BEFORE THE INSURANCE COMMISSIONER OF THE STATE OF OKLAHOMA

STATE OF OKLAHOMA, ex rel. JOHN DOAK, Insurance Commissioner,	)	
Petitioner,	)	
v.	)	**Case No. 13-0477-DIS**
BOB TENNON, JR., a licensed insurance producer,	)	
Respondent.	)	

CONDITIONAL ADMINISTRATIVE ORDER AND NOTICE OF RIGHT TO BE HEARD

COMES NOW the State of Oklahoma, ex rel. John Doak, Insurance Commissioner, by and through his attorney, Barron B. Brown, and alleges and states as follows:

JURISDICTION

1. John Doak is the Insurance Commissioner of the State of Oklahoma and is charged with the duty of administering and enforcing all provisions of the Oklahoma Insurance Code, 36 O.S. §§ 101 et seq.

2. Respondent is licensed by the State of Oklahoma as a resident insurance producer holding license number 0040165345. His address of record with the Oklahoma Insurance Department ("OID") is 5928 S. Richmond, Ave., Tulsa, Oklahoma 74135.

3. The Insurance Commissioner may place on probation, censure, suspend, revoke or refuse to issue or renew a license issued pursuant to the Oklahoma Producer Licensing Act and/or may levy a fine up to $1,000.00 for each occurrence of a violation of the Oklahoma Insurance Code, 36 O.S. § 1435.13(A) and (D).

ALLEGATIONS OF FACT

1. On or about February 8, 2013, the OID Anti-Fraud Division received a complaint against Respondent from Kevin Wilson ("Wilson"), an Oklahoma-licensed insurance producer. In his complaint, Wilson stated that Respondent previously worked for him at Premier Financial Solutions ("Premier") until August of 2012, when Respondent left to work for Pioneer Financial Group ("Pioneer"). Within the complaint, Wilson asserted that Respondent had completed applications for life insurance with Monumental Life Insurance Company ("MLIC") for four of his clients without those clients' knowledge or consent. Wilson stated that he became aware of the situation when he met with each of those clients and was reviewing their coverage.

2. On or about March 11, 2013, OID Anti-Fraud Division Investigator Rick Koch ("Koch") interviewed Respondent. Respondent told Koch that he had talked to each of the four clients about expanding their coverage. However, all four clients stated that no such discussion ever took place. Respondent acknowledged that simply having a discussion about coverage was not an authorization to apply for such coverage on an individual's behalf without receiving the approval of the individual to acquire said coverage. Ultimately, Respondent admitted to Koch that he had completed the applications for coverage for the four clients, signed the respective clients' names to the application and submitted the applications to MLIC without the consent or knowledge of any of the involved clients. Copies of the applications are attached as Petitioner's Exhibits A-D.

3. On or about March 13, 2013. Respondent met with Koch at the OID Tulsa office and expressed remorse for his actions.

ALLEGED VIOLATIONS OF LAW

1. Respondent violated 36 O.S. § 1435.13(A)(8); using fraudulent, coercive, or dishonest practices, or demonstrating incompetence, untrustworthiness or financial irresponsibility in the conduct of business in this state or elsewhere.

2. Respondent violated 36 O.S. § 1435.13(A)(10); forging another's name to an application for insurance or to any document related to an insurance transaction.

ORDER

IT IS THEREFORE ORDERED by the Insurance Commissioner that Bob Tennon, Jr. is **CENSURED** and **FINED ONE THOUSAND DOLLARS ($1,000.00)** for using fraudulent, coercive, or dishonest practices, or demonstrating incompetence, untrustworthiness or financial irresponsibility in the conduct of business in this state or elsewhere and for forging another's name to an application for insurance or to any document related to an insurance transaction. **The $1,000.00 fine is to be paid within thirty (30)** days made payable to the Oklahoma Insurance Department. The $1,000.00 civil fine shall be paid by money order or cashier's check. Failure to pay the civil fine or request a hearing within thirty (30) days may result in further administrative action.

IT IS FURTHER ORDERED, ADJUDGED AND DECREED by the Insurance Commissioner that this Order is a Conditional Order. Unless the Respondent requests a hearing with respect to the Allegations of Fact set forth above within thirty (30) days of the date of mailing of this Order, this Order and the penalties set forth above shall become a Final Order on the thirty-first day following the date of mailing this Order. A request for hearing should be in writing addressed to Barron Brown, Oklahoma Insurance Department, Legal Division, 3625 NW

56th St., Suite 100, Oklahoma City, Oklahoma 73112. The request for hearing must state the grounds for the request to set aside or modify the Order.

Any such hearing shall be conducted according to the procedures for contested cases under the Insurance Code and 75 O.S. § 250-323. If the Respondent serves a timely request for hearing on the Oklahoma Insurance Department, this Conditional Order shall act as notice of the matters to be reviewed at the hearing, and the Allegations of Fact, Alleged Violations of Law, and penalties imposed in this Conditional Order shall be considered withdrawn, pending final resolution at the hearing.

WITNESS My Hand and Official Seal this 27th day of April, 2015.

JOHN DOAK
INSURANCE COMMISSIONER
STATE OF OKLAHOMA

Barron B. Brown
Assistant General Counsel
3625 NW 56th St., Suite 100
Oklahoma City, OK 73112

CERTIFICATE OF MAILING

I, Barron B. Brown, hereby certify that a true and correct copy of the above and foregoing Conditional Administrative Order and Notice of Right to be Heard was mailed via regular mail and by certified mail, with postage prepaid and return receipt requested, on this 27th day of April, 2015, to:

Bob Tennon, Jr.
5928 S. Richmond Ave.
Tulsa, OK 74135

CERTIFIED MAIL NO. 7014 2870 0000 5493 1852

and a copy was delivered to:

Karen Wojtek
Licensing Division

and a copy was delivered to:

Rick Koch
Anti-Fraud Division

Barron B. Brown
Assistant General Counsel

DOUGLAS NAPIER
014442578

Monumental Life Insurance Company

EXPRESS ISSUE COVER SHEET

(Please submit completed sheet with every application)

Agent Information		
Agent ID ML687410.	Agent Name (Print) Bob Teeman Jr	Agent Phone (918) 924-0776
Agent Email bob.teeman@pfgagency.com		Agent Fax (918) 369-9845
Proposed Insured Information		
Insured's name (Print) Douglas L. Napier		Last 4 digits of Insured's social security # [redacted]

Required Disclosures with Application:

☐ HIPAA Authorization Form ☐ Bank Draft Form

Other Disclosures (if applicable):

☐ Accelerated Death Benefit Disclosure Form ☐ HIV Consent Form ☐ Replacement Form(s)

How are you paying the initial Premium?

☐ By Check: Available with all methods, but must be used if subsequent payments are quarterly, semi-annual or annual

- Is the check for initial premium payment on the same account as monthly EFT payments? ☐ Yes ☐ No

☐ Draft initial premium upon receipt

☑ Draft initial premium at future date, please indicate the month and day (mm/dd): 01 / 17th

Month Day (1st thru 28th only)

- If you choose a specific Initial Premium draft date (in the future), the recurring draft date will be the same as the initial premium draft date and may not be greater than 30 days after the application date.

If you select an Initial Premium Draft date in the future, you will not have potential coverage until that date under the Conditional Receipt.

(See 'Draft Date Procedures & Scenarios' on Web site)

Submitting Application to Monumental: *(Faxing is the preferred method)*

If faxing, fax to 1-866-834-0437 and enter date faxed 12-21-2012 . Do Not mail originals if faxing.

If mailing the application and/or check for initial premium please send with cover sheet to:

Monumental Life, 4333 Edgewood Road NE, Cedar Rapids, IA 52499

Monumental Life Insurance Company
Home Office: 4333 Edgewood Road NE, Cedar Rapids, Iowa 52499

LIFE APPLICATION

Agent ID #	State Application Taken	Policy # (H.O. Use Only)
ML527410	Oklahoma	

Part A1 - Proposed Insured

Name (First, M.I., Last)	Address, City, State, Zip Code (cannot be a P.O. Box)			
Douglas L. Napier	[redacted]			
SSN	Gender	D.O.B. (MM/DD/YYYY)	Age	U.S. State or Country of Birth	Phone Number
[redacted]	M	03/12/1942	70	Oklahoma, U.S	(918) 361-5698

1) Within the last 12 months has the proposed Insured used tobacco products in any form? ☐ Yes ☑ No

2) Life Insurance Face Amount $ 10,000
   a) Plan: Standard
   b) Accidental Death Benefit Rider Face Amount $ 0
   c) Total Premium $ 99.90
   d) If a policy cannot be issued as applied for, would you accept a rated policy if available? ☐ Yes ☑ No
   e) If 'yes,' adjust face amount to premium? ☐ Yes ☑ No

3) Does the applicant have any existing life insurance or annuity contracts with the company or any other company? ☑ Yes ☐ No

4) Is this insurance intended to replace or change any life insurance or annuity contract in force with the company or any other company? (If yes, submit the state required forms) ☐ Yes ☑ 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) (cannot be a P.O. Box)	Are you a citizen of the U.S.? If not, what country?
	☐ Yes ☐ No

Part A3 - Beneficiary

Primary Name (First, MI, Last)	SSN	Gender	Relationship to Insured	D.O.B. (MM/DD/YYYY)
Debra Napier	[redacted]	F	Wife	
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 ☑ No

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? ☐ Yes ☑ No
   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)? ☐ Yes ☑ No
   c) Been in a diabetic coma or had or been advised to have an amputation due to disease or disorder? ☐ Yes ☑ No

3) Within the past 2 years has the proposed Insured:
   a) Been diagnosed with, been treated for or advised to receive treatment for cancer (other than basal cell carcinoma)? ☐ Yes ☑ No
   b) Undergone testing by a medical professional for which the results have not been received? ☐ Yes ☑ No

Part B2

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? ☐ Yes ☑ No

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)? ☐ Yes ☑ No

6) Within the past 7 years has the proposed Insured:
   a) Used illegal drugs or been diagnosed with, been treated for or advised to receive treatment for alcohol abuse, drug abuse or muscular dystrophy? ☐ Yes ☑ No
   b) Had more than 12 seizures or been diagnosed with, been treated for or advised to receive treatment for congestive heart failure, cirrhosis, hepatitis B or C or other liver disease? ☐ Yes ☑ No
   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? ☐ Yes ☑ No
   d) Used oxygen to assist in breathing due to a disease or disorder, received kidney dialysis or been diagnosed with, been treated for or advised to receive treatment for kidney failure due to a disease or disorder? ☐ Yes ☑ No

- If All Questions in Part B2 Are Answered "No," Proceed to Part B3.
- If One Question in Part B2 Is Answered "Yes," The proposed Insured Is Eligible For The Graded Death Benefit Product. Proceed to Part C1.
- If Two Or More Questions in Part B2 Are Answered "Yes," The proposed Insured Is Not Eligible For Any Coverage.

Last Name and Last 4 Digits of SSN: Napier – [redacted]

Part B3

7) Within the past 2 years has the proposed Insured:
   a) Had or been treated for a heart attack, angina (chest pain), stroke (CVA), transient ischemic attack (TIA), aneurysm, circulatory or blood disorder, heart surgery including bypass or irregular heart rhythm such as atrial fibrillation? ☐ Yes ☑ No
   b) Had more than 12 seizures, taken insulin shots or been diagnosed with, been treated for or advised to receive treatment for congestive heart failure, cirrhosis, hepatitis B or C or other liver disease? ☑ Yes ☐ No
   c) Used illegal drugs or been diagnosed with, been treated for or advised to receive treatment for alcohol abuse or drug abuse? ☐ Yes ☑ No
8) Within the past 4 years has the proposed Insured been diagnosed with, been treated for or advised to receive treatment for kidney disease? ☐ Yes ☑ No
9) Has the proposed Insured ever been diagnosed with, been treated for or advised to receive treatment for Parkinson's disease, multiple sclerosis, chronic obstructive pulmonary disease (COPD) including emphysema, chronic asthma, black lung or other chronic respiratory disease? ☐ Yes ☑ No
10) Is the proposed Insured currently under the age of 50 and if so, has the proposed Insured within the past 5 years been diagnosed with, been treated for or advised to receive treatment for any mental disorder such as manic or clinical depression, schizophrenia, bipolar disease or post traumatic stress syndrome? ☐ Yes ☑ No

- If All Questions In Part B3 Are Answered "No," The proposed Insured Is Eligible For The Preferred Product. Please Check The Appropriate Box And Proceed to B4:
  ☐ Preferred LP99 ☐ Preferred 10PL ☐ Preferred Other: _____
- If One Question In Part B3 Is Answered "Yes," The proposed Insured Is Eligible For The Standard Product. Please Check The Appropriate Box And Proceed to B4:
  ☑ Standard LP99 ☐ Standard 10PL ☐ Standard Other: _____
- If Two Or More "Yes" Answers In Part B3, The proposed Insured Is Eligible For The Graded Death Benefit Product. Proceed To C1.

Part B4 - Nursing Home Option - If The Following Question Is Answered "Yes," The Proposed Insured Is Not Eligible For The Nursing Home Option On The Accelerated Death Benefit Rider.

Does the proposed Insured need any assistance from other persons in performing any Activities of Daily Living such as eating, bathing, toileting, dressing, taking medications, walking or moving in and out of bed or chair or does the proposed Insured have ongoing incontinence or, in the 2 years prior to the application, has a medical professional recommended that the proposed Insured be confined to a Nursing Home? ☐ Yes ☑ No

Part C1 - Face Amount & Payment Method

Face Amount: 10,000 | Payment Method: ☑ Monthly EFT ☐ Quarterly ☐ Semi-Annual ☐ Annual

Full Modal Premium Included or Authorized With Application Is: $99.90

Part C2 - Payor Information

The Payor is the ☐ Proposed Insured ☐ Owner ☐ Other (If Other, please provide the following information:)

Name (First, MI, Last)	SSN	Gender	Relationship to Insured

Address, City, State, Zip Code (cannot be a P.O. Box)	Are you a citizen of the U.S.? ☐ Yes ☐ No If not, what country?

Part C3 - Premium Payment Authorization For Electronic Funds Transfer (EFT): Payor's Authorization To Insurance Company

As a convenience to myself, I hereby authorize Monumental Life Insurance Company to draft premium payments from my financial institution account.

It is understood that credit for payment is conditioned upon the draft being honored when presented for payment. Furthermore, this authorization may be terminated (a) at the option of the Company if any draft is not honored when presented for payment; or (b) by the Company, financial institution or the undersigned upon 30 days written notice to the parties hereto.

If this authorization is terminated, the amount due on the policy involved will be billed on a quarterly basis.

Draft Date (1st-28th): 17th If no date selected, the draft date will be the policy date.

☑ Checking ☐ Savings Financial Institution Name: Arvest Bank City/State: Muskogee, OK

Routing #: 1 0 3 1 1 2 9 7 6 Account #: 0 0 7 4 2 6 4 4 8 7

Payor Signature (if other than proposed Insured or Owner) Douglas L. Napier Date: 12-17-2012

Last Name and Last 4 Digits of SSN: Napier - [redacted]

Agent's Report

I represent that:

1) I have personally seen the proposed Insured. ☑ Yes ☐ No

2) I have truly and accurately recorded on this application the information as supplied by the Owner and the proposed Insured. ☑ Yes ☐ No

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

Best time to call for a Personal History Interview 10 a.m. _____ p.m.

Home or work phone number 918-924-0776

Agent Signature Bob Tennon Jr

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. The proposed Insured shall be the policyowner unless another owner is named above. I understand that I may revoke this authorization in writing to the agent or the Company.

I have received the MIB 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 to give any such information, including medical information, to the life insurance company. A photocopy or facsimile of this authorization shall be made as valid as the original. This authorization will expire 24 months from the date signed.

FRAUD WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Signed at City Muskogee State Oklahoma Proposed Insured Signature Douglas L. Napier

Date December 17, 2012 Owner Signature _____ (If Owner other than Insured)

Witness Bob Tennon Jr (Agent Signature) Bob Tennon Jr ML647410 (Print Agent's Name and I.D. Number)

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

HARVEY BITTLE
014442575

Monumental Life Insurance Company

EXPRESS ISSUE COVER SHEET

(Please submit completed sheet with every application)

Agent Information		
Agent ID: MLSR7410	Agent Name (Print): Bob Tenon Jr	Agent Phone: (918)924-0776
Agent Email: bobtennon@pfgagency.com		Agent Fax: (918)367-9845
Proposed Insured Information		
Insured's name (Print): Tom Bittle		Last 4 digits of Insured's social security #: [redacted]

Required Disclosures with Application:

☐ HIPAA Authorization Form ☐ Bank Draft Form

Other Disclosures (if applicable):

☐ Accelerated Death Benefit Disclosure Form ☐ HIV Consent Form ☐ Replacement Form(s)

How are you paying the Initial Premium?

☐ By Check: Available with all methods, but must be used if subsequent payments are quarterly, semi-annual or annual

- Is the check for initial premium payment on the same account as monthly EFT payments? ☐ Yes ☐ No

☐ Draft initial premium upon receipt

☑ Draft initial premium at future date, please indicate the month and day (mm/dd): 01 / 14
Month · Day (1st thru 28th only)

- If you choose a specific Initial Premium draft date (in the future), the recurring draft date will be the same as the initial premium draft date and may not be greater than 30 days after the application date.

If you select an Initial Premium Draft date in the future, you will not have potential coverage until that date under the Conditional Receipt.

(See 'Draft Date Procedures & Scenarios' on Web site)

Submitting Application to Monumental: *(Faxing is the preferred method)*

If faxing, fax to 1-866-834-0437 and enter date faxed 12-21-2012. Do Not mail originals if faxing.

If mailing the application and/or check for initial premium please send with cover sheet to:

Monumental Life, 4333 Edgewood Road NE, Cedar Rapids, IA 52499

Monumental Life Insurance Company
Home Office: 4333 Edgewood Road NE, Cedar Rapids, Iowa 52499

LIFE APPLICATION

Agent ID #	State Application Taken	Policy # (H.O. Use Only)
ML587410	Oklahoma	

Part A1 - Proposed Insured

Name (First, M.I., Last)	Address, City, State, Zip Code (cannot be a P.O. Box)
Harvey T. Battle	[redacted]

SSN	Gender	D.O.B. (MM/DD/YYYY)	Age	U.S. State or Country of Birth	Phone Number
[redacted]	M	09/28/1986	26	Arkansas, U.S	(918) 775-6124

1) Within the last 12 months has the proposed insured used tobacco products in any form? ☐ Yes ☑ No

2) Life Insurance Face Amount $ 12,000
   a) Plan: Preferred
   b) Accidental Death Benefit Rider Face Amount $ 0
   c) Total Premium $ 125.90
   d) If a policy cannot be issued as applied for, would you accept a rated policy if available? ☐ Yes ☑ No
   e) If "yes," adjust face amount to premium? ☐ Yes ☑ No

3) Does the applicant have any existing life insurance or annuity contracts with the company or any other company? ☒ Yes ☐ No

4) Is this insurance intended to replace or change any life insurance or annuity contract in force with the company or any other company? ☐ Yes ☒ No
   (If yes, submit the state required forms)

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) (cannot be a P.O. Box)	Are you a citizen of the U.S.? If not, what country?
	☐ Yes ☐ No

Part A3 - Beneficiary

Primary Name (First, MI, Last)	SSN	Gender	Relationship to Insured	D.O.B. (MM/DD/YYYY)
Terri Lynn Cox		F	Daughter	
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 ☑ No

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? ☐ Yes ☑ No
   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)? ☐ Yes ☑ No
   c) Been in a diabetic coma or had or been advised to have an amputation due to disease or disorder? ☐ Yes ☒ No

3) Within the past 2 years has the proposed insured:
   a) Been diagnosed with, been treated for or advised to receive treatment for cancer (other than basal cell carcinoma)? ☐ Yes ☑ No
   b) Undergone testing by a medical professional for which the results have not been received? ☐ Yes ☒ No

Part B2

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? ☐ Yes ☑ No

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)? ☐ Yes ☒ No

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, drug abuse or muscular dystrophy? ☐ Yes ☑ No
   b) Had more than 12 seizures or been diagnosed with, been treated for or advised to receive treatment for congestive heart failure, cirrhosis, hepatitis B or C or other liver disease? ☐ Yes ☒ No
   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? ☐ Yes ☑ No
   d) Used oxygen to assist in breathing due to a disease or disorder, received kidney dialysis or been diagnosed with, been treated for or advised to receive treatment for kidney failure due to a disease or disorder? ☐ Yes ☒ No

- If All Questions In Part B2 Are Answered "No", Proceed to Part B3.
- If One Question In Part B2 Is Answered "Yes", The proposed Insured Is Eligible For The Graded Death Benefit Product. Proceed to Part C1.
- If Two Or More Questions In Part B2 Are Answered "Yes", The proposed Insured Is Not Eligible For Any Coverage.

Last Name and Last 4 Digits of SSN: Bittle - [redacted]

Part B3

7) Within the past 2 years has the proposed Insured:
   a) Had or been treated for a heart attack, angina (chest pain), stroke (CVA), transient ischemic attack (TIA), aneurysm, circulatory or blood disorder, heart surgery including bypass or irregular heart rhythm such as atrial fibrillation? ☐ Yes ☑ No
   b) Had more than 12 seizures, taken insulin shots or been diagnosed with, been treated for or advised to receive treatment for congestive heart failure, cirrhosis, hepatitis B or C or other liver disease? ☐ Yes ☑ No
   c) Used illegal drugs or been diagnosed with, been treated for or advised to receive treatment for alcohol abuse or drug abuse? ☐ Yes ☑ No
8) Within the past 4 years has the proposed Insured been diagnosed with, been treated for or advised to receive treatment for kidney disease? ☐ Yes ☑ No
9) Has the proposed Insured ever been diagnosed with, been treated for or advised to receive treatment for Parkinson's disease, multiple sclerosis, chronic obstructive pulmonary disease (COPD), including emphysema, chronic asthma, black lung or other chronic respiratory disease? ☐ Yes ☑ No
10) Is the proposed Insured currently under the age of 50 and if so, has the proposed Insured within the past 5 years been diagnosed with, been treated for or advised to receive treatment for any mental disorder such as manic or clinical depression, schizophrenia, bipolar disease or post traumatic stress syndrome? ☐ Yes ☑ No

- If All Questions in Part B3 Are Answered "No," The proposed Insured Is Eligible For The Preferred Product. Please Check The Appropriate Box And Proceed to B4:
  ☑ Preferred LP99 ☐ Preferred 10PL ☐ Preferred Other: _____
- If One Question In Part B3 Is Answered "Yes," The proposed Insured Is Eligible For The Standard Product. Please Check The Appropriate Box And Proceed to B4:
  ☐ Standard LP99 ☐ Standard 10PL ☐ Standard Other: _____
- If Two Or More "Yes" Answers In Part B3, The proposed Insured Is Eligible For The Graded Death Benefit Product. Proceed To C1.

Part B4 - Nursing Home Option - If The Following Question Is Answered "Yes," The Proposed Insured Is Not Eligible For The Nursing Home Option On The Accelerated Death Benefit Rider.

Does the proposed Insured need any assistance from other persons in performing any Activities of Daily Living such as eating, bathing, toileting, dressing, taking medications, walking or moving in and out of bed or chair or does the proposed Insured have ongoing incontinence or, in the 2 years prior to the application, has a medical professional recommended that the proposed Insured be confined to a Nursing Home? ☐ Yes ☑ No

Part C1 - Face Amount & Payment Method

Face Amount: 12,000 | Payment Method: ☑ Monthly EFT ☐ Quarterly ☐ Semi-Annual ☐ Annual

Full Modal Premium Included or Authorized With Application Is: $ 125.90

Part C2 - Payor Information

The Payor Is the: ☐ Proposed Insured ☐ Owner ☐ Other (If Other, please provide the following information:)

Name (First, MI, Last)	SSN	Gender	Relationship to Insured

Address, City, State, Zip Code (cannot be a P.O. Box)	Are you a citizen of the U.S.? ☐ Yes ☐ No If not, what country?

Part C3 - Premium Payment Authorization For Electronic Funds Transfer (EFT): Payor's Authorization To Insurance Company

As a convenience to myself, I hereby authorize Monumental Life Insurance Company to draft premium payments from my financial institution account.

It is understood that credit for payment is conditioned upon the draft being honored when presented for payment. Furthermore, this authorization may be terminated (a) at the option of the Company if any draft is not honored when presented for payment; or (b) by the Company, financial institution or the undersigned upon 30 days written notice to the parties hereto.

If this authorization is terminated, the amount due on the policy involved will be billed on a quarterly basis.

Draft Date (1st-28th): 9th of Jan If no date selected, the draft date will be the policy date.

☑ Checking ☐ Savings Financial Institution Name: National Bank of Sallisaw City/State: Sallisaw, OK

Routing #: 1 0 3 1 1 2 3 4 5 Account #: 0 0 1 1 1 8 5

Payor Signature (if other than proposed Insured or Owner) Harvey Thomas Bittle Date: 12-19-2012

Last Name and Last 4 Digits of SSN: B-Ille - [redacted]

Agent's Report

I represent that:

1) I have personally seen the proposed Insured. ☑ Yes ☐ No

2) I have truly and accurately recorded on this application the information as supplied by the Owner and the proposed Insured. ☑ Yes ☐ No

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

Best time to call for a Personal History Interview 10 a.m. _____ p.m.

Home or work phone number 918-924-0776

Agent Signature Bob Yeamon Jr

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. The proposed Insured shall be the policyowner unless another owner is named above. I understand that I may revoke this authorization in writing to the agent or the Company.

I have received the MIB 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 to give any such information, including medical information, to the life insurance company. A photocopy or facsimile of this authorization shall be made as valid as the original. This authorization will expire 24 months from the date signed.

FRAUD WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Signed at City Sallisaw State Oklahoma Proposed Insured Signature Harvey Thomas Bille

Date December 19th 2012 Owner Signature _____ (If Owner other than Insured)

Witness Bob Yeamon Jr (Agent Signature) Bob Yeamon Jr MLSR7410 (Print Agent's Name and I.D. Number)

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

HERMAN SHAW
014451077

Monumental Life Insurance Company

EXPRESS ISSUE COVER SHEET

(Please submit completed sheet with every application)

Agent Information		
Agent ID: MLSR7410	Agent Name (Print): Bob Tenor	Agent Phone: (918) 924-0776
Agent Email: bob.tenor@ftgagency.com		Agent Fax: (918) 867-9845
Proposed Insured Information		
Insured's name (Print): Herman Shaw		Last 4 digits of insured's social security #: [redacted]

Required Disclosures with Application:

☐ HIPAA Authorization Form ☐ Bank Draft Form

Other Disclosures (if applicable):

☐ Accelerated Death Benefit Disclosure Form ☐ HIV Consent Form ☐ Replacement Form(s)

How are you paying the initial Premium?

☐ By Check: Available with all methods, but must be used if subsequent payments are quarterly, semi-annual or annual

- Is the check for initial premium payment on the same account as monthly EFT payments? ☐ Yes ☐ No

☐ Draft initial premium upon receipt

☑ Draft initial premium at future date, please indicate the month and day (mm/dd): 02 (Month) , 14th (Day (1st thru 28th only))

- If you choose a specific Initial Premium draft date (in the future), the recurring draft date will be the same as the initial premium draft date and may not be greater than 30 days after the application date.

If you select an Initial Premium Draft date in the future, you will not have potential coverage until that date under the Conditional Receipt.

(See 'Draft Date Procedures & Scenarios' on Web site)

Submitting Application to Monumental: *(Faxing is the preferred method)*

If faxing, fax to 1-866-834-0437 and enter date faxed 01-14-2013. Do Not mail originals if faxing.

If mailing the application and/or check for initial premium please send with cover sheet to:

Monumental Life, 4333 Edgewood Road NE, Cedar Rapids, IA 52499

Monumental Life INSURANCE COMPANY

Monumental Life Insurance Company
Home Office: 4333 Edgewood Road NE, Cedar Rapids, Iowa 52499

LIFE APPLICATION

Agent ID #	State Application Taken	Policy # (H.O. Use Only)
MLSR7410	Oklahoma	

Part A1 - Proposed Insured

Name (First, M.I., Last)	Address, City, State, Zip Code (cannot be a P.O. Box)				
Herman Shaw	[redacted]				
SSN	Gender	D.O.B. (MM/DD/YYYY)	Age	U.S. State or Country of Birth	Phone Number
[redacted]	M	07-06-1947	65	Oklahoma, U.S	918 592-0905

1) Within the last 12 months has the proposed Insured used tobacco products in any form? ☐ Yes ☑ No

2) Life Insurance Face Amount $ 10,000
   a) Plan: Preferred
   b) Accidental Death Benefit Rider Face Amount $ 0
   c) Total Premium $ 57.50
   d) If a policy cannot be issued as applied for, would you accept a rated policy if available? ☐ Yes ☐ No
   e) If "yes," adjust face amount to premium? ☐ Yes ☐ No

3) Does the applicant have any existing life insurance or annuity contracts with the company or any other company? ☐ Yes ☐ No

4) Is this insurance intended to replace or change any life insurance or annuity contract in force with the company or any other company? (If yes, submit the state required forms) ☐ Yes ☐ 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) (cannot be a P.O. Box)	Are you a citizen of the U.S.? If not, what country?
	☐ Yes ☐ No

Part A3 - Beneficiary

Primary Name (First, MI, Last)	SSN	Gender	Relationship to Insured	D.O.B. (MM/DD/YYYY)
Lavarne Shaw	[redacted]	F	Wife	01/16/1944
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 ☑ No

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? ☐ Yes ☑ No
   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)? ☐ Yes ☑ No
   c) Been in a diabetic coma or had or been advised to have an amputation due to disease or disorder? ☐ Yes ☑ No

3) Within the past 2 years has the proposed Insured:
   a) Been diagnosed with, been treated for or advised to receive treatment for cancer (other than basal cell carcinoma)? ☐ Yes ☑ No
   b) Undergone testing by a medical professional for which the results have not been received? ☐ Yes ☑ No

Part B2

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? ☐ Yes ☑ No

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)? ☐ Yes ☑ No

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, drug abuse or muscular dystrophy? ☐ Yes ☑ No
   b) Had more than 12 seizures or been diagnosed with, been treated for or advised to receive treatment for congestive heart failure, cirrhosis, hepatitis B or C or other liver disease? ☐ Yes ☑ No
   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? ☐ Yes ☑ No
   d) Used oxygen to assist in breathing due to a disease or disorder, received kidney dialysis or been diagnosed with, been treated for or advised to receive treatment for kidney failure due to a disease or disorder? ☐ Yes ☑ No

- If All Questions In Part B2 Are Answered "No," Proceed to Part B3.
- If One Question In Part B2 Is Answered "Yes," The proposed Insured Is Eligible For The Graded Death Benefit Product. Proceed to Part C1.
- If Two Or More Questions In Part B2 Are Answered "Yes," The proposed Insured Is Not Eligible For Any Coverage.

Last Name and Last 4 Digits of SSN: Shaw - [redacted]

Part B3

7) Within the past 2 years has the proposed insured:
   a) Had or been treated for a heart attack, angina (chest pain), stroke (CVA), transient ischemic attack (TIA), aneurysm, circulatory or blood disorder, heart surgery including bypass or irregular heart rhythm such as atrial fibrillation? ☐ Yes ☑ No
   b) Had more than 12 seizures, taken insulin shots or been diagnosed with, been treated for or advised to receive treatment for congestive heart failure, cirrhosis, hepatitis B or C or other liver disease? ☐ Yes ☑ No
   c) Used illegal drugs or been diagnosed with, been treated for or advised to receive treatment for alcohol abuse or drug abuse? ☐ Yes ☑ No
8) Within the past 4 years has the proposed insured been diagnosed with, been treated for or advised to receive treatment for kidney disease? ☐ Yes ☑ No
9) Has the proposed insured ever been diagnosed with, been treated for or advised to receive treatment for Parkinson's disease, multiple sclerosis, chronic obstructive pulmonary disease (COPD) including emphysema, chronic asthma, black lung or other chronic respiratory disease? ☐ Yes ☑ No
10) Is the proposed insured currently under the age of 50 and if so, has the proposed insured within the past 5 years been diagnosed with, been treated for or advised to receive treatment for any mental disorder such as manic or clinical depression, schizophrenia, bipolar disease or post traumatic stress syndrome? ☐ Yes ☑ No

- If All Questions In Part B3 Are Answered "No," The proposed Insured Is Eligible For The Preferred Product. Please Check The Appropriate Box And Proceed to B4:
  ☑ Preferred LP99 ☐ Preferred 10PL ☐ Preferred Other: _____
- If One Question In Part B3 Is Answered "Yes," The proposed Insured Is Eligible For The Standard Product. Please Check The Appropriate Box And Proceed to B4:
  ☐ Standard LP99 ☐ Standard 10PL ☐ Standard Other: _____
- If Two Or More "Yes" Answers In Part B3, The proposed Insured Is Eligible For The Graded Death Benefit Product. Proceed To C1.

Part B4 - Nursing Home Option - If The Following Question Is Answered "Yes," The Proposed Insured Is Not Eligible For The Nursing Home Option On The Accelerated Death Benefit Rider.

Does the proposed Insured need any assistance from other persons in performing any Activities of Daily Living such as eating, bathing, toileting, dressing, taking medications, walking or moving in and out of bed or chair or does the proposed Insured have ongoing incontinence or, In the 2 years prior to the application, has a medical professional recommended that the proposed Insured be confined to a Nursing Home? ☐ Yes ☑ No

Part C1 - Face Amount & Payment Method

Face Amount: 10,000 | Payment Method: ☑ Monthly EFT ☐ Quarterly ☐ Semi-Annual ☐ Annual

Full Modal Premium Included or Authorized With Application Is: $57.50

Part C2 - Payor Information

The Payor is the ☐ Proposed Insured ☐ Owner ☐ Other (If Other, please provide the following information:)

Name (First, MI, Last)	SSN	Gender	Relationship to Insured

Address, City, State, Zip Code (cannot be a P.O. Box)	Are you a citizen of the U.S.? If not, what country? ☐ Yes ☐ No

Part C3 - Premium Payment Authorization For Electronic Funds Transfer (EFT): Payor's Authorization To Insurance Company

As a convenience to myself, I hereby authorize Monumental Life Insurance Company to draft premium payments from my financial institution account.

It is understood that credit for payment is conditioned upon the draft being honored when presented for payment. Furthermore, this authorization may be terminated (a) at the option of the Company if any draft is not honored when presented for payment; or (b) by the Company, financial institution or the undersigned upon 30 days written notice to the parties hereto.

If this authorization is terminated, the amount due on the policy involved will be billed on a quarterly basis.

Draft Date (1st-28th): 14th of Feb If no date selected, the draft date will be the policy date.

☑ Checking ☐ Savings Financial Institution Name: Bank of America City/State: Tulsa, OK

Routing #: 103000017 Account #: 003042079656

Payor Signature (If other than proposed Insured or Owner): Herman Shaw Date: January 14, 2013

Last Name and Last 4 Digits of SSN: Shaw - [redacted]

Agent's Report

I represent that:

1) I have personally seen the proposed insured. ☑ Yes ☐ No

2) I have fully and accurately recorded on this application the information as supplied by the Owner and the proposed insured. ☑ Yes ☐ No

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

Best time to call for a Personal History Interview 10 a.m. _____ p.m.

Home or work phone number 918-592-0905

Agent Signature Bob Tennon Jr

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. The proposed insured shall be the policyowner unless another owner is named above. I understand that I may revoke this authorization in writing to the agent or the Company.

I have received the MIB 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 to give any such information, including medical information, to the life insurance company. A photocopy or facsimile of this authorization shall be made as valid as the original. This authorization will expire 24 months from the date signed.

FRAUD WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Signed at City Tulsa State Oklahoma Proposed Insured Signature Herman Shaw

Date January 14, 2013 Owner Signature _____ (If Owner other than Insured)

Witness Bob Tennon Jr (Agent Signature) Bob Tennon Jr MLSR7410 (Print Agent's Name and I.D. Number)

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

MONUMENTAL LIFE INSURANCE COMPANY

Administrative Office located at: 4333 Edgewood Road N.E., Cedar Rapids, Iowa 52499

AMENDMENT OF APPLICATION

Herman Shaw
Proposed Owner

Herman Shaw
Proposed Insured

The application to Monumental Life Insurance Company dated, 01/14/2013, on the above named Proposed Insured is hereby amended as follows:
General Question Number 2 D & E,are Both NO
General Question Number 3 and 4,are both NO

The undersigned agrees that these changes shall be an amendment to and form a part of the original application and of the Policy/Certificate issued thereunder, if any, and that they shall be binding on any person who shall have or claim any interest under such Policy/Certificate.

The undersigned declares that there has been no change in the Proposed Insured's occupation, residence, or family history, that the Proposed Insured has suffered no illness or injury or other change in health condition, and that no company or association has taken adverse action with reference to the Proposed Insured's insurability since the date of the Proposed Insured's application to Monumental Life Insurance Company.

The undersigned declares that they have signed a copy of the amendment attached to, and made a part of, the Policy/Certificate issued on this application.

Dated at Tulsa, Oklahoma day 22nd month January year 13

/Herman Shaw
Herman Shaw

Bob Jennon Jr
Licensed Agent

(Proposed Insured If Other Than Proposed Owner Or Parent/Legal Guardian If Proposed Insured Is A Minor)

TO BE ATTACHED AND MADE PART OF POLICY/CERTIFICATE NO. #014451077

PLEASE RETURN ONE COPY TO THE ADMINISTRATIVE OFFICE
NEW BUSINESS DEPARTMENT

N Stacy Boyer
SECRETARY

Linda Cleary
PRESIDENT

LAVERNE SHAW
014451089

MONUMENTAL LIFE®
INSURANCE COMPANY

Monumental Life Insurance Con
333 Edgewood Road NE
Cedar Rapids, Iowa 52499

March 1, 2013

Ms. Laverne J. Shaw
[redacted]

RE: Policy Number: 014451089

Dear Ms. Shaw,

Thank you for your recent telephone communication with representatives of the Monumental Life Insurance Company ("Monumental"). Your concerns regarding the above-referenced policy and your interactions with agent Bob Tennon have been forwarded to me for response. I appreciate the opportunity to be of assistance.

During your conversation with our Customer Service Center, you alleged that you did not complete an application for coverage with Monumental and that you had not met with Mr. Tennon since September of 2011. In response to your allegations, I contacted Mr. Tennon in an effort to obtain additional information in this regard. Mr. Tennon indicated that he has in fact met with you on several occasions since September of 2011, most recently of which was in January of 2013. Mr. Tennon also indicated that he was set to follow-up with you to discuss your Medicare Supplement plan, but was unable to make the appointment. Mr. Tennon subsequently received notice that you wanted to cancel your life insurance coverage because you felt you could not afford it.

In any event, please note that this policy has been cancelled as though it was never in force. Because no premium was submitted in association with this policy, no refund is due. Pursuant to your request, I have enclosed a copy of your signed application for coverage with Monumental. Please review the enclosed application carefully. If after your review, you are certain that you did not sign this document, please complete and sign the Affidavit (including notarization of your signature) and return to us. We also request that you include with the completed Affidavit, a clear and legible copy of a current U.S. government and/or State issued identification card (i.e. drivers license, passport or state issued I.D.) with your signature appearing on the copy of the document you provide to us. Upon receipt of the requested documentation, we will re-open our investigation into this matter; otherwise, we will consider this matter closed.

I hope that this response has adequately addressed your concerns. Should you have additional questions, or if we may be of further assistance to you, please do not hesitate to contact our Customer Service Center toll-free at (800) 238-4302. Our representatives would be happy to assist you in any way they can.

MONUMENTAL LIFE®
INSURANCE COMPANY

Monumental Life Insurance Co
3333 Edgewood Road NE
Cedar Rapids, Iowa 52499

Sincerely,

Jessica R. Amyett

Jessica R. Amyett, FLMI
Consumer Affairs Analyst

cc:

Monumental Consumer Affairs Compliance	
Bob Tennon	00MLSR7410
Educator Group Plans	00MLSR7574

MONUMENTAL LIFE®
INSURANCE COMPANY

Monumental Life Insurance Company
4333 Edgewood Road NE
Cedar Rapids, Iowa 52499

March 1, 2013

Laverne J Shaw
[redacted]

RE: Policy #: 014451089
Insured: Laverne J Shaw

Dear Ms. Shaw:

Thank you for allowing us the opportunity to assist you.

As you requested, your policy has been cancelled as of the issue date.

If you requested additional information, you will receive it in a separate mailing.

We are committed to providing quality service to our customers. Our Customer Contact Center is available to you weekdays at 1-800-238-4302.

Sincerely,

Customer Contact Center
Monumental Life Insurance Company

cc: Bob Tennon 00MLSR7410
Bcg Financial 00MLSR2233

Monumental Life Insurance Company

EXPRESS ISSUE COVER SHEET

(Please submit completed sheet with every application)

Agent Information

Agent ID	Agent Name (Print)	Agent Phone
MLSR7410	Bob Temoer	(918)924-0776
Agent Email		**Agent Fax**
bob.temoer@pfagency.com		(918)367-9845

Proposed Insured Information

Insured's name (Print)	Last 4 digits of Insured's social security #
Laverne Shaw	2691

Required Disclosures with Application:

☐ HIPAA Authorization Form ☐ Bank Draft Form

Other Disclosures (if applicable):

☐ Accelerated Death Benefit Disclosure Form ☐ HIV Consent Form ☐ Replacement Form(s)

How are you paying the Initial Premium?

☐ By Check: Available with all methods, but must be used if subsequent payments are quarterly, semi-annual or annual

- Is the check for initial premium payment on the same account as monthly EFT payments? ☐ Yes ☐ No

☐ Draft initial premium upon receipt

☑ Draft initial premium at future date, please indicate the month and day (mm/dd): 02 (Month) / 14th (Day (1st thru 28th only))

- If you choose a specific Initial Premium draft date (in the future), the recurring draft date will be the same as the initial premium draft date and may not be greater than 30 days after the application date.

If you select an Initial Premium Draft date in the future, you will not have potential coverage until that date under the Conditional Receipt.

(See 'Draft Date Procedures & Scenarios' on Web site)

Submitting Application to Monumental: *(Faxing is the preferred method)*

If faxing, fax to 1-866-834-0437 and enter date faxed 01-14-2013. Do Not mail originals if faxing.

If mailing the application and/or check for initial premium please send with cover sheet to:

Monumental Life, 4333 Edgewood Road NE, Cedar Rapids, IA 52499

Monumental Life Insurance Company
Home Office: 4333 Edgewood Road NE, Cedar Rapids, Iowa 52499

LIFE APPLICATION

Agent ID #	State Application Taken	Policy # (H.O. Use Only)
ML587410	Oklahoma	

Part A1 - Proposed Insured

Name (First, M.I., Last)	Address, City, State, Zip Code (cannot be a P.O. Box)				
Lavern J. Shaw	[redacted]				
SSN	Gender	D.O.B. (MM/DD/YYYY)	Age	U.S. State or Country of Birth	Phone Number
[redacted]	F	01-16-1944	69	Illinois, United States	(918) 592-0905

1) Within the last 12 months has the proposed Insured used tobacco products in any form? ☐ Yes ☑ No

2) Life Insurance Face Amount $ 10,000
   a) Plan: Preferred
   b) Accidental Death Benefit Rider Face Amount $ 0
   c) Total Premium $ 52.40
   d) If a policy cannot be issued as applied for, would you accept a rated policy if available? ☐ Yes ☑ No
   e) If 'yes,' adjust face amount to premium? ☐ Yes ☑ No

3) Does the applicant have any existing life insurance or annuity contracts with the company or any other company? ☐ Yes ☑ No

4) Is this insurance intended to replace or change any life insurance or annuity contract in force with the company or any other company? ☐ Yes ☑ No
   (If yes, submit the state required forms)

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) (cannot be a P.O. Box)	Are you a citizen of the U.S.? If not, what country?
	☐ Yes ☐ No

Part A3 - Beneficiary

Primary Name (First, MI, Last)	SSN	Gender	Relationship to Insured	D.O.B. (MM/DD/YYYY)
Herman Shaw	[redacted]	M	Husband	07/06/1945
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 ☑ No

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? ☐ Yes ☑ No
   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)? ☐ Yes ☑ No
   c) Been in a diabetic coma or had or been advised to have an amputation due to disease or disorder? ☐ Yes ☑ No

3) Within the past 2 years has the proposed Insured:
   a) Been diagnosed with, been treated for or advised to receive treatment for cancer (other than basal cell carcinoma)? ☐ Yes ☑ No
   b) Undergone testing by a medical professional for which the results have not been received? ☐ Yes ☑ No

Part B2

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? ☐ Yes ☑ No

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)? ☐ Yes ☑ No

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, drug abuse or muscular dystrophy? ☐ Yes ☑ No
   b) Had more than 12 seizures or been diagnosed with, been treated for or advised to receive treatment for congestive heart failure, cirrhosis, hepatitis B or C or other liver disease? ☐ Yes ☑ No
   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? ☐ Yes ☑ No
   d) Used oxygen to assist in breathing due to a disease or disorder, received kidney dialysis or been diagnosed with, been treated for or advised to receive treatment for kidney failure due to a disease or disorder? ☐ Yes ☑ No

- If All Questions In Part B2 Are Answered "No", Proceed to Part B3.
- If One Question In Part B2 Is Answered "Yes", The proposed Insured Is Eligible For The Graded Death Benefit Product. Proceed to Part C1.
- If Two Or More Questions In Part B2 Are Answered "Yes", The proposed Insured Is Not Eligible For Any Coverage.

Last Name and Last 4 Digits of SSN: Shaw - [redacted]

Part B3

7) Within the past 2 years has the proposed Insured:
   a) Had or been treated for a heart attack, angina (chest pain), stroke (CVA), transient ischemic attack (TIA), aneurysm, circulatory or blood disorder, heart surgery including bypass or irregular heart rhythm such as atrial fibrillation? ☐ Yes ☑ No
   b) Had more than 12 seizures, taken insulin shots or been diagnosed with, been treated for or advised to receive treatment for congestive heart failure, cirrhosis, hepatitis B or C or other liver disease? ☐ Yes ☑ No
   c) Used illegal drugs or been diagnosed with, been treated for or advised to receive treatment for alcohol abuse or drug abuse? ☐ Yes ☑ No
8) Within the past 4 years has the proposed Insured been diagnosed with, been treated for or advised to receive treatment for kidney disease? ☐ Yes ☑ No
9) Has the proposed Insured ever been diagnosed with, been treated for or advised to receive treatment for Parkinson's disease, multiple sclerosis, chronic obstructive pulmonary disease (COPD) including emphysema, chronic asthma, black lung or other chronic respiratory disease? ☐ Yes ☑ No
10) Is the proposed Insured currently under the age of 50 and if so, has the proposed Insured within the past 5 years been diagnosed with, been treated for or advised to receive treatment for any mental disorder such as manic or clinical depression, schizophrenia, bipolar disease or post traumatic stress syndrome? ☐ Yes ☑ No

- If All Questions In Part B3 Are Answered "No," The proposed Insured Is Eligible For The Preferred Product. Please Check The Appropriate Box And Proceed to B4:
  ☑ Preferred LP99 ☐ Preferred 10PL ☐ Preferred Other: _____
- If One Question in Part B3 Is Answered "Yes," The proposed Insured Is Eligible For The Standard Product. Please Check The Appropriate Box And Proceed to B4:
  ☐ Standard LP99 ☐ Standard 10PL ☐ Standard Other: _____
- If Two Or More "Yes" Answers In Part B3, The proposed Insured Is Eligible For The Graded Death Benefit Product. Proceed To C1.

Part B4 - Nursing Home Option - If The Following Question Is Answered "Yes," The Proposed Insured Is Not Eligible For The Nursing Home Option On The Accelerated Death Benefit Rider.

Does the proposed Insured need any assistance from other persons in performing any Activities of Daily Living such as eating, bathing, toileting, dressing, taking medications, walking or moving in and out of bed or chair or does the proposed Insured have ongoing incontinence or, in the 2 years prior to the application, has a medical professional recommended that the proposed Insured be confined to a Nursing Home? ☐ Yes ☑ No

Part C1 - Face Amount & Payment Method

Face Amount: $10,000 | Payment Method: ☑ Monthly EFT ☐ Quarterly ☐ Semi-Annual ☐ Annual

Full Modal Premium Included or Authorized With Application Is: $52.40

Part C2 - Payor Information

The Payor Is the ☐ Proposed Insured ☐ Owner ☐ Other (If Other, please provide the following information:)

Name (First, MI, Last)	SSN	Gender	Relationship to Insured

Address, City, State, Zip Code (cannot be a P.O. Box)	Are you a citizen of the U.S.? ☐ Yes ☐ No If not, what country?

Part C3 - Premium Payment Authorization For Electronic Funds Transfer (EFT): Payor's Authorization To Insurance Company

As a convenience to myself, I hereby authorize Monumental Life Insurance Company to draft premium payments from my financial institution account.

It is understood that credit for payment is conditioned upon the draft being honored when presented for payment. Furthermore, this authorization may be terminated (a) at the option of the Company if any draft is not honored when presented for payment; or (b) by the Company, financial institution or the undersigned upon 30 days written notice to the parties hereto.

If this authorization is terminated, the amount due on the policy involved will be billed on a quarterly basis.

Draft Date (1st-28th): 4th of Feb If no date selected, the draft date will be the policy date.

☑ Checking ☐ Savings Financial Institution Name: Bank of America City/State: Tulsa, OK

Routing #: 1 0 2 0 0 0 1 1 7 Account #: 0 0 3 0 4 2 0 7 9 6 5 6

Payor Signature (if other than proposed Insured or Owner) LaVerne Shaw Date: 01-14-2012

Last Name and Last 4 Digits of SSN: Shaw – [redacted]

Agent's Report

I represent that:

1) I have personally seen the proposed Insured. ☑ Yes ☐ No

2) I have truly and accurately recorded on this application the information as supplied by the Owner and the proposed Insured. ☑ Yes ☐ No

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

Best time to call for a Personal History Interview 10 a.m. _____ p.m.

Home or work phone number 918-592-0905

Agent Signature Bob Yenson Jr

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. The proposed Insured shall be the policyowner unless another owner is named above. I understand that I may revoke this authorization in writing to the agent or the Company.

I have received the MIB 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 to give any such information, including medical information, to the life insurance company. A photocopy or facsimile of this authorization shall be made as valid as the original. This authorization will expire 24 months from the date signed.

FRAUD WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Signed at City Tulsa State Oklahoma Proposed Insured Signature LaVerne Shaw

Date January 14, 2012 Owner Signature _____ (If Owner other than Insured)

Witness Bob Yenson Jr (Agent Signature) Bob Yenson Jr MLSA7410 (Print Agent's Name and I.D. Number)

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

MONUMENTAL LIFE INSURANCE COMPANY

Administrative Office located at: 4333 Edgewood Road N.E., Cedar Rapids, Iowa 52499

AMENDMENT OF APPLICATION

Laverne J Shaw
Proposed Owner

Laverne J Shaw
Proposed Insured

The application to Monumental Life Insurance Company dated, January 14, 2013, on the above named Proposed Insured is hereby amended as follows:
The application date of this policy/certificate is January 14, 2013.

The undersigned agrees that these changes shall be an amendment to and form a part of the original application and of the Policy/Certificate issued thereunder, if any, and that they shall be binding on any person who shall have or claim any interest under such Policy/Certificate.

The undersigned declares that there has been no change in the Proposed Insured's occupation, residence, or family history, that the Proposed Insured has suffered no illness or injury or other change in health condition, and that no company or association has taken adverse action with reference to the Proposed Insured's insurability since the date of the Proposed Insured's application to Monumental Life Insurance Company.

The undersigned declares that they have signed a copy of the amendment attached to, and made a part of, the Policy/Certificate issued on this application.

Dated at Tulsa, Oklahoma day 17th month January year 13

Laverne Shaw
Laverne J Shaw

Bob Yennon Jr
Licensed Agent

(Proposed Insured If Other Than Proposed Owner Or Parent/Legal Guardian If Proposed Insured Is A Minor)

TO BE ATTACHED AND MADE PART OF POLICY/CERTIFICATE NO. #014451089

PLEASE RETURN ONE COPY TO THE ADMINISTRATIVE OFFICE
NEW BUSINESS DEPARTMENT

N Stacy Boyer
SECRETARY

Linda Clancy
PRESIDENT