



# 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

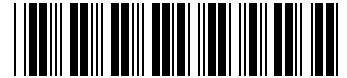
- ▶ Give the *Notice to Proposed Insured and Owner* to the Proposed Insured or Owner before completing the application.
- ▶ Make sure that the circle for the appropriate Insurer is marked in item 4.a. on Page 1.
- ▶ Ask all questions and fully and accurately record all answers given — the application 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

a. Insurer:  FCL  GECA  GE Life & Annuity  
(Select one)

b. Plan of Insurance:

c. Amount of Insurance: \$

## 5. Death Benefit Option (Universal Life only)

Level (Specified Amount only)

Increasing (Specified Amount plus cash value)

Scheduled Increases (if available):  
 Simple \_\_\_\_\_%  Compound \_\_\_\_\_%

## 6. Riders (If available with Plan)

Waiver

Children's Term Ins.: Units

Other (Amount and Description):

## 7. Premiums

a. Payment Method:  Pre-Arranged Withdrawal (PAW)  Direct Bill  Other (Specify):

b. Payment Mode:  Monthly (PAW only)  Quarterly  Semiannual  Annual  Single

c. Automatic Premium Loan:  Yes  No (if available)

d. Send Premium Notices to:  Insured (Section 1.f.)  Owner (Section 2.a.)  Other (Specify):

e. Premium Source:  Salary  Investments  Savings  Gifts/Inheritance  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.

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

**ORIGINAL** Return with the application and the payment.  
Licensed Insurance Agent Number(s)

4/2001  
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# 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

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## 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.

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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

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

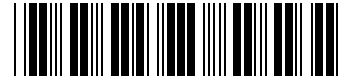
**COPY** Give to the Owner only if payment is made at the time the Application – Part I is signed.

Licensed Insurance Agent Number(s)

4/2001  
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# Pre-Arranged Withdrawals Authorization (PAW)



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. Instructions: Please complete this form and attach a void check or deposit slip from your account.**

Insurer (Select only one):

- FCL
- GECA
- GE Life & Annuity

Proposed Insured

**2. Account Information**

a. Name of Account Holder (as shown on Account)

b. Account Identification Number

c. Kind of Account

d. Name of Financial Institution

**3. Premium Payment Frequency: Please indicate premium payment frequency by checking the appropriate box.**

- Monthly
- Quarterly
- Semi-annually
- Annually

**Non-annual payment frequencies include an additional cost; therefore, your yearly premium cost will be higher if you choose to pay more frequently than annually.**

I authorize the Insurer to initiate withdrawals against the account identified in item 2. above. I understand and agree that this Authorization is subject to the following conditions:

- (1) It will be effective only after the first premium (first two premiums if premium payment frequency chosen is Monthly) has been paid by check or money order.
- (2) If any withdrawal request is not paid upon presentation, the Insurer may terminate this premium payment method and bill directly for premium payments. Please be aware that if any premium due remains unpaid, the policy will terminate subject to its terms.
- (3) The payment of premiums under this plan may be discontinued by the Insurer or the undersigned upon thirty (30) days written notice to the other.

Authorized Signature of Premium Payor

Date

**Remember to attach a void check or deposit slip to your completed form.**



# 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.

## 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 green card

## 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 (617) 426-3660; 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.

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## **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**

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.

# Acknowledgment (in lieu of illustration)



Affiliated Life Insurance Companies of GE Financial Assurance

**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      Service Center, P.O. Box 6700  
Richmond, VA 23261-7601      Lynchburg, VA 24505-6700

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

## Applicant/Owner Acknowledgment Section

I acknowledge that no illustration was provided for the policy I applied for. I understand that an illustration for any policy issued will be provided no later than at the time that policy is delivered.

I acknowledge that I viewed a computer screen illustration based on the information as stated below. No hard copy of the illustration was furnished. I understand that an illustration conforming to the policy as issued will be provided to me no later than at the time the policy is delivered. [In Washington, an illustration conforming to the policy as displayed on the computer screen also will be provided.]

1. Gender: Male <input type="radio"/> Female <input type="radio"/>	2. Age/Date of Birth	3. Underwriting/rating class
4. Type of policy (generic name, form no.)		
5. Type of rider (Include generic name, company name and form number)		
6. Initial death benefit	7. Premiums (amount and years payable)	8. Number of policy years illustrated
9. Guaranteed interest rate(s)		10. Non-guaranteed interest rate(s)
11. Dividend option election (or application of non-guaranteed elements, if applicable)		

Applicant's/Owner's signature	Date
Applicant's/Owner's Name (print)	Social Security Number

## Agent/Broker Certification Section

I certify that I displayed a computer screen illustration for (product name) \_\_\_\_\_ that complies with state requirements and for which no hard copy was furnished. The illustration was based on the above personal and policy information.

I certify that no illustration was provided for the policy applied for.

Agent/Broker's signature	Date
Agent/Broker's Name (print)	Broker Code No.

## **NOTICE AND CONSENT FOR TESTING WHICH MAY INCLUDE AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING**

To determine your insurability, the Insurer indicated on this form (the Insurer) has requested that you provide a sample of your blood, oral fluid or urine for testing and analysis. All tests will be performed by a licensed laboratory.

The consent you give by signing this form authorizes the Insurer to withdraw a blood sample, collect oral fluid or urine samples, and order laboratory tests only in regard to your present application for insurance. In order to perform all testing procedures, it may be necessary for you to provide more than one of these body fluid samples.

Unless precluded by law, tests may be performed to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. The HIV test that we perform is actually a series of tests done by a medically accepted procedure. These tests are extremely reliable, utilizing two ELISA tests followed by a Western Blot test to confirm positive results. Testing will proceed according to the following protocol:

1. If the initial ELISA test is negative, a negative finding will be reported to the Insurer.
2. If the initial ELISA test is positive, it will be repeated.
  - (A) If the second ELISA test is also positive, a Western Blot test will be performed to confirm the positive results of the two ELISA tests.
  - (B) If the second ELISA test is negative, a third ELISA test will be performed. If the third ELISA test is positive, a Western Blot test will be performed to confirm the previous positive results. If the third ELISA test is negative, a negative result will be reported to the Insurer.
3. Only if at least two ELISA tests and a Western Blot test are all positive will the result be reported as a positive.

Other tests to determine blood cholesterol and related lipids (fats) and screening for liver or kidney disorders, diabetes, immune disorders, and any other condition affecting your insurability may be performed.

Positive HIV antibody or antigen test results do not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions.

Federal authorities say that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others.

If your HIV test results are normal, no routine notification will be sent to you. If the HIV test results are other than normal, the Insurer will contact a licensed physician designated by you. You may identify the physician in the space provided on this form. The Insurer may also contact you if there are other abnormal test results which, in the Insurer's opinion, are significant.

All test results and medical information will be treated confidentially. There will be no disclosure of testing results, or medical information, except as required by law or as authorized by you.



You authorize, in connection with insurance you have or have applied for with the Insurer, the disclosure of test results to others involved solely in the underwriting process such as Insurer's affiliates, reinsurers, employees or contractors. If the Insurer is a member of the Medical Information Bureau (MIB, Inc.), and if the test result for HIV antibodies/antigens is other than normal, the Insurer will report to the MIB, Inc., a generic code which signifies only a non-specific test abnormality. If the test result is normal, no report will be made about it to the MIB, Inc. Other test results may be reported to the MIB, Inc., in a more specific manner. Test results may be maintained in a file or a data bank.

Positive HIV antibody or antigen test results or other significant test result abnormalities 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.

I have read and I understand this Notice and Consent For Testing Which May Include HIV Antibody/Antigen Testing. I voluntarily consent to the withdrawal of a blood sample from me, the collection of oral fluid or urine samples, the testing of those samples, and the disclosure of the test results as described.

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.

\_\_\_\_\_  
 Proposed Insured (Please Print) \_\_\_\_\_  
 Date of Birth

Name and address of designated Physician:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 Signature of Proposed Insured or Parent/Guardian \_\_\_\_\_  
 Date \_\_\_\_\_  
 State of Residence

- |   |   |
|---|---|
| <input type="radio"/> <b>First Colony Life Insurance Company</b><br>P.O. Box 320<br>Lynchburg, VA 24505-0320    | <input type="radio"/> <b>Federal Home Life Insurance Company</b><br>Service Center, P.O. Box 466<br>Lynchburg, VA 24505-0466        |
| <input type="radio"/> <b>GE Life and Annuity Assurance Company</b><br>P.O. Box 27601<br>Richmond, VA 23261-7601 | <input type="radio"/> <b>General Electric Capital Assurance Company</b><br>Service Center, P.O. Box 461<br>Lynchburg, VA 24505-0461 |
| <input type="radio"/> <b>Service Center, P.O. Box 6700</b><br>Lynchburg, VA 24505-6700                          |   |

## LISTING OF CALIFORNIA AIDS COUNSELING RESOURCES EARLY INTERVENTION PROJECTS/CENTERS

Following is a list of counseling resources where you can obtain assistance in understanding the meaning of the HIV antibody/antigen testing and the test results.

### **ALAMEDA COUNTY**

Fairmont Hospital  
15400 Foothill Boulevard  
**San Leandro, CA 94578**

(510) 667-3937  
FAX (510) 667-4400

Operating Hours: M/Tu/W/Th/F – 8am to 5pm  
Contact Person: Project Director – Raygenia Stewart-Budd

(510) 271-4229

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### **ALAMEDA/CONTRA COSTA COUNTIES**

SisterCare  
Women's Early Intervention Center  
3000 Colby Street, #206  
**Berkeley, CA 94705**

(510) 204-2700  
FAX (510) 549-2673

Operating Hours: M/Tu/W/Th/F – 9am to 5pm  
Contact Person: Project Director – Gay Calhoun

(510) 204-2700

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### **BUTTE/GLENN/SHASTA/TEHAMA/TRINITY COUNTIES**

Butte County Department of Public Health  
695 Oleander Avenue  
**Chico, CA 95926**

(530) 895-6562  
FAX (530) 891-2873

Operating Hours: M/Tu/W/Th – 8am to 5:30pm  
Contact Person: Project Director – Carmen Ochoa

(530) 895-6545

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### **FRESNO COUNTY**

Fresno County Health Services Agency  
1221 Fulton Mall  
**Fresno, CA 93775**

(209) 445-3434  
FAX (209) 445-3535

Operating Hours: M/Tu/W/Th/F – 8am to 5pm  
Contact Person: Project Director – Alan Gilmore

(209) 445-3434

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### **HUMBOLDT/DEL NORTE COUNTIES**

Humboldt County Department of Public Health  
North Coast AIDS Project  
529 "I" Street  
**Eureka, CA 95501**

(707) 268-2132  
FAX (707) 445-6097

Operating Hours: M/Tu/W/Th/F – 8:30am to 5pm  
Contact Person: Project Director – Peggy Falk

(707) 268-2142

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**KERN COUNTY**

Kern County Department of Public Health  
1700 Flower Street  
**Bakersfield**, CA 93305

(805) 868-0327  
FAX (805) 868-0263

Operating Hours: M/Tu/W/Th/F – 8am to 5pm  
Contact Person: Project Director – Veva Islas

(805) 868-0331

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**KINGS COUNTY**

Kings County Department of Public Health  
AIDS Care Program  
330 Campus Drive  
**Hanford**, CA 93230

(209) 584-1401  
FAX (209) 582-0927

Operating Hours: M/Tu/W/Th/F – 8am to 5pm  
Contact Person: Project Director – Barbara Van Baren

(209) 584-1401, Ext. 4531

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**LONG BEACH CITY**

Long Beach Department of Health & Human Services  
2525 Grand Avenue, Room 204  
**Long Beach**, CA 90815

(562) 570-4317  
FAX (562) 570-4033

Operating Hours: M/Tu/W/Th/F – 8am to 5pm  
Contact Person: Project Director – Patrick Burkhardt

(562) 570-4328

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**LOS ANGELES COUNTY**

Los Angeles County Health Department  
3209 North Alameda, Suite K  
**Compton**, CA 90222

(310) 761-8444  
FAX (310) 761-8448

Operating Hours: M/Tu/W/Th/F – 8am to 5pm  
Contact Person: Project Director – Deloris Pace

(310) 761-8444

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**WomensCare**

Women's Early Intervention Center  
1300 North Vermont, #401  
**Los Angeles**, CA 90027

(213) 662-7420  
FAX (213) 662-3910

Operating Hours: M/Tu/W/Th/F – 9am to 5:30pm  
Contact Person: Project Director – Lupe Carreon

(213) 662-7420

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**MADERA/MARIPOSA/MERCED COUNTIES**

Madera County Department of Public Health  
14215 Road 28  
**Madera**, CA 93638

(209) 675-7627  
FAX (209) 674-7262

Operating Hours: By Appointment  
Contact Person: Project Director – Anne Harris

(209) 675-7627

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**ORANGE COUNTY**

Orange County Health Care Agency  
1725 West 17th Street, Building 50  
**Santa Ana**, CA 92706

(714) 834-7991  
FAX (714) 834-7958

Operating Hours: M/W/Th/F – 8am to 4pm, Tu – 10am to 5:30pm  
Contact Person: Project Director – Karen Schneider

(714) 834-8406

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**PLUMAS/LASSEN/MODOC/SIERRA/SISKIYOU COUNTIES**

Plumas County Department of Health Services  
P.O. Box 3140  
586 Jackson Street  
**Quincy, CA 95971**

(530) 283-6113  
FAX (530) 283-6156

Operating Hours: Flexible, by appointment  
Contact Person: Project Director – Karla Burnworth

(530) 283-6257

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**RIVERSIDE COUNTY**

Riverside Neighborhood Health Center  
7140 Indiana Avenue  
**Riverside, CA 92507**

(909) 358-6005  
FAX (909) 358-6007

Operating Hours: M/Th/F – 8am to 5pm, Tu/W – 8am to 9pm  
Contact Person: Project Director – Victoria Jauregui

(909) 358-5307

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**SACRAMENTO COUNTY**

Center for AIDS Research, Education and Service (CARES)  
1500 21st Street  
**Sacramento, CA 95814**

(916) 443-3299  
FAX (916) 443-2438

Operating Hours: M/Tu/W/Th/F – 9am to 5pm  
Contact Person: Project Director – Robert Caulk

(916) 443-3299

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**SAN BERNARDINO COUNTY**

San Bernardino County Department of Public Health  
799 East Rialto Avenue  
**San Bernardino, CA 92415**

(909) 383-3060  
FAX (909) 387-6228

Operating Hours: M/Tu/W/Th/F – 8am to 5pm  
Chino EIP Clinic: F – 8am to 10:45am (Call (909) 383-3060 for appointment)  
Hesperia EIP Clinic: W/F – 8am to 10:45am (Call (909) 383-3060 for appointment)  
Contact Person: Project Director – Alex Taylor

(909) 387-6206

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**SAN DIEGO COUNTY**

Department of Health Services  
1700 Pacific Highway, Room 110  
**San Diego, CA 92101**

(619) 515-6655  
FAX (619) 515-6646

Operating Hours: M/Tu/W/Th/F – 8am to 4:30pm  
Contact Person: Project Director – Michelle Ginsberg, M.D.

(619) 515-6638

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**SAN FRANCISCO CITY/COUNTY**

La Clinica Esperanza  
Mission Neighborhood Health Center  
240 Shotwell Street (at 16th Street)  
**San Francisco, CA 94110**

(415) 431-3212  
FAX (415) 863-6384

Operating Hours: Office: M/Tu/W/Th/F – 9am to 6pm  
Clinic: M/Tu/W/Th – 12pm to 9pm, F – 9am to 6pm  
Contact Person: Project Director – Brenda Storey

(415) 552-1013, Ext. 203

**SAN LUIS OBISPO COUNTY**

San Luis Obispo County Health Agency  
2191 Johnson Avenue  
San Luis Obispo, CA 93401

(805) 781-5540  
FAX (805) 781-1154

Operating Hours: Flexible, call for appointment  
Contact Person: Project Director – Marsha Bollinger

(805) 781-4200

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**SAN MATEO COUNTY**

San Mateo County AIDS Program  
3700 Edison Street  
San Mateo, CA 94403

(650) 573-2385  
FAX (650) 573-2474

Operating Hours: M/Tu/W/Th/F – 8am to 5pm  
Contact Person: Project Director – Jonathan Mesinger

(650) 573-2587

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**SANTA BARBARA COUNTY**

AIDS Project Central Coast  
126 East Haley Street, Suite A-17  
Santa Barbara, CA 93101

(805) 681-5488  
FAX (805) 681-4782

Operating Hours: M/Tu/W/Th/F – 9am to 5pm, some evenings  
Contact Person: Project Director – Angela Antenore

(805) 681-5365

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**SANTA CLARA COUNTY**

Santa Clara County Health Department  
PACE Clinic  
2400 Moorpark Avenue, Suite 316  
San Jose, CA 95128

(408) 885-5935  
FAX (408) 885-4699

Operating Hours: Clinic – M – 8am to 8pm, Tu/W/Th/F – 8am to 5pm  
Contact Person: Project Director – Pat Cox

(408) 885-4693

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**SONOMA COUNTY**

Sonoma County Public Health Department  
499 Humboldt Street  
Santa Rosa, CA 95404

(707) 524-7400  
FAX (707) 524-7346

Operating Hours: Clinic – M/Tu/W/Th/F – 8:30am to 5pm  
Contact Person: Project Director – Pat Kuta

(707) 524-7379

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**TULARE COUNTY**

Tulare County Health & Human Services Agency  
1062 South “K” Street  
Tulare, CA 93274

(209) 685-2535  
FAX (209) 685-2661

Operating Hours: M/Tu/W/Th/F – 8am to 5pm  
Contact Person: Project Director – Kathleen Farrell

(209) 685-2535

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**VENTURA COUNTY**

Ventura County Public Health  
3147 Loma Vista Road  
Ventura, CA 93003

(805) 652-6162  
FAX (805) 652-3320

Operating Hours: M/Tu/W/Th/F – 8am to 4:30pm  
Client Contact Person: Case Manager – Craig Webb  
Contact Person: Project Director – Diane Seyl

(805) 652-6162  
(805) 652-6152

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**First Colony Life Insurance Company**  
**Lynchburg, Virginia**

**DISCLOSURE STATEMENT FOR POLICIES WITH GUARANTEED OR ILLUSTRATED  
LEVEL PREMIUMS FOR THE FIRST SEVERAL YEARS FOLLOWED BY HIGHER  
GUARANTEED OR ILLUSTRATED PREMIUMS**

This policy is similar to a term policy for the same level premium period, but does not provide any nonforfeiture benefits (such as cash surrender values) at any time during those years. This means that if you fail to pay a premium within a specified time as of its due date, this policy will lapse without any value.

You should compare this policy to a level-premium term policy. Such a term policy would provide identical insurance coverage; but may also be required to provide nonforfeiture benefits at certain durations where this policy does not. However, the premiums for the term policy might be higher than the premiums for this policy.

When considering the purchase of this policy, you should compare the value of having nonforfeiture benefits (such as cash values) versus the level of the premiums that you will pay.

**First Colony Life Insurance Company**  
**Lynchburg, Virginia**

**DISCLOSURE STATEMENT FOR TERM POLICIES WITH GUARANTEED OR ILLUSTRATED  
LEVEL PREMIUMS FOR THE FIRST SEVERAL YEARS FOLLOWED BY HIGHER  
GUARANTEED OR ILLUSTRATED PREMIUMS**

This policy is similar to a term policy expiring at the end of the level premium period, but does not provide any nonforfeiture benefits (such as cash surrender values) at any time during those years. This means that if you fail to pay a premium within a specified time as of its due date, this policy will lapse without any value.

You should compare this policy to a level-premium term policy expiring at the end of the level premium period. Such a term policy would provide identical insurance coverage for the level premium period; but may also be required to provide nonforfeiture benefits at certain durations where this policy does not. However, the premiums for the term policy might be higher than the premiums for this policy.

When considering the purchase of this policy, you should compare the value of having nonforfeiture benefits (such as cash values) versus the level of the premiums that you will pay.



# 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
- Federal Home Life Insurance Company**  
Service Center, P.O. Box 466, Lynchburg, VA 24505-0466
- GE Life and Annuity Assurance Company**  
Service Center, PO Box 6700 • Lynchburg, VA 24505 6700
- 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

### 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

Description of Personal Representative's Authority or Relationship to Patient