



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

Agent Contact Information

Agent ID _____ Agent Name (print) _____

Agent Email _____ Agent Phone _____ Agent FAX _____

Point of Sale (POS) Interview

(A policy cannot be placed without a POS Interview)

Was a Point of Sale (POS) Interview completed? Date _____ Approximate time _____

Were you present? **YES** **NO**

If Unable to Contact the Interview Operation Center:

Did you leave on the POS message machine:

	YES	NO	
Insured Name	<input type="checkbox"/>	<input type="checkbox"/>	
Insured Phone No.	<input type="checkbox"/>	<input type="checkbox"/>	
Best Time to Call	<input type="checkbox"/>	<input type="checkbox"/>	
Agent ID	<input type="checkbox"/>	<input type="checkbox"/>	

OR

Did you ask the insured to contact the interviewer at 1-866-397-9468 and leave your agent ID with the insured? **YES** **NO**

Common Errors to Avoid *(Please check all that are applicable)*

- The Agreement/Authorization is complete with City, State and dated and all parties signatures.
- Insured and owner sections completed including SS#
- Beneficiary is listed
- The plan of insurance, mode of payment and policy face amount is completed
- All correspondence should have your Monumental assigned Agent ID and printed agent name.

Be sure you have requested an appointment with Monumental Life Insurance (Website: www.monlifeimo.com)
All Monumental Forms are available on the website.

Insured Data *(When sending a check separately)*

Insured Name (Print exactly as on application) _____
 Last four digits of Insured SS# _____ Amount of 1st premium check accompanying this cover sheet _____

EFT is Only Available on MONTHLY mode. Will the check for payment be the EFT account? **YES** **NO**

 Did you attach a void check where indicated on application?

Submitting Application to Monumental

If the application was faxed to 1-866-721-3097, enter date faxed _____
 Remember to send the first premium with cover sheet. Mail to:

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



Agent ID #	State Application Taken	Policy # (H.O. Use Only)
------------	-------------------------	--------------------------

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

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

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

Part B1 - If Any Question In This Section Is Answered "Yes", The Proposed Insured Is Not Eligible For Any Coverage.			
1	Is the Proposed Insured hospitalized, bedridden, residing in a nursing home or long term care facility, receiving hospice or home health care, confined to a wheelchair, been advised or planning to have inpatient surgery or currently waiting for an organ transplant?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2	Has the Proposed Insured ever:		
	a) Been diagnosed with, been treated for or advised to receive treatment for Alzheimer's disease, senile dementia, organic brain disease, mental incapacity, Lou Gehrig's disease (ALS), Downs Syndrome, Huntington's disease, sickle cell anemia, Spina Bifida not surgically corrected, cystic fibrosis, cerebral palsy or any terminal medical condition?	<input type="checkbox"/>	<input type="checkbox"/>
	b) Tested positive for the antibodies to the AIDS (HIV) virus or been medically diagnosed with or received treatment for HIV, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	<input type="checkbox"/>	<input type="checkbox"/>
	c) Been in a diabetic coma or had or been advised to have an amputation due to disease or disorder?	<input type="checkbox"/>	<input type="checkbox"/>
3	Within the past 2 years has the Proposed Insured undergone testing by a medical professional for which the results have not been received?	<input type="checkbox"/>	<input type="checkbox"/>
4	Has the Proposed Insured been diagnosed with, been treated for or advised to receive treatment for diabetes (other than gestational diabetes) before the age of 18?	<input type="checkbox"/>	<input type="checkbox"/>
5	Within the past 4 years has the Proposed Insured been diagnosed with, been treated for or advised to receive treatment for cancer (other than basal cell carcinoma)?	<input type="checkbox"/>	<input type="checkbox"/>
6	Within the past 1 year has the Proposed Insured:		
	a) Used illegal drugs or been diagnosed with, been treated for or advised to receive treatment for alcohol abuse or drug abuse?	<input type="checkbox"/>	<input type="checkbox"/>
	b) Been treated for or advised to receive treatment for cirrhosis, hepatitis B or C or other liver disease?	<input type="checkbox"/>	<input type="checkbox"/>
	c) Been diagnosed with, been treated for or advised to receive treatment for heart attack, stroke (CVA), transient ischemic attack (TIA), aneurysm, angina, or had or been advised to have heart surgery of any kind including bypass surgery or pacemaker implant?	<input type="checkbox"/>	<input type="checkbox"/>
	d) Used oxygen to assist in breathing due to a disease or disorder?	<input type="checkbox"/>	<input type="checkbox"/>
	e) Received kidney dialysis or been diagnosed with, been treated for or advised to receive treatment for kidney failure due to a disease or disorder?	<input type="checkbox"/>	<input type="checkbox"/>
	f) Been diagnosed with, been treated for or advised to receive treatment for muscular dystrophy?	<input type="checkbox"/>	<input type="checkbox"/>
	g) Had more than 12 seizures?	<input type="checkbox"/>	<input type="checkbox"/>
	h) Been diagnosed with, been treated for or advised to receive treatment for congestive heart failure?	<input type="checkbox"/>	<input type="checkbox"/>

Last Name and Last 4 Digits of SSN: _____

Agent's Report

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

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

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

Agent Signature _____

AGREEMENT / AUTHORIZATION

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

I have received the M.I.B. Disclosure Notification, Notice to Persons Applying For Insurance, Accelerated Death Benefit Disclosure and Conditional Receipt. I hereby authorize any licensed physician, medical practitioner, or the Medical Information Bureau or other institution that has any records or knowledge of the Proposed Insured's medical history to give any such information to the life insurance company. A photocopy or facsimile of this authorization shall be made as valid as the original. This authorization expires 26 months from its date.

Signed at City _____ State _____

Proposed Insured Signature _____

Date _____

Owner Signature _____
(If Owner other than Insured)

Witness _____
(Agent Signature)

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

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

NOTICE TO PERSONS APPLYING FOR INSURANCE

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

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

MONUMENTAL LIFE INSURANCE COMPANY
Two East Chase Street, Baltimore, Maryland 21202

M.I.B. DISCLOSURE NOTIFICATION

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

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is: Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660.

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

CONDITIONAL RECEIPT

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

Conditions of Coverage

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

Effective Date

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

A05402

ACCELERATED DEATH BENEFIT RIDER DISCLOSURE

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

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

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

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

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

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

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

Acknowledgement:

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

Date

Owner's Signature

Agent's Signature