowledgement Form and all requirements are received by the Insurer.
- The initial amount drafted will be returned to the above account if coverage provided by the TIAA ends as described in the TIAA Stop Date.

Signature of Policy Owner (if different than Premium Payer)	Date
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Remember to attach a void check to your completed form.

Electronic Fund Transfer Authorization (EFT)



First Colony Life Insurance Company (FCL) • General Electric Capital Assurance Company (GECA)
700 Main Street • Lynchburg, VA 24504

Instructions

- **Complete this form and attach a void check from your checking account. Keep a copy of the form for your records.**

Insurer (Select only one.) <input type="radio"/> FCL <input type="radio"/> GECA	Name of Account Owner (as shown on account)	<input type="radio"/> Check this box to ONLY draft for renewal premiums
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Account No.	Name of Financial Institution
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Premium Payment Frequency (check the appropriate box below)

- Monthly** (initial draft will be 2 monthly premiums) **Quarterly** **Semi-annually** **Annually**

Non-annual payment frequencies include an additional cost, and the premiums you pay each year will be higher than the annual premium paid at the beginning of the policy year.

Amount of Authorized Draft Per Frequency \$	Policy or Application Number	Insured's Name
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Authorization

As a convenience to me, I authorize the Insurer indicated above (the "Insurer") to make pre-authorized electronic fund withdrawals or other forms of pre-authorized check withdrawals from my account for my insurance premiums.

- I understand that, if a withdrawal request is not honored by the financial institution, Insurer will not consider that my premium has been paid.
- If any withdrawal request is not paid by the financial institution for any reason, Insurer may terminate this premium payment method and bill directly for premium payments.
- I may cancel this authorization at any time by giving Insurer prior written notification at the above address. Any notice hereunder shall not be deemed effective until the 15th business day after the Insurer receives notice.
- I may modify this authorization by authorizing Insurer to make preauthorized electronic fund transfers or other forms of check withdrawals from any other bank account or financial institution that I so designate either verbally, in writing or by such other methods as Insurer may permit. Any such non-written request will be confirmed by Insurer in writing.

Signature of Premium Payer (Account Owner)	Date
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Acknowledgement

- **Signing the EFT authorization does not mean that insurance is effective. Insurance is effective only as stated in (1) the application for insurance; or (2) the Temporary Insurance Application Agreement (TIAA) if one is properly issued in connection with the application.**
- The Insurer will promptly initiate payment of the initial premium only after (1) a completed and signed Application – Part 1 has been received by the Insurer and a TIAA has been properly issued, or (2) a Policy Delivery and Acknowledgement form and all requirements requested during delivery of any policy issued to the Owner are received by the Insurer and reviewed for proper dates and signatures.
- If a policy is issued, it may be issued at a premium rate different from the rate applied for. In such a case, Insurer will provide advance notice to the premium payer of the EFT premium amount before drafting future premiums if a TIAA is used. Thereafter, future premiums will be drafted on the day of the month corresponding with the policy's contract date (the date that the policy owner signs the Policy Delivery and Acknowledgment form or the date of the month that the TIAA is signed if one was submitted with the policy application).
- For coverage under the TIAA to be effective, the amount of the initial premium drafted must be equal to the first premium for the plan applied for on the payment frequency chosen or the first two if the payment frequency is monthly. (We will draft the Initial Premium once this form is received in our Home Office along with a TIAA and application).
- There is no coverage provided by Insurer if the initial premium EFT withdrawal is not honored (1) after a submission of the TIAA with the application; or (2) if no TIAA is used, after the policy is delivered and a Policy Delivery Acknowledgement Form and all requirements are received by the Insurer.
- The initial amount drafted will be returned to the above account if coverage provided by the TIAA ends as described in the TIAA Stop Date.

Signature of Policy Owner (if different than Premium Payer)	Date
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Remember to attach a void check to your completed form.

Authorization for Payment of Initial Premium by Credit Card



First Colony Life Insurance Company (FCL) • General Electric Capital Assurance Company (GECA)
700 Main Street • Lynchburg, VA 24504

Instructions

- Credit Card not available in AK, CA, MD, NC, NJ and PA. Only applicable for Colony and Sure Term® term life insurance.
- Select the appropriate Insurer and enter the name of the Proposed Insured.
- Indicate the amount of Initial Premium. It must at least equal the first modal premium or first two if paying monthly.
- Sign and date this Authorization and return it.

Insurer (Select only one.) <input type="radio"/> FCL <input type="radio"/> GECA	Name of Proposed Insured
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Amount of Initial Premium: \$ _____ (Must at least equal first modal premium or first two if paying monthly.)

Credit / Debit Card (Visa or MasterCard only. Select one: Visa MasterCard)

Name of Card Holder as Shown on Card _____

Card Number/Expiration Date - - / -

Billing Address of Card Holder (Street) _____ (City) _____ (State) _____ (Zip Code) _____

Authorization

I authorize the Insurer to collect the Initial Premium stated above by the Payment Method I have selected. I understand and agree that this Authorization is subject to the following conditions:

- **Signing this Authorization does not mean that insurance is effective. Insurance is effective only as stated in (1) the application for insurance; or (2) the Temporary Insurance Application and Agreement (TIAA) if one is properly issued in connection with the application.**
- Use of the selected Payment Method does not alter any provision of any policy issued by the Company.
- The Company will initiate payment of the Initial Premium only after (1) a completed and signed Application-Part 1 has been received by the Company and a TIAA or Conditional Receipt has been properly issued; or (2) all requirements requested during delivery to the Owner of any policy issued are received by the Company and reviewed for proper dates and signatures.
- If a policy is issued, it may be issued at a premium rate different from the rate applied for. If no TIAA is issued and the Initial Premium does not equal or exceed the first modal premium (first two if paying monthly) for the policy that is issued, the Company will not initiate payment, this authorization will be revoked, and no insurance will be effective.
- This Authorization pertains to payment of the initial premium only. No further premiums will be collected under this Authorization.
- Any refund of premium will be made directly to me or credited to my account.
- If the Payment Method selected is not honored upon presentation, this Authorization will not be effective as a premium payment; no insurance will be effective, and the Company will make no further attempts to use this Authorization to obtain payment of premium.
- This Authorization may be revoked by me upon written notice at any time prior to its use by the Company to obtain payment of the Initial Premium.

Signature of Premium Payer _____	Date _____
Signature of Policy Owner (if different) _____	Date _____



Notice to Proposed Insured and Owner

Affiliated Life Insurance Companies of GE Financial Assurance

First Colony Life Insurance Company (FCL) • General Electric Capital Assurance Company (GECA) • GE Life and Annuity Assurance Company (GE Life & Annuity)

700 Main Street • Lynchburg, VA 24504

Thank you for your application. We greatly appreciate your completing each part truthfully and accurately. This Notice tells you what to expect after completing the Application – Part I and provides other important information, including information required by state law and regulation. If you have any questions, please ask the soliciting licensed insurance agent (licensed agent). The licensed agent should gather information about your personal situation, insurable needs, and financial objectives and explain how the insurance recommendations are appropriate to fulfill those needs and objectives. When deciding insurance needs, consider the following: the losses you want to protect against; the kind of insurance; how long you will need the coverage; your future liquidity needs, e.g., college funding; your ability to pay the planned premium; taxes; and your other financial assets, e.g., Social Security, pension plans.

Policies Available Only in English

Our insurance applications, illustrations, disclosures and our insurance policies are available only in English. In addition, all of our servicing to our policyholders is only in English. You are responsible for fully understanding these English materials. We do not permit our insurance agents to translate these materials to a different language and you may not rely on any translation by our insurance agent.

What Happens Next

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 seek information from other sources to help us in our evaluation. During underwriting 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. For example, if you have ever used any kind of tobacco or other nicotine product, you may not be eligible for our lowest rate.

Physical Exam

Virtually all Proposed Insureds are required to take a physical exam. The exam is done by a qualified examiner and takes approximately 30 minutes. During the exam, you should expect the following: to provide your medical history; to be weighed and measured; to have an EKG (not always required); to provide a blood or saliva sample and a urine sample; to have your blood pressure and pulse taken.

Here are some of the ways you can help with the exam process:

- Schedule your exam within 24 hours after you complete the Application – Part I
- Have a list of the names and addresses of all licensed health care providers and facilities seen during the past 20 years and be prepared to provide reasons, dates and any treatments received as a result of those visits
- Do not eat or drink (except water) for 12 hours prior to your scheduled exam time
- Have a photo ID ready, e.g., driver's license, passport, or greencard

Other Important Information

Contestability

Because your application will be our primary source of information, we strongly urge you to review the completed application closely for accuracy. 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. A claim may be denied or your coverage may be contested by a lawsuit if the application is incomplete or if it contains false statements or misrepresentations. If the lawsuit is successful, the policy will be void and coverage will be lost. Any policy that is delivered to you will indicate when and under what circumstances it may be contested. In addition, you may be violating state law if you knowingly conceal material facts or submit an application that contains materially false information.

Replacement of Existing Coverage

If you have existing coverage, answer "yes" to this question in the application. If you intend to replace existing coverage, tell the licensed agent of your intention and answer "yes" to the replacement question in the application. State law may require the licensed agent 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, answer the replacement question "yes." Doing so 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. Stopping premium payments, surrendering, or borrowing from an existing policy as a result of applying for this policy could be considered replacement. State law may define replacement to include other situations. Ask the licensed agent if you are unsure about replacement.

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 Act**. 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 to see and copy 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 P.O. Box 461, Lynchburg, Virginia 24505-0461.

Premium Payments on Term and Excess Interest Whole Life

For premiums not paid on an annual basis at the beginning of a policy year, we adjust the annual premium by a modal factor to compensate for the lost investment earnings, additional administrative costs, and expected early lapses. These modal factors and associated APRs are available and will be provided. Ask the licensed agent for this information.

Federal Fair Credit Reporting Act

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. ("Mode of living" does not include information related directly or indirectly to your sexual orientation.) The agency will 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 within a reasonable time after you receive this Notice, 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.

MIB (Medical Information Bureau) Disclosure

We will treat the information regarding your insurability as confidential. We and our reinsurers may, however, make a brief report to the MIB, Inc. MIB, Inc. is a non-profit membership organization of life insurance companies. It operates an information exchange bureau on behalf of its members. If you apply to another member company for life, health, or disability insurance, or a claim for benefits is submitted to such a company, MIB, Inc., upon request, will supply that company with any information it may have in its file.

Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in that file, you may contact MIB, Inc. and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. To contact MIB, Inc., you may: write P.O. Box 105, Essex Station, Boston, MA 02112; phone toll free (866) 692-6901 (TTY 866 346-3642 for hearing impaired); or use the website <http://www.mib.com>.

We and our reinsurers may also release information in our files to other insurance companies to whom you may apply for life, health, or disability insurance or to whom a claim for benefits may be submitted.

Free Look Period

If we deliver a policy to you, you will have a brief period of time to examine the policy and, if you desire, to return the policy to us for a full refund of any premium you paid. This period – known as the "free look period" — is usually 20 days from our delivery of the policy to you, but it may be a slightly longer period in some states. To return the policy, simply mail or deliver the policy to the Company or any of its agents within the free look period for your state. The policy will then be made void from the beginning.

FRAUD WARNINGS

ARKANSAS and LOUISIANA

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information on an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

COLORADO

It is unlawful to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or insurance agent who knowingly provides false, incomplete, or misleading information for the purpose of defrauding or attempting to defraud a policy holder or claimant with regard to an insurance settlement shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

DISTRICT OF COLUMBIA

It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

FLORIDA

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

KENTUCKY

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

MAINE and TENNESSEE

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

NEW JERSEY

Any person who includes any false or misleading information on an application for an insurance policy, is subject to criminal and civil penalties.

NEW MEXICO

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information on an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

OHIO

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

PENNSYLVANIA

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.



Aviso al solicitante de seguro

Las compañías de seguro de vida afiliadas de Genworth Financial

First Colony Life Insurance Company (FCL) • General Electric Capital Assurance Company (GECA) • GE Life and Annuity Assurance Company (GE Life & Annuity)

700 Main Street • Lynchburg, VA 24504

Gracias por su solicitud. Apreciaremos que llene cada una de las partes de este formulario correctamente. Este Aviso indica lo que sucederá después de llenar la Solicitud — la Parte 1 proporciona información adicional importante, incluso la que requieren las leyes y los reglamentos estatales. Si tiene dudas, consulte con el agente de seguros autorizado solicitante (agente autorizado). El agente autorizado debe reunir información acerca de su situación personal, sus necesidades de seguros y sus objetivos financieros, y le explicará cómo las recomendaciones de seguro cumplen estas necesidades y objetivos. Al tomar decisiones sobre sus necesidades de seguro, tome en cuenta todo lo siguiente: las pérdidas contra las cuales desea contar con protección; el tipo de seguro; por cuánto tiempo necesitará la cobertura; sus necesidades futuras de fondos líquidos (p. ej.: para pagar la educación universitaria); su capacidad de pagar la prima; los impuestos; y los demás activos financieros, tales como el Seguro Social y los planes de jubilación.

Pólizas disponibles sólo en inglés

Nuestros formularios de solicitud, ilustraciones, información pública y nuestras pólizas de seguros están disponibles sólo en inglés. Además, todos los servicios que proporcionamos a nuestros asegurados se ofrecen sólo en inglés. Usted es responsable de comprender en su totalidad esta información que se le proporciona en inglés. No permitimos que nuestros agentes de seguros traduzcan estos materiales a distintos idiomas y usted no debe fiarse de ninguna traducción proporcionada por nuestros agentes.

Los próximos pasos

Evaluación

Una vez que recibamos su solicitud, empezaremos un proceso de evaluación para determinar si reúne los requisitos para el seguro y, en caso afirmativo, la tarifa que debe pagar por él. Puede que solicitemos información de otras fuentes para ayudar con la evaluación. Durante la evaluación, cabe la posibilidad de que descubramos que no podemos ofrecerle el seguro que ha solicitado, o que sólo podemos ofrecérselo en forma modificada o a una tarifa mayor que la tarifa más baja.

Por ejemplo, si alguna vez ha consumido cualquier clase de tabaco u otro producto con nicotina, posiblemente no califique para la tarifa más baja.

Examen físico

A casi todos los solicitantes de seguro se les requiere someterse a un examen físico. Este examen lo realiza una persona calificada para ello, y lleva aproximadamente 30 minutos. Durante el examen, puede que tenga que dar su historial médico; que se pese y se mida; que se le haga un EKG (electrocardiograma; no se requiere en todos los casos); que proporcione una muestra de sangre o de saliva y otra de orina; que se le tome la presión arterial y el pulso.

A continuación, se ofrecen sugerencias para que el examen se lleve a cabo sin problemas:

- Programe el examen dentro de las 24 horas después de llenar la Parte 1 de la Solicitud.
- Prepare una lista de los nombres y las direcciones de todos los proveedores y centros de servicios de salud autorizados a los que ha recurrido durante los últimos 20 años, y esté preparado para indicar los motivos de las visitas, las fechas y cualquier tratamiento recibido como resultado de ellas.
- No coma ni beba (salvo agua) durante las 12 horas previas al examen.
- Tenga a mano un documento identificativo con su foto (p. ej.: licencia para manejar, pasaporte o tarjeta verde)

Otros datos importantes

Disputabilidad

Debido a que su solicitud será nuestra fuente principal de información, le recomendamos que la revise con detenimiento para asegurarse de que sea correcta. Antes de aceptar una póliza, usted nos debe informar de cualquier cambio de respuesta en cualquier parte de la solicitud; de hecho, usted conviene en hacer esto al momento de firmar la solicitud. Si la solicitud no está completa o contiene declaraciones falsas o engañosas, puede ser motivo de que se rechace un reclamo o que se dispute su derecho a cobertura. Si la compañía de seguros prevalece en el litigio, la póliza quedará anulada y se perderá la cobertura. Cualquier póliza que se le entregue indicará cuándo y en qué circunstancias podrá ser disputada. Además, es posible que se encuentre en violación de leyes estatales si esconde a propósito hechos materiales o presenta una solicitud con información falsa.

Sustitución de la cobertura existente

Si ya tiene cobertura bajo otra póliza, responda "sí" a esta pregunta en la solicitud. Si desea sustituir a la cobertura existente, indique sus intenciones al agente autorizado y conteste "sí" a la pregunta que se trata de la sustitución de cobertura. Las leyes estatales pueden requerir que el agente autorizado le proporcione información que le ayude a comparar la póliza solicitada con la que desea sustituir. Si no está decidido acerca de conservar la cobertura que ya tiene, conteste "sí" a la pregunta de sustitución. Esto podría ayudarle a obtener la información necesaria para tomar una decisión. Si reemplaza a la cobertura existente, la nueva póliza podría especificar nuevos períodos de exención por suicidio y de disputabilidad. Si deja de pagar las primas de una póliza existente, o si recibe el valor de rescate de la misma o saca un préstamo de ella como resultado de solicitar esta nueva póliza, esto podría considerarse como una sustitución. La ley estatal podría definir el reemplazo para que también incluya otras situaciones. Si tiene dudas en cuanto al reemplazo, consulte con el agente autorizado.

Prácticas de información relacionadas con seguros

Dependeremos principalmente de la información que nos dé. Podemos obtener, además, otra información de otras fuentes, tales como los profesionales de cuidado de la salud que lo hayan tratado. En algunos casos podemos pedirle a una agencia de información sobre consumidores que recopilen información y que presenten un informe investigativo sobre el consumidor, tal como se explica en este Aviso bajo Federal Fair Credit Reporting Act (Ley sobre la garantía de equidad crediticia). Puede solicitar una entrevista con relación a la preparación de este informe.

En ciertas situaciones, la ley nos permite divulgar datos necesarios de carácter personal a terceros, sin que usted lo autorice de forma específica.

Tiene derecho a estar enterado de (y de ver y copiar, si así lo desea), elementos de información personal acerca de usted que figuran en nuestros archivos, incluso información que se encuentra en los informes investigativos sobre el consumidor. También tiene el derecho a procurar que se corrija cualquier información que considere incorrecta.

Si nos envía una solicitud escrita le enviaremos una explicación más detallada de nuestras prácticas relacionadas con la información. Envíe su solicitud a: P.O. Box 461, Lynchburg, Virginia 24505-0461.

Pago de primas sobre pólizas de seguro de vida a plazo fijo y completo con exceso de interés

En el caso de las primas que no se paguen anualmente al comienzo del año de la póliza, aplicamos un valor de ajuste a la prima para compensar los retornos de inversión perdidos, los costos administrativos adicionales y el vencimiento temprano de algunas pólizas. Estos factores de ajuste y las APR (tasas de interés anual) están disponibles y se le proporcionarán a petición.

Pídale esta información al agente autorizado.

Federal Fair Credit Reporting Act (Ley sobre la garantía de equidad crediticia)

Como parte de nuestra evaluación podemos pedir que se prepare un informe investigativo sobre el consumidor. Este informe lo preparará una entidad independiente, conocida como agencia de información sobre consumidores. El informe incluye, generalmente, información en cuanto a su carácter, reputación general, modo de vida y características personales. (El "modo de vida" no incluye información relacionada directamente con su orientación sexual.) Para obtener esta información la agencia realizará entrevistas personales con sus familiares, amistades, vecinos, colegas profesionales o de negocios, referencias financieras u otros que lo conozcan. Si nos escribe dentro un tiempo razonable después de que reciba este Aviso, le diremos si se solicitó un informe o no. Si se solicitó un informe, le indicaremos el nombre, la dirección y el número de teléfono de la agencia a la cual se hizo la solicitud. La agencia proporcionará, a petición, información en cuanto a la naturaleza y el alcance de su investigación. Si desea inspeccionar y recibir una copia del informe, lo puede hacer poniéndose en contacto con la agencia directamente.

Divulgación de información de la MIB (Agencia de información médica)

Respetaremos la confidencialidad de la información relativa a su asegurabilidad. No obstante, nosotros y nuestras compañías de reaseguro podrán presentar un breve informe a MIB, Inc., una organización sin fines de lucro constituida por compañías de seguro de vida. Esta empresa opera una agencia de intercambio de información en nombre de sus miembros. Si solicita un seguro de vida, salud o incapacidad a cualquier otra compañía miembro, o si se presenta un reclamo por beneficios a cualquiera de estas compañías, MIB, Inc. proporcionará, a solicitud de dicha compañía, cualquier información que tenga en sus archivos.

A petición de usted, MIB Inc. hará los arreglos necesarios para divulgarle cualquier información que tenga acerca de usted en sus archivos. Si duda de la exactitud de la información contenida en este archivo, podrá ponerse en contacto con MIB, Inc. y pedir una corrección de acuerdo con los procedimientos establecidos en la Federal Fair Credit Reporting Act. Para ponerse en contacto con MIB, Inc., diríjase por escrito a: P.O. Box 105, Essex Station, Boston, MA 02112; teléfono libre de cargo 1-866-692-6901 (1-866-346-3642 para déficit de audición); o vaya al sitio web <http://www.mib.com>.

Nosotros, así como nuestras compañías de reaseguro, también podemos proporcionar la información que se encuentra en nuestros archivos a otras compañías de seguro a las que solicite un seguro de vida, salud o incapacidad, o a las que presente un reclamo por beneficios.

Periodo de gracia

Cuando le entregamos una póliza, usted dispone de un breve periodo de tiempo para examinarla y, si lo desea, devolvérsela para obtener el reembolso completo pagado por la prima. Este periodo, conocido como "periodo de gracia," es por lo general de 20 días a partir de la fecha en que le entregamos la póliza. Sin embargo, en algunos estados puede que el periodo sea más largo. Para devolvérsela, envíela por correo postal o entréguela en la compañía o a cualquiera de sus agentes durante el periodo de gracia dentro de los límites fijados por su estado. La póliza se anulará desde el principio.

ADVERTENCIAS CONTRA EL FRAUDE

ARKANSAS y LOUISIANA

Cualquier persona que a sabiendas presente una reclamación falsa o fraudulenta para obtener pago por una pérdida o un beneficio, o que presente deliberadamente información falsa en una solicitud de seguro, comete un delito y puede estar sujeta a multas y penas de prisión.

COLORADO

Es ilegal proporcionar a sabiendas información falsa, incompleta o engañosa a una compañía de seguros con el propósito de defraudar o intentar defraudar a la compañía. Las sanciones pueden incluir prisión, multas, denegación del seguro e indemnización por daños civiles. Se deberá denunciar ante la División de Seguros de Colorado, en el Departamento de Agencias Reguladoras, a cualquier compañía de seguros o agente de seguros que a sabiendas proporcione información falsa, incompleta o engañosa con el propósito de defraudar o intentar defraudar a un asegurado o reclamante con respecto a la liquidación de un reclamo.

DISTRITO DE COLUMBIA

Constituye un delito proporcionar información falsa o engañosa a un asegurador con el propósito de defraudar al asegurador o a cualquier otra persona. Las sanciones incluyen prisión y/o multas. Asimismo, un asegurador podrá denegar los beneficios del seguro si el solicitante ha proporcionado información falsa que tenga relación importante con el reclamo.

FLORIDA

Cualquier persona que, a sabiendas y con intención de perjudicar, defraudar o engañar a una empresa aseguradora, presente una reclamación o una solicitud con información falsa, incompleta o engañosa, comete un delito grave en tercer grado.

KENTUCKY

Cualquier persona que, a sabiendas y con la intención de defraudar a una compañía de seguros u otra persona, presente una solicitud de seguro que contenga información falsa o que oculte, con fines engañosos, información con respecto a cualquier hecho importante, está cometiendo un fraude de seguros, lo cual constituye un delito.

MAINE y TENNESSEE

Es un crimen proporcionar a sabiendas información falsa, incompleta o engañosa a una compañía de seguros con el propósito de defraudar a dicha compañía. Las sanciones pueden incluir prisión, multas o la denegación de los beneficios del seguro.

NUEVA JERSEY

Cualquier persona que incluya información falsa o engañosa en una solicitud de póliza de seguro está sujeta a sanciones civiles y penales.

NUEVO MÉXICO

Cualquier persona que presente a sabiendas una reclamación falsa o fraudulenta para obtener pago por una pérdida o un beneficio, o presente deliberadamente información falsa en una solicitud de seguro, comete un delito y puede estar sujeta a multas civiles y sanciones criminales.

OHIO

Cualquier persona que presente una solicitud o un reclamo de seguro que contenga información falsa o engañosa, con la intención de defraudar o a sabiendas de que está facilitando un fraude contra un asegurador, comete fraude de seguros.

PENSILVANIA

Cualquier persona que, a sabiendas y con la intención de realizar un fraude a cualquier compañía de seguros u otra persona, presente una solicitud de seguro o una declaración de reclamo que contenga información falsa o que oculte, con fines engañosos, información con respecto a cualquier hecho importante está cometiendo un fraude de seguros, lo cual constituye un delito y puede implicar la aplicación de sanciones civiles y penales.

NOTICE AND CONSENT FOR HIV-RELATED TESTING

To evaluate your insurability, the Insurer indicated on this form (the Insurer) has requested that you provide a sample of your blood, oral fluid extracted from cheek and gum tissue, or urine for testing and analysis to determine the presence of human immunodeficiency virus (HIV) antibodies. By signing and dating this form you agree that this test may be done and that underwriting decisions will be based on the test result. A series of three tests will be performed by a licensed laboratory through a medically accepted procedure.

Pre-Testing Considerations

Many public health organizations have recommended that before taking an HIV-related test a person seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, prior to being tested.

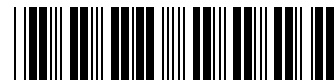
Meaning of Positive Test Result

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

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

Confidentiality of Test Results

All test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed as required by law or 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 Results

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 will receive written notification of such results from a physician you have designated or, in the absence of such designation, from the Texas Department of Health. Because a trained person should deliver that information so that you can understand clearly what the test result means, please 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 possible positive test result: _____

Address: _____

In the event the test is positive and you are denied coverage because of that fact and you request the reason for the denial, the Insurer may require you to name a physician at that time in order to receive the information.

If the test indicates a positive result, but you do not designate a private physician, the test results will be provided to you by a representative of the Texas Department of Health.

Consent

I have read and I understand this Notice and Consent for HIV-Related Testing. I voluntarily consent to the collection of a sample of blood, oral fluid extracted from cheek and gum tissue, or urine from me, the testing of that sample, and the disclosure of the test results as described above. I have read the information on this form about what a test result means.

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

First Colony Life Insurance Company
P.O. Box 320
Lynchburg, VA 24505-0320

Federal Home Life Insurance Company
Service Center, P.O. Box 466
Lynchburg, VA 24505-0466

GE Life and Annuity Assurance Company
P.O. Box 27601
Richmond, VA 23261-7601

Service Center, P.O. Box 6700
Lynchburg, VA 24505-6700

General Electric Capital Assurance Company
Service Center, P.O. Box 461
Lynchburg, VA 24505-0461



Summary of Premium Provisions for Indeterminate Premium Policies

First Colony Life Insurance Company

P.O. Box 320

Lynchburg, VA 24505-0320

During Guaranteed Premium Period

The insurance you have applied for is indeterminate premium insurance. The company guarantees that your Annual Premium will not change for the first _____ policy years. This is the Guaranteed Premium Period. The Annual Premium is the premium payable at the beginning of the Policy Year. If you chose non-annual premium payments, the total of those payments paid during the course of the Policy Year will exceed the Annual Premium. Please read the paragraph titled, "Non-annual Premium Payments."

After Guaranteed Premium Period

The Policy Schedule pages show two types of premiums for each Policy Year, an Annual Premium and a Maximum Annual Premium. After the Guaranteed Premium Period, the Annual Premium and the Maximum Annual Premium generally increase each Policy Year and these increases are shown on the Policy Schedule pages. The Annual Premium is the premium payable at the beginning of the Policy Year; however, the Annual Premiums shown on the policy schedule after the Guaranteed Premium Period are not guaranteed. The company may change the Annual Premium for any such Policy Year, but the company will never increase the Annual Premium to an amount greater than the Maximum Annual Premium for that year. If you chose to make non-annual premium payments, please read the paragraph titled, "Non-annual Premium Payments."

Other than the annual scheduled increases, which are due to your increasing age, any change in the Annual Premium will be due to the company's reevaluation of future investment earnings, mortality, persistency, expenses, and taxes with respect to the basic policy premium. The change will be applied uniformly to a class of insureds. Class may be determined by any or all of the following: (1) issue age and sex; (2) premium classification; (3) amount of insurance in force; or (4) the number of years the insurance has been in force. The Company will not change the Annual Premium more than once in a Policy Year.

Non-annual Premium Payments

The Annual Premium is the premium payment that is required to be paid in full, at the beginning of the Policy Year. Available non-annual premium payment modes are: semi-annual, quarterly and monthly. For premiums not paid on an annual basis at the beginning of the Policy Year, we adjust the corresponding Annual Premium by a modal factor to compensate for the lost investment earnings, expenses, taxes, and other administrative costs, as well as expected early lapses. **Therefore, your policy will cost more during the course of a Policy Year if you pay semi-annual, quarterly or monthly.** Modal factors and associated APRs are available and will be provided in your policy if one is issued. During the Guaranteed Premium Period, premiums paid on a non-annual premium payment mode will exceed the Maximum Annual Premiums shown in the Policy Schedule. After the Guaranteed Premium Period, premiums paid on a non-annual premium payment mode may exceed the Maximum Annual Premiums shown in the Policy Schedule.

I understand that after the Guaranteed Premium Period, the premiums I will pay for this insurance are subject to change as described above. I also understand that the Annual Premiums will never exceed the Maximum Annual Premiums but that semi-annual, quarterly, or monthly premiums paid during the course of a Policy Year will exceed the Maximum Annual Premium during the level guarantee period and may exceed the Maximum Annual Premium after the Guaranteed Premium Period.

Date

Signature of Owner



Disclosure Statement For Accelerated Death Benefit Rider

First Colony Life Insurance Company
Home Office: P.O. Box 320
Lynchburg, Virginia 24505-0320

RIDER BENEFIT

This Rider provides for the early payment of part of the Policy's death benefit. We will make this accelerated death benefit payment to the Owner of the Policy upon receiving proof that the Insured's life expectancy does not exceed six months.

The Owner may make only one request for an accelerated payment. We must receive written approval from any irrevocable beneficiary, as well as the full release of any collateral assignment of the Policy, before making any payment.

There is no premium or cost of insurance charge for this Rider.

CONSEQUENCES OF RECEIVING ACCELERATED DEATH BENEFIT PAYMENT

An accelerated death benefit payment may be considered taxable income. A payment may also adversely affect the recipient's eligibility for Medicaid benefits or other state or federal government benefits or entitlements. The Owner should contact a qualified tax advisor and the appropriate government agencies before electing to receive a payment.

AMOUNT OF BENEFIT AVAILABLE

The Owner requests the amount of accelerated death benefit. Generally, the maximum amount available is the lesser of (1) and (2) where (1) is the loan value of the Policy plus 75% of the difference between the death benefit of the Policy and the loan value and (2) is \$500,000. The maximum amount available can vary by state, however, and is defined by the Rider.

We will discount the accelerated death benefit based on a life expectancy of six months, adjust for any outstanding policy loan, and deduct an administrative fee prior to payment to the Owner.

EFFECT OF AN ACCELERATED DEATH BENEFIT PAYMENT

The death benefit, any policy values (including any loan value or policy loan), and any nonforfeiture values for the Policy will be reduced as a result of an accelerated death benefit payment. See the illustration on the back of this Statement.

Premiums for the Policy will be recalculated based on the reduced death benefit and will remain payable.

ACKNOWLEDGEMENT

I acknowledge that: (a) I have received and read this Disclosure Statement, including the sample illustration on the back, and (b) I understand that only the actual provisions of the Rider will control payment of an accelerated death benefit.

Signature of (Proposed) Insured

Date

Signature of Owner (if different)

Date

Signature of Broker

Date

Below is a sample illustration of the effect of an accelerated death benefit payment. This illustration shows the effect on the death proceeds immediately after the accelerated death benefit payment has been made.

This sample illustration assumes: (1) \$500,000 death benefit; (2) \$100,000 loan value; (3) \$105,000 cash value; (4) no policy loans; (5) the maximum accelerated death benefit is elected; (6) the discount interest rate is 8.00%; (7) the policy loan interest rate is 8.00%; and (8) \$5,000 annual premium.

Sample Illustration

Before Accelerated Death Benefit Payment:

Death Benefit		\$	500,000
less: Loan Value		\$	100,000
		\$	400,000
			x 75%
		\$	300,000
plus: Loan Value		\$	100,000
Maximum Accelerated Death Benefit Available		\$	400,000

Immediately After Payment of Accelerated Death Benefit:

Amount of Accelerated Death Benefit		\$	400,000
less: Discount		\$	15,100
less: Administrative Fee		\$	250
Amount Paid to Owner		\$	384,650

Accelerated Death Benefit Factor = .2 {1 - (400,000/500,000)}

New Death Benefit (Payable at Insured's Death)	\$	100,000	(\$500,000 - \$400,000)
New Loan Value	\$	20,000	(\$100,000 x .2)
New Cash Value	\$	21,000	(\$105,000 x .2)
New Premium	\$	1,000	(\$ 5,000 x .2)



Authorization for Release of Health-Related Information

Members of the GE Financial family of companies

- First Colony Life Insurance Company**
Service Center, P.O. Box 320 • Lynchburg, VA 24505-0320
- GE Life and Annuity Assurance Company**
Service Center, PO Box 6700 • Lynchburg, VA 24505 6700
- Federal Home Life Insurance Company**
Service Center, P.O. Box 466, Lynchburg, VA 24505-0466
- General Electric Capital Assurance Company**
Service Center, P.O. Box 461 • Lynchburg, VA 24505-0461

This authorization complies with the HIPAA Privacy Rule

Name of proposed insured/patient (please print)	Date of birth
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Authorization

This Authorization for Release of Health-Related Information to the Life Insurer

Life Insurer

First Colony Life Insurance Company, Federal Home Life Insurance Company, General Electric Capital Assurance Company, or GE Life and Annuity Company as shown above

Protected Health Information

Protected Health Information is my entire medical record and other health information. It includes information such as: the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection, sexually transmitted diseases and mental illness; and the use of alcohol, drugs, and tobacco. It excludes psychotherapy notes.

My Providers

My Providers are: any health plan; physician; health care professional; hospital; clinic; laboratory; pharmacy; medical facility; or other health care provider that has provided payment, treatment or services to me or on my behalf.

I authorize My Providers to disclose my Protected Health Information to the Life Insurer and its agents, employees and representatives.

By signing below: 1) I acknowledge that any agreements I made that restrict my Protected Health Information do not apply to this Authorization; and 2) I instruct My Providers to release and disclose my Protected Health Information without restriction.

This Protected Health Information is to be disclosed under this Authorization so that the Life Insurer may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or provide coverage and benefits; 4) administer coverage; and 5) conduct other activities that are allowed or required by law and relate to any coverage I have or have applied for with the Life Insurer.

This Authorization shall remain in force for 30 months following the date below. A copy of this Authorization is as valid as the original. I understand that: 1) I have the right to revoke this Authorization in writing, at any time, by sending a written notice to the Life Insurer at 3100 Albert Langford Drive, Lynchburg, VA 24501, Attention: Privacy Official; and 2) written revocation is not effective if any of My Providers has relied on this Authorization or if the Life Insurer has a legal right to contest a claim under an insurance policy or to contest the policy itself. I also understand that any Protected Health Information disclosed pursuant to this Authorization may be redisclosed and no longer covered by the 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 to release my Protected Health Information, the Life Insurer may not be able to perform the underwriting necessary to process my life insurance application. I acknowledge that I have received a copy of this Authorization.

Signature of Proposed Insured/Patient or Personal Representative	Date
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Description of Personal Representative's Authority or Relationship to Patient
