IN-FORCE ILLUSTRATION REQUEST

Top portion of this form needs to be completed by the requesting agent.
Insured MUST sign the bottom portion before any information can be released to the agent.

Company ______________________________ Date: ______________

Attn: In-Force Illustration Department

Address 1: ______________________________

Address 2: ______________________________

____

Phone: ______________ Fax: ______________

Email: ______________

RE: Insured(s) and Owner(s)

SS# or TIN#: ______________ Policy #: ______________

Please accept this letter as authorization to provide the following information on the above referenced policy to the address listed below:

1. Copy of the most recent annual statement to include current cash values and surrender values
2. In-force policy projections with current premiums, interest and/or dividends
3. In-force projections assuming no future premiums

Additionally, please confirm the following contractual information:

1. Owner name and contact information
2. Insured name and date of birth
3. Named beneficiary(ies) and contingent beneficiary(ies)
4. Name of premium payor
5. Rate class at date of issue

I AUTHORIZE Simplicity Des Moines (formerly Davis Life & Annuity) to obtain any and all in-force and projected policy information as well as the above referenced contractual information on this policy for the purposes of an annual policy review. Please note that a faxed copy of this request for information shall be deemed valid as the original. Also note that I authorize your company to release all information to the representatives noted above whether the request be made in writing or via the telephone. I ask this request be processed within 5 business days.

X ______________________ ______________________ ______________
Signature of Insured / Owner / Trustee — Printed Name — Date

X ______________________ ______________________ ______________
Signature of Insured / Owner / Trustee — Printed Name — Date

X ______________________ ______________________ ______________
Signature of Insured / Owner / Trustee — Printed Name — Date

PLEASE MAIL, FAX OR EMAIL ALL INFORMATION TO:

4949 Pleasant St., Suite 204, West Des Moines, Iowa 50266 | Fax: 888-618-7444 | Email: dsm.dlb@simplicitygroup.com

SAMPLE
YOUR LETTERHEAD GOES HERE

Today's Date

Valued Client
Address1
Address2

Dear Valued Client:

First, I want to thank you for your continued business with XYZ Insurance and secondly I want to take this opportunity to introduce you to a service XYZ Insurance is initiating on behalf of our existing life insurance clients - a Life Insurance Review.

I believe that one of the key fiduciary responsibilities of my agency is to conduct a periodic review of your life insurance policies to ensure that your policies are keeping up with the current interest environment and the many changes within the insurance industry. Please remember, premium rates vary by a number of factors, including carrier, product, health, age, and a number of other factors.

In keeping with this fiduciary responsibility, I would like to request an in-force illustration on your current life insurance policy. This allows us to determine how long your policy will stay in-force with your current premium payments and find out if we can reduce your current premium, keep the same death benefit, and or increase your current death benefit by utilizing the same amount of current premium.

Please be advised that this is a review of your current policy and ***NO ACTIONS*** *will be taken without your direct approval. There are* ***NO FEES OR OBLIGATIONS*** *to you for having my office review your current life insurance policies.*

As a part of this review process, I have included an in-force illustration request form that my office will fax directly to the insurance company. It requires you to do two things: 1) sign the bottom signature line, and 2) mail or fax the signed form back to my office.

I want to thank you for your continued business with our XYZ Insurance Agency, and I encourage you to contact me if you have questions about this life insurance service.

Sincerely,

XYZ Advisor
<<Enclose personal disclosure or disclosure from your business entity or firm, if applicable>>

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SAMPLE REVIEW INTRODUCTION LETTER

For Banks, Trust Departments, Attorneys and Accountants

Your letterhead goes here

Today's Date

Valued Client
Address 1
Address 2

Re: Annual Life Insurance Review

Dear Valued Client:
Bank XYZ wants to take this opportunity to notify you of a new service which <<Bank XYZ's Trust Department>> is initiating on behalf of our clients.

We believe that one of the key fiduciary responsibilities of any trust department is to conduct a periodic review of our clients' in-force life insurance policies in which our trust department has an advisory capacity to ensure that your policies are performing at competitive levels.

In keeping with these fiduciary responsibilities, we would like to request an in-force illustration of your current life insurance policies which are owned by the trust(s) created and administered at <<Bank XYZ>>. The purpose of this review is to make sure that these policies are not only fulfilling their initial purpose relative to your overall financial needs and goals, but to also determine whether they are doing so in the most cost- effective way possible. Please be advised, however, that no action will be taken without your direct approval and there are no fees or obligations for evaluating your current life insurance policies.

Premium rates vary by a number of factors, including carrier, product, health, age and a number of other factors. As a part of this life insurance review process, our office will be contacting you to answer any questions you may have and to find a convenient time that we can sit down and go through your life insurance policies.

We thank you for your business, and encourage you to call us at any time if you have questions about this valued-added service.

Sincerely,

<<Trust Officer's Name>>
<<Enclose personal disclosure or disclosure of the firm, if applicable>>

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Davis Life & Annuity | Simplicity Des Moines
4949 Pleasant St., Suite 204
West Des Moines, Iowa 50266
www.DavisLifeAnnuity.com | Tel 800-747-5612 | Fax 888-618-7444

Preliminary Underwriting Questionnaire and Authorization

Information and Instructions

Thank you for taking the time to complete the following pages. It is our goal to get the best possible offer for your client. In order to do that we need to have the most current health and lifestyle information regarding the proposed insured. After all pages have been completed and signed, please scan and e-mail them to your life marketer or fax them to:

Attention: Life New Business Coach
Fax Number: 888-618-7444
Email: DSM.lifenewbusiness@simplicitygroup.com

Please allow 48 hours for someone to contact you regarding this case.
If you are unsure of the email of your life new business coach, please call 800-747-5612 for assistance.

Submitting Agent Information

Name______________________________ Telephone____________________
Ext__________
Address______________________________ Unit____________________
City____________________ State____________________ Zip____________
Fax____________________ E-mail______________________________
Are you shopping this case? YES NO
If YES, what companies have you submitted or are you going to submit this case to?__________________
____
Based on your client's history what offer are you expecting?______________________
What is the best way to contact you?______________________________

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Preliminary Underwriting Questionnaire

Please take a few moments to complete all sections of this questionnaire.
We will be better able to help if we have the most current and accurate information possible.

Section 1...Proposed Insured Information

Full Name_______________________ Age_________ Date of Birth_____/_____/_____

Sex_____ Height_____ Weight_____ Place of Birth_______________________ Marital Status_________

SSN/Tax ID Number___________________ Employer & Occupation_______________________________

Home Address____ Unit/Apt___________

City___________________________________ State_______________________ Zip Code_____________

Driver's License Number______________________________ License State_________________________

US Citizen_________ If No, Date of Entry________________ Type of Visa_________________________

Section 2...Current and Desired Coverage Information

Amount of Coverage Requested_____________________________ Type of Coverage Term UL WL

Owner_______________________________ Relationship to Insured________________________________

Beneficiary_____________________________ Relationship to Insured______________________________

Annual Income_____________________________ Net Worth______________________________________

Please List All Current Coverage

Company_____________________ Face Amount___________ Issue Year_______ Cash Value________
Will This Policy Be Replaced_____________

Company_____________________ Face Amount___________ Issue Year_______ Cash Value________
Will This Policy Be Replaced_____________

Company_____________________ Face Amount___________ Issue Year_______ Cash Value________
Will This Policy Be Replaced_____________

Has the Proposed Insured ever been denied, rated or had to postpone any life insurance coverage?______

If yes, please complete the information below

Company_________________________ Rated / Declined / Postponed Year___________
Reason____

Company_________________________ Rated / Declined / Postponed Year___________
Reason____

Company_________________________ Rated / Declined / Postponed Year___________
Reason____

Section 3...Medical History

Please circle Yes or No for all questions.

If yes answer applies to any questions, please provide details, such as: date of first diagnosis, name and address of doctor, test performed, test results, medication(s) recommended, and any treatment information in the area provided.

1. Has the Proposed Insured ever been diagnosed as having, been treated for, or consulted a licensed health care provider for:
   - A. Heart disease, heart attack, chest pain, irregular heartbeat, heart murmur, high cholesterol, high blood pressure or other disorder of the heart? **YES NO**
   - B. A blood clot, aneurysm, stroke, or other disease, disorder or blockage of the arteries or veins? **YES NO**
   - C. Cancer, tumors, masses, cysts or other such abnormalities? **YES NO**
   - D. Diabetes, a disorder of the thyroid or other glands, or a disorder of the immune system, blood or lymphatic system? **YES NO**
   - E. Colitis, hepatitis or a disorder of the esophagus, stomach, liver, pancreas, gall bladder or intestines? **YES NO**
   - F. A disorder of the kidneys, bladder, prostate or reproductive organs or sugar or protein in the urine? **YES NO**
   - G. Asthma, bronchitis, emphysema, sleep apnea, or other breathing or lung disorder? **YES NO**
   - H. Seizures, a disorder of the brain or spinal cord, or other nervous system abnormality including a mental or nervous disorder? **YES NO**
   - I. Arthritis, muscle disorder, connective tissue disease or other bone or joint disorders? **YES NO**

2. Has the Proposed Insured in the past three years had but not sought treatment for:
   - A. Fainting spells, nervous disorder, headaches, convulsions or paralysis **YES NO**
   - B. Any pain or discomfort in the chest or shortness of breath? **YES NO**
   - C. Disorders of the stomach, intestines, or rectum or blood in the urine? **YES NO**

3. What is the Proposed Insured's height_________________ Weight___________________

4. Is the Proposed Insured currently under treatment, therapy, or medical observation? **YES NO**
   If YES, Please explain____
   ____
   ____

5. Please list all medications and dosages____
   ____
   ____
   ____
   ____

Please explain any questions answered YES above____
____
____
____
____
____

Section 4...Lifestyle Information

1. Has the Proposed Insured used tobacco of any form in the past 24 months? **YES NO**
   If YES, please list date of last nicotine use_______________ Type of Tobacco__________
   Are you currently using nicotine gum or patch? **YES NO**

2. Has the Proposed Insured ever sought or received advice, counseling or treatment by a medical professional for the use of alcohol or drugs, including prescription drugs? **YES NO**

3. Has the Proposed Insured ever used cocaine, marijuana, heroin, controlled substances or any other drug, except as legally prescribed by a physician? **YES NO**

If YES is answered to questions 2 or 3, please complete a Drug/Alcohol Questionnaire

4. Does the Proposed Insured engage in regular physical exercise other than which occurs during their work? **YES NO**

Type of exercise	Number of times each week	For how many minutes

5. Is there a history of diabetes, stroke, heart disease, high blood pressure or kidney disease among the Proposed Insured's parents or siblings? **YES NO**

	Age, if living	Health	Age at Death	Cause of Death
Father				
Mother				
Brother/Sister				
Brother/Sister				

6. In the past three years, has the Proposed Insured been in a motor vehicle accident, been charged with a moving violation, or had their license restricted or revoked? **YES NO**
   If YES, please explain____

   ____

7. Does the Proposed Insured intend to travel or reside outside of the United States or Canada within the next two years? **YES NO**
   If YES, please list country, date, length of stay and purpose______________________________

   ____

Section 5...Physician Contact Information

Applicant's Personal Physician________________________________ Telephone_____________________
Name of Clinic____
Address____ Suite___________________________
City_____________________________________ State______________________ Zip___________________
Date of Last Visit__________________________
Reason for visit?____

____

Please list any other physicians, clinics, hospitals, or sanitariums the Proposed Insured has consulted with or been a patient of within the last five years on a separate piece of paper.

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HIPAA AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

Applicant's Name:____

Address:____

____

City:____________________ State:______________ Zip:________________

Telephone:________________________

Date of Birth:________________________

SSN:_________-__________-_________

DURATION: This authorization shall become effective immediately and shall remain in effect until ______________________ or two years from date of signature.
(Date)

EVOCATION: This authorization is also subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party. My written revocation will be effective upon receipt, but will not be effective to the extent that the Requester or others have acted in reliance upon this Authorization.

REDISCLOSURE: I understand that the Requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

PURPOSE: To obtain life insurance.

______________________________ ______________________
Signature of Proposed Insured or Representative Date

____
Print Name of Proposed Insured or Representative

______________________________ or ______________________
Relationship to Insured or Legal Authority
Attach supporting documentation

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Authorization to Obtain Information Waiver and Acknowledgment Form

AUTHORIZATION:

I AUTHORIZE______________________, OR any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider (My Providers) that has provided treatment or services to me or on my behalf to disclose my entire medical record and any other protected health information concerning me to Davis Life & Annuity | Simplicity Des Moines and its agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By signing below. I terminate any agreements I have made with My Providers to restrict my protected health information and I instruct My Providers to release and disclose my entire medical record without restriction.

I UNDERSTAND my protected health information is to be disclosed under this authorization so the Davis Life & Annuity | Simplicity Des Moines may: 1) underwrite my application for coverage by making eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain insurance; and 3) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Insurance Companies named below.

Accordia/Global Atlantic Life Insurance	Allianz Life Insurance Company	American General Life Insurance Company
American National Insurance Company	Ameritas Life Insurance Company	Assurity Life Assurance Co.
Athene Annuity & Life Insurance Company	AXA Equitable Life Insurance Company	Banner Life Insurance Company
Equitrust Life Insurance Company	Foresters Life Insurance Company	John Hancock Life Insurance Company
Life Insurance Company of the Southwest	Lincoln National Life Insurance Company	Metropolitan Life/Brighthouse
Minnesota Life/Securian Life Insurance	National Western Life Insurance Company	Nationwide Life Insurance Company
New York Life Insurance Company	North American Company for Life & Health	One America Life Insurance Company
Principal Life Insurance Company	Protective Insurance Company of America	Prudential Life Insurance Company
Sagicor Life Insurance Company	SBLI - Savings Bank Life of Massachusetts	Symetra Life Insurance Company
Transamerica Life Insurance Company	United of Omaha Life Insurance Company	Innovative Underwriting Solutions
Other:	Other:	Other:

This authorization shall remain in force for 24 months, beginning___________________. A copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization at any time. I understand my revocation must be in writing and addressed to the attention of the Privacy Official at the above named facility or Davis Life & Annuity | Simplicity Des Moines, 3737 Woodland Ave. Ste. 600, West Des Moines, IA 50266. I understand that a revocation is not effective if any of My Providers has relied on this authorization or to contest the policy/certificate itself. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by certain federal rules governing privacy and confidentiality of health information.

WAIVER AND ACKNOWLEDGMENT

This Waiver and Acknowledgment (the "Waiver") has been signed on the date set forth below by the undersigned (the "Applicant") in favor of Davis Life & Annuity | Simplicity Des Moines, its successors, assigns, shareholders, directors and employees (collectively "Simplicity Des Moines").

Applicant acknowledges, understands and agrees as follows:

* that Applicant has filed an application with Simplicity Des Moines intending to secure life insurance from one or more insurance underwriters.
* that, in the course of applying for life insurance coverage, Simplicity Des Moines has asked for and received information concerning Applicant's medical condition and history, as well as other information that is of a personal and confidential nature.
* that Simplicity Des Moines will provide that information, or parts of it, to a number of potential insurers and their agents, employees, and representatives.
* that Simplicity Des Moines maintains, or will maintain, an electronic data interchange (the "Interchange") through which certain Authorized underwriters and/or other insurance industry representatives (referred to in this Waiver as "Underwriters") may gain access to information concerning persons either covered by or applying for coverage under insurance policies issued and serviced by those Underwriters.
* that Simplicity Des Moines will use the Interchange to store some or all of the confidential and personal information Applicant has provided to Simplicity Des Moines, and, therefore, that Underwriters will be able to gain access to that information through the Interchange.
* that the Underwriters will gain access to the Interchange via the Internet or other, similar computer-based telecommunications systems.
* that, even though Simplicity Des Moines has in place security measures, Simplicity Des Moines believes appropriate to protect the Interchange and the information it contains from unauthorized access and use, and even though Simplicity Des Moines will continue to upgrade those security measures from time to time as circumstances warrant, Simplicity Des Moines can make no guarantee as to Simplicity Des Moines' ability to protect the Interchange and the information it contains from unauthorized access by "hackers" or other persons, who, through wrongful means, may bypass the security measures protecting the integrity of the Interchange.
* that Simplicity Des Moines cannot control the use, dissemination, publishing or interpretation of the information contained in the Interchange once that information is gathered by an Underwriter.
* that Applicant will hold harmless from and against any unauthorized access to or use of, by any person or company, any information pertaining to Applicant in Simplicity Des Moines' possession and/or stored on the Interchange.
* that Applicant will indemnify Simplicity Des Moines for all costs and expenses incurred by Simplicity Des Moines or any of its employees, shareholders, directors, agents or representatives in enforcing this Waiver.

Applicant has evidenced his/her acknowledgment, understanding, and agreement with respect to the foregoing by signing this document below.

I ACKNOWLEDGE that I have received a copy of this document.
I AGREE this form shall be valid for twenty-four (24) months from the date shown below.

Signed on this date: ___________/______/__________

City:__________________ State:_________________

X____
Signature of Proposed Insured/Parent or Guardian

X____________________________________
Signature of Witness

____
Printed name of Proposed Insured/Parent or Guardian

HIPAA Privacy Rule compliant