The Penn Mutual Life Insurance Company
The Penn Insurance and Annuity Company

Application for Life Insurance

TEXAS

Penn Mutual
A better way of life

The Penn Mutual Life Insurance Company

The Penn Insurance and Annuity Company

Application for Life Insurance

This packet includes an application for all plans of life insurance currently offered by the company. Also included are the Notice of Insurance Information Practices, Life Insurance Buyer's Guide, Authorization form, Temporary Insurance Agreement, Agent's Underwriting Report, Confidential Financial Statement and Variable Universal Life Supplemental Application.

General Instructions for Completion of the Application

(1) The Notice of Insurance Information Practices and the Life Insurance Buyer's Guide must be detached and given to the Proposed Insured before completion of the application.

(2) The Temporary Insurance Agreement (TIA) must be completed whenever money is collected. Do not accept money if the amount of insurance requested exceeds $5,000,000, or if either of the questions on the TIA is answered "Yes". The maximum amount of temporary coverage provided under the TIA is the lesser of the amount stated on the application or $1,000,000.

(3) The proposed insured(s), applicant, and owner must sign the form where indicated.

(4) Complete Section B for a Joint Life Policy or Additional Insured Riders (spouses or adult children).

(5) If the proposed insured is under age 18, the application must be signed by a parent or guardian.

(6) If Insured is under 18, occupation, income and business information apply to the parent or guardian, and must be completed.

(7) All appropriate sections of the application required for the coverage requested must be completed in their entirety.

(8) The authorization must be signed, dated and forwarded with the application to the Home Office.

(9) Taxpayer Identification Number and Certification must be completed whenever appropriate.

(10) For Variable business, be sure to have the Owner sign the VUL Supplement.

(11) For non-variable business in states that follow the NAIC Illustration Regulations, the Illustration must be signed and match the application exactly. If it does not, be sure to check the non-conforming statement box on page 8.

(12) Be sure to check the box regarding replacement in the Agent Certification section on page 11.

(13) The Agent's Underwriting Report **MUST** be completed in it's entirety and submitted with the application.

Notice of Insurance Information Practices

Penn Mutual / Penn Insurance and Annuity Company (PIA) wishes to thank you for your application for insurance. In order for us to accurately underwrite this application, it is necessary to obtain some personal information about you. This information is necessary and vital to our business because it enables us to classify each applicant appropriately according to the risk he or she represents.

We at the Company are and always have been acutely aware of the responsibility placed upon us as possessors of private information. We safeguard such information and disclose it only for legitimate business or legal reasons. Below we will outline some of our underwriting procedures and explain certain rights that you have.

How We Collect Our Information

In addition to the information included in the application, the Company, its subsidiaries or its reinsurers will, as a part of our underwriting procedures, collect information relating to any proposed insured's physical and mental condition, health history, mode of living, general character and reputation, personal characteristics, habits, finances, occupation, other insurance coverage or participation in hazardous activities.

This information may be obtained from you personally or from physicians, medical professionals, hospitals, clinics or other medical care institutions which have provided care to you or to members of your family, from the MIB, Inc., public records, consumer reporting agencies, financial sources (such as your lawyer and/or accountant), other insurance companies, agents, friends, neighbors, employers, or business associates. We may obtain this information through exchanges of correspondence, by telephone, or by personal contact.

An investigative consumer report may be necessary. You have the right to obtain a copy of this report and to be interviewed personally as part of this process. If you desire this personal interview, please inform your agent. Should you want a copy of this report, write to us, and we will furnish the name and address of the consumer reporting agency. You may then contact this agency and request a copy. Should an investigative consumer report be obtained, the consumer reporting agency may retain that information in its files. Federal law prohibits such organizations from disclosing such information to other parties without your authorization.

We will also ask you some marketing questions which we will use solely for marketing analysis.

Access To This Information

The information about you, which we obtain and keep in our files, will not be disclosed to others without your authorization except to the extent necessary for the conducting of our business. For example, necessary items of information may be disclosed to persons or organizations which perform a business, professional or insurance function for us.

We may occasionally disclose certain information to a State Insurance Department, or when required, to law enforcement or other governmental authority to prevent or prosecute fraud or other unlawful activities.

Information about you may be given to other insurers, agents or insurance support organizations to enable them to perform a business function concerning an insurance transaction with you, or to help detect or prevent insurance fraud or misrepresentation. For your benefit we may disclose to your physician a medical problem of which you may not be aware. In addition, we may give information about you to an affiliated company so that it can inform you of insurance products or services.

How To Obtain This Information

You have the right of access to this information which the Company maintains in its files about you and which you reasonably describe. Within 30 business days of our receipt of your written request, you may have access to recorded information about you which is retrievable. However, medical information will be released only to a physician whom you designate. Your right of access does not extend to information which relates to and in connection with, or in reasonable anticipation of, a claim or civil or criminal proceeding. We will inform you of the nature and substance of the information and identify any institution source which gave us information. If recorded, we will advise you of those persons to whom such information has been disclosed within two years prior to the request, or if not recorded, we will give you the names of the persons or organizations to whom such information is normally disclosed. If you wish, we can arrange for you to see this information or obtain a copy by mail. You may request correction, amendment or deletion of any information in our files pertaining to you, and we will respond within 30 days.

DETACH AND LEAVE WITH PROPOSED INSURED

We will tell you if we complied with your request. If we do not agree with you, we will notify you of our refusal, give you our reasons and give you the opportunity to file a concise statement of dispute with us. Your statement will be sent with any disclosure of the information which we make.

In either event, we will notify any insurance support organization that furnished the information to us and any person whom you designate and who may have received such information within the preceding two years of the dispute regarding the information. Your statement of dispute will be sent to these parties if we did not comply with your request.

Please direct all requests involving the above procedures to the Penn Mutual Life Insurance Company, Attn.: Life New Business Department, 600 Dresher Rd., Horsham, PA 19044. Give your full name, address, date of birth and policy number. You may also call us at (800) 523-0650, and ask for the Life New Business Department.

Fair Credit Reporting Act Notice

As part of our regular underwriting procedures, an investigative consumer report may be obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry will include information as to your character, general health, general reputation, personal characteristics, driving record, criminal activity, and mode of living. As part of your application for insurance, you have authorized the Company to obtain such a report, and you should understand that you have the right to make a written request within a reasonable period of time to the Company's Underwriting Department to receive additional detailed information about the nature and scope of this investigation. You should also understand that upon written request, you will be informed whether such a report has actually been ordered, and if it has, you will be furnished the name and address of the consumer reporting agency to whom the request was made. You may contact this consumer reporting agency and request a copy of any such report.

MIB, Inc. Notice

Information regarding your insurability will be treated as confidential. The Company or its reinsurers may, however, make a brief report thereon to MIB, Inc., a nonprofit organization of life insurance companies, which operates as an information exchange on behalf of its members. If you request coverage from another MIB, Inc., member company for life or health insurance or a claim for benefits is submitted to such a company, MIB, Inc. upon request, will supply such company with the information it may have in its file.

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

If you have requested or request life or health insurance or have a claim for benefits with other life insurance member companies, Penn Mutual or its reinsurers may release information in our files to them if they so request, provided they have your authorization to request this information.

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FOR THE CLIENT

LIFE INSURANCE BUYER'S GUIDE

Prepared by the National Association of Insurance Commissioners

The National Association of Insurance Commissioners is an association of state insurance regulatory officials. This association helps the various insurance departments to coordinate insurance laws for the benefits of all consumers.

This guide does not endorse any company or policy.

Reprinted by the Penn Mutual Life Insurance Company.

Important Things to Consider

1. Review your own insurance needs and circumstances. Choose the kind of policy that has benefits that most closely fit your needs. Ask an agent or company to help you.

2. Be sure that you can handle premium payments. Can you afford the initial premium? If the premium increases later and you still need insurance, can you still afford it?

3. Don't sign an insurance application until you review it carefully to be sure all the answers are complete and accurate.

4. Don't buy life insurance unless you intend to stick with your plan. It may be very costly if you quit during the early years of the policy.

5. Don't drop one policy and buy another without a thorough study of the new policy and the one you have now. Replacing your insurance **may be costly.**

6. Read your policy carefully. Ask your agent or company about anything that is nor clear to you.

7. Review your life insurance program with your agent or company every few years to keep up with changes in your income and your needs.

Buying Life Insurance

When you buy life insurance, you want coverage that fits your needs.

First, decide how much you need—and for how long—and what you can afford to pay. Keep in mind the major reason you buy life insurance is to cover the financial effects of unexpected or untimely death. Life insurance also can be one of many ways you plan for the future.

Next, learn what kinds of policies will meet your needs and pick the one that best suits you.

Then, choose the combination of policy premium and benefits that emphasizes protection in case of early death, or benefits in case of long life, or a combination of both.

It makes good sense to ask a life insurance agent or company to help you. An agent can help you review your insurance needs and give you information about the available policies. If one kind of policy doesn't seem to fit your needs, ask about others.

This guide provides only basic information. You can get more facts from a life insurance agent or company or from your public library.

What About the Policy You Have Now?

If you are thinking about dropping a life insurance policy, here are some things you should consider:

- If you decide to replace your policy, don't cancel your old policy until you have received the new one. You then have a minimum period to review your new policy and decide if it is what you wanted.
- It may be costly to replace a policy. Much of what you paid in the early years of the policy you have now, paid for the company's cost of selling and issuing the policy. You may pay this type of cost again if you buy a new policy.
- Ask your tax advisor if dropping your policy could affect your income taxes.
- If you are older or your health has changed, premiums for the new policy will often be higher. You will not be able to buy a new policy if you are not insurable.
- You may have valuable rights and benefits in the policy you now have that are not in the new one.
- If the policy you have now no longer meets your needs, you may not have to replace it. You might be able to change your policy or add to it to get the coverage or benefits you now want.
- At least in the beginning, a policy may pay no benefits for some causes of death covered in the policy you have now.

In all cases, if you are thinking of buying a new policy, check with the agent or company that issued you the one you have now. When you bought your old policy, you may have seen an illustration of the benefits of your policy. Before replacing your policy, ask your agent or company for an updated illustration. Check to see how the policy has performed and what you might expect in the future, based on the amounts the company is paying now.

How Much Do You Need?

Here are some questions to ask yourself:

- How much of the family income do I provide? If I were to die early, how would my survivors, especially my children, get by? Does anyone else depend on me financially, such as a parent, grandparent, brother or sister?

- Do I have children for whom I'd like to set aside money to finish their education in the event of my death?

- How will my family pay final expenses and repay debts after my death?

- Do I have family members or organizations to whom I would like to leave money?

- Will there be estate taxes to pay after my death?

- How will inflation affect future needs?

As you figure out what you have to meet these needs, count the life insurance you have now, including any group insurance where you work or veteran's insurance. Don't forget Social Security and pension plan survivor's benefits. Add other assets you have: savings, investments, real estate and personal property. Which assets would your family sell or cash in to pay expenses after your death?

What is the Right Kind of Life Insurance?

All policies are not the same. Some give coverage for your lifetime and others cover you for a specific number of years. Some build up cash values and others do not. Some policies combine different kinds of insurance, and others let you change from one kind of insurance to another. Some policies may offer other benefits while you are still living. Your choice should be based on your needs and what you can afford.

There are two basic types of life insurance: **term insurance** and **cash value insurance**. Term insurance generally has lower premiums in the early years, but does not build up cash values that you can use in the future. You may combine cash value life insurance with term insurance for the period of your greatest need for life insurance to replace income.

Term Insurance covers you for a term of one or more years. It pays a death benefit only if you die in that term. Term insurance generally offers the largest insurance protection for your premium dollar. It generally does not build up cash value.

You can renew most term insurance policies for one or more terms even if your health has changed. Each time you renew the policy for a new term, premiums may be higher. Ask what the premiums will be if you continue to renew the policy. Also ask if you will lose the right to renew the policy at some age. For a higher premium, some companies will give you the right to keep the policy in force for a guaranteed period at the same price each year. At the end of that time you may need to pass a physical examination to continue coverage, and premiums may increase.

You may be able to trade many term insurance policies for a cash value policy during a

conversion period—even if you are not in good health. Premiums for the new policy will be higher than you have been paying for the term insurance.

Cash Value Life Insurance is a type of insurance where the premiums charged are higher at the beginning than they would be for the same amount of term insurance. The part of the premium that is not used for the cost of insurance is invested by the company and builds up a cash value that may be used in a variety of ways. You may borrow against a policy's cash value by taking a policy loan. If you don't pay back the loan and the interest on it, the amount you owe will be subtracted from the benefits when you die, or from the cash value if you stop paying premiums and take out the remaining cash value. You can also use your cash value to keep insurance protection for a limited time or to buy a reduced amount without having to pay more premiums. You also can use the cash value to increase your income in retirement or to help pay for needs such as a child's tuition without canceling the policy. However, to build up this cash value, you must pay higher premiums in the earlier years of the policy. Cash value life insurance may be one of several types; whole life, universal life and variable life are all types of cash value insurance.

Whole Life Insurance covers you for as long as you live if your premiums are paid. You generally pay the same amount in premiums for as long as you live. When you first take out the policy, premiums can be several times higher than you would pay initially for the same amount of term insurance. But they are smaller than the premiums you would eventually pay if you were to keep renewing a term policy until your later years.

Some whole life policies let you pay premiums for a shorter period such as 20 years, or until age 65. Premiums for these policies are higher since the premium payments are made during a shorter period.

Universal Life Insurance is a kind of flexible policy that lets you vary your premium payments. You can also adjust the face amount of your coverage. Increases may require proof that you qualify for the new death benefit. The premiums you pay (less expense charges) go into a policy account that earns interest. Charges are deducted from the account. If your yearly premium payment plus the interest your account earns is less than the charges, your account value will become lower. If it keeps dropping, eventually your coverage will end. To prevent that, you may need to start making premium payments, or increase your premium payments, or lower your death benefits. Even if there is enough in your account to pay the premiums, continuing to pay premiums yourself means that you build up more cash value.

Variable Life Insurance is a kind of insurance where the death benefits and cash values depend on the investment performance of one or more separate accounts, which may be invested in mutual funds or other investments allowed under the policy. Be sure to get the prospectus from the company when buying this kind of policy and STUDY IT CAREFULLY. You will have higher death benefits and cash value if the underlying investments do well. Your benefits and cash value will be lower or may disappear if the investments you chose didn't do as well as you expected. You may pay an extra premium for a guaranteed death benefit.

Life Insurance Illustrations

You may be thinking of buying a policy where cash values, death benefits, dividends or premiums may vary based on events or situations the company does not guarantee (such as interest rates). If so, you may get an illustration from the agent or company that helps explain how the policy works. The illustration will show how the benefits that are not guaranteed will change as interest rates and other factors change. The illustration will show you what the company guarantees. It will also show you what *could* happen in the future. Remember that nobody knows what will happen in the future. You should be ready to adjust your financial plans if the cash value doesn't increase as quickly as shown in the illustration. You will be asked to sign a statement that says you understand that some of the numbers in the illustration are not guaranteed.

Finding a Good Value in Life Insurance

After you have decided which kind of life insurance is best for you, compare similar policies from different companies to find which one is likely to give you the best value for your money. A simple comparison of the premiums is not enough. There are other things to consider. For example:

- Do premiums or benefits vary from year to year?
- How much do the benefits build up in the policy?
- What part of the premiums or benefits is not guaranteed?
- What is the effect of interest on money paid and received at different times on the policy?

Once you have decided which type of policy to buy, you can use a cost comparison index to help you compare similar policies. Life insurance agents or companies can give you information about several different kinds of indexes that each work a little differently. One type helps you compare the costs between two policies if you give up the policy and take out the cash value. Another helps you compare your costs if you don't give up your policy before its coverage ends. Some help you decide what kind of questions to ask the agent about the numbers used in an illustration. Each index is useful in some ways, but they all have shortcomings. Ask your agent which will be most helpful to you. Regardless of which index you use, compare index numbers only for similar policies—those that offer basically the same benefits, with premiums payable for the same length of time.

Remember that no one company offers the lowest cost at **all** ages for **all** kinds and amounts of insurance. You should also consider other factors:

- How quickly does the cash value grow? Some policies have low cash values in the early years that build quickly later on. Other policies have a more level cash value build-up. A year-by-year display of values and benefits can be very helpful. (The agent or company will give you a policy summary or an illustration that will show benefits and premiums for selected years.)

- Are there special policy features that particularly suit your needs?

- How are non-guaranteed values calculated? For example, interest rates are important in determining policy returns. In some companies increases reflect the average interest earnings on all of that company's policies regardless of when issued. In others, the return for policies issued in a recent year, or a group of years, reflects the interest earnings on that group of policies; in this case, amounts paid are likely to change more rapidly when interest rates change.

CHECK BOX OF APPLICABLE COMPANY

☐ **The Penn Mutual Life Insurance Company**
Philadelphia, PA 19172

☐ **The Penn Insurance and Annuity Company**
Philadelphia, PA 19172

TEMPORARY LIFE INSURANCE AGREEMENT (TIA)

This Agreement provides a **Limited Amount** of Life Insurance Protection, for a **Limited Period** of time, subject to the terms of this Agreement. Advance payment in the amount of $_____ in connection with the application dated _____ is made for Life Insurance on _____.
Name of Proposed Insured(s)

Health Questions

Has the person(s) listed above as Proposed Insured(s):

1. Within the past 90 days, been admitted to a hospital or other medical facility, been advised to be admitted, or had surgery performed or recommended? ☐ Yes ☐ No

2. Within the past 2 years, been treated for heart trouble, chest pain, stroke or cancer, or had such treatment recommended by a physician or other medical practitioner? ☐ Yes ☐ No

If either of the above questions is answered **YES** or **Left Blank,** no representative of the Company is authorized to accept money; and **NO COVERAGE** will take effect under this Agreement.

Terms and Conditions

MAXIMUMS: ISSUE AGE 70 (as measured from nearest birthday); AMOUNT OF COVERAGE $1,000,000
If money has been accepted by the Company as advance payment for an application for Life Insurance and a Proposed Insured dies while this temporary insurance is in effect, in accordance with the terms and conditions of the plan applied for, the Company will pay to the beneficiary designated in the application the lesser of (a) the amount of all death benefits applied for in the Application, including any accidental or supplemental death benefits, if applicable, or (b) $1,000,000. In no event shall the total benefit payable under this Agreement and under any other Temporary Insurance Agreement with the Company exceed $1,000,000 with respect to ALL Proposed Insured(s).
In order for all or any part of any Accidental Death Benefit amount to be included in the Temporary Insurance Agreement Death Benefit for a Proposed Insured, the Accidental Death Benefit Rider must be applied for with respect to such Proposed Insured, and the death of such Proposed Insured must have been such that the Accidental Death Benefit would be payable if the Accidental Death Benefit Rider of the policy applied for were in force.

DATE COVERAGE BEGINS
Temporary Life Insurance under this Agreement will begin on the date of this Agreement but only if Sections A through Q of the signed Application have been completed on the same date or prior to the date of this Agreement and the modal premium reflected in the application for the policy applied for is received on the date of this Agreement.

DATE COVERAGE TERMINATES
Temporary Life Insurance under this Agreement will terminate on the **earliest** of:
(a) the date that insurance takes effect under the policy applied for, or
(b) the date a policy, other than as applied for, is offered to the Applicant, or
(c) the date the Company mails notice of termination of coverage and/or returns prepayment to the premium notice address designated in the Application. The Company may terminate coverage at any time.

The cost of your temporary insurance is incorporated in the policy for which you applied. The effective date of the policy will be the date your payment is received with this agreement by the Company, but in no event will this date be more than 30 days prior to the issuance of your policy. Any interest credited on flexible premium adjustable policies will be done so from the policy effective date.

LIMITATIONS
In no event will a death benefit be paid under both the Agreement and the policy applied for on the Application.
Fraud or material misrepresentations in the Application or in the answers to the Health questions of this Agreement invalidate this Agreement and the Company's only liability is for refund of any payment made.
If the Proposed Insured dies by suicide, the Company's liability under this Agreement is limited to a refund of payment made.
There is no coverage under this Agreement if the check or draft submitted as payment is not honored by the bank.
No one is authorized to waive or modify any of the provisions of this agreement.

I (WE) HAVE RECEIVED A COPY OF AND HAVE READ THIS AGREEMENT AND DECLARE THAT THE ANSWERS ARE TRUE TO THE BEST OF MY(OUR) KNOWLEDGE AND BELIEF. I (WE) UNDERSTAND AND AGREE TO ALL ITS TERMS.

Date of this agreement is _____

_____
Signature of Proposed Insured 1
(If Proposed Insured is under age 18, parent or guardian must sign.)

_____
Applicant (if other than Proposed Insured)

_____
Signature of Soliciting Agent - Licensed Resident Agent Where Required by Law

_____
Signature of Proposed Insured 2

NOTICE: The Applicant should retain the copy of this agreement; the original will be retained by the Company. All checks must be made payable to the company designated above. Do not make check payable to the agent or leave check blank.

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(b) the date a policy, other than as applied for, is offered to the Applicant, or
(c) the date the Company mails notice of termination of coverage and/or returns prepayment to the premium notice address designated in the Application. The Company may terminate coverage at any time.

The cost of your temporary insurance is incorporated in the policy for which you applied. The effective date of the policy will be the date your payment is received with this agreement by the Company, but in no event will this date be more than 30 days prior to the issuance of your policy. Any interest credited on flexible premium adjustable policies will be done so from the policy effective date.

LIMITATIONS
In no event will a death benefit be paid under both the Agreement and the policy applied for on the Application.
Fraud or material misrepresentations in the Application or in the answers to the Health questions of this Agreement invalidate this Agreement and the Company's only liability is for refund of any payment made.
If the Proposed Insured dies by suicide, the Company's liability under this Agreement is limited to a refund of payment made.
There is no coverage under this Agreement if the check or draft submitted as payment is not honored by the bank.
No one is authorized to waive or modify any of the provisions of this agreement.

I (WE) HAVE RECEIVED A COPY OF AND HAVE READ THIS AGREEMENT AND DECLARE THAT THE ANSWERS ARE TRUE TO THE BEST OF MY(OUR) KNOWLEDGE AND BELIEF. I (WE) UNDERSTAND AND AGREE TO ALL ITS TERMS.

Date of this agreement is _____

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Signature of Proposed Insured 1
(If Proposed Insured is under age 18, parent or guardian must sign.)

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Applicant (if other than Proposed Insured)

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Signature of Soliciting Agent - Licensed Resident Agent Where Required by Law

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NOTICE AND CONSENT FOR AIDS-RELATED (HIV) ANTIBODY TESTING

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

Pre-Testing Considerations

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

Meaning of Positive Test Result

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

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

Confidentiality of Test Results

All test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed as required by law or may be disclosed to employees of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer or to outside legal counsel who needs such information to effectively represent the Insurer in regard to your application. The results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover results of tests for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular person.

Notification of Test Result

If your test results are negative, no routine notification will be sent to you. If your test results are reported by the laboratory to the Insurer as being positive, you will receive written notification of such results from a physician you have designated or, in the absence of such designation, from the Texas Department of Health. Because a trained person should deliver that information so that you can understand clearly what the test result means, you are asked to list your private physician so that the Insurer can have him or her tell you the test result and explain its meaning.

Name of physician for reporting a possible positive test results: _____

Address: _____

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

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

Consent

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

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

_____	_____
Name of Proposed Insured	Signature of Proposed Insured or Parent/Guardian
_____	_____
Address	Date Signed

CHECK BOX OF APPLICABLE COMPANY

☐ **The Penn Mutual Life Insurance Company**
Philadelphia, PA 19172
☐ **The Penn Insurance and Annuity Company**
Philadelphia, PA 19172

Application for Life Insurance

PART 1

A. PROPOSED INSURED 1

1. Name of First Insured (First, Middle, Last) | 2. Sex ☐ Male ☐ Female | 3. Date of Birth Month Day Year

4. Social Security No. — — | 5. Birth Place | 6. Citizen of (Country) | 7. For Non-US citizen Visa # and Type (attach copy)

8. Residence: Street | City | State | Zip

9. Years at this Address | 10. Marital Status ☐ M ☐ D ☐ S ☐ W | 11. Home Phone No. ( ) | 12. Drivers License State and No.

13. Occupation (include duties)

14. Employer | 15. How Long | 16. Area Code and Business Phone No. ( )

17. Street | City | State | Zip

B. PROPOSED INSURED 2

Complete for

☐ *Survivorship*
☐ *Additional Insured Rider*

For Children's Rider, complete form PM5023

If info for PI 1 is same as PI 2 indicate same.

1. Name of Second Insured (First, Middle, Last) | 2. Sex ☐ Male ☐ Female | 3. Date of Birth Month Day Year

4. Social Security No. — — | 5. Birth Place | 6. Citizen of (Country) | 7. For Non-US citizen Visa # and Type (attach copy)

8. Residence: Street | City | State | Zip

9. Years at this Address | 10. Marital Status ☐ M ☐ D ☐ S ☐ W | 11. Home Phone No. ( ) | 12. Drivers License State and No.

13. Relationship to First Insured | 14. Occupation (include duties)

15. Employer | 16. How Long | 17. Area Code and Business Phone No. ( )

18. Street | City | State | Zip

C. PLAN OF INSURANCE

1. Plan Name | 2. Term Rider Name

DEATH BENEFIT	3. Face Amt. (Base Only) $	4. Face Amt. (Term Portion) $	5. Total Initial Coverage $
DEATH BENEFIT OPTION (UL and VUL only)	6. Check One	☐ Level Death Benefit	☐ Increasing Death Benefit
PREMIUM TEST (UL and VUL only)	7. Check One	☐ Guideline Premium	☐ Cash Value

D. ADDITIONAL BENEFITS AND RIDERS

1. Universal Life Plans

- ☐ Disability Waiver of Monthly Deductions
- ☐ Disability Completion Benefit and Disability Waiver of Monthly Deductions
- ☐ Accidental Death Benefit $ _____
- ☐ Guaranteed Increase Option $ _____
- ☐ Guaranteed Continuation of Policy
- ☐ Extended No Lapse Guarantee
- ☐ Option to Extend Maturity Rider
- ☐ Other _____

2. Traditional / Term Plans

- ☐ Guaranteed Premium Benefit
- ☐ Option to Purchase Add'l Ins. $ _____
- ☐ Accidental Death Benefit $ _____
- ☐ Term Waiver of Premium (choose below)
  - ☐ Option A ☐ Option B
- ☐ Whole Life Waiver of Premium
- ☐ Other _____
- ☐ Other _____

Automatic Premium Loan ☐ Yes ☐ No

E. DIVIDEND OPTIONS

Universal Life	Traditional Plans
☐ Cash	☐ Cash ☐ Accumulate at Interest
☐ Credited to Cash Value	☐ Paid-up Additions ☐ Other_____
	☐ Premium Reduction (Not available with Penn Check or Salary Allotment)

F. PREMIUM

1. Was Money collected with the Application?

☐ Yes ☐ No Amount $ _____ Number of Months (UL only) _____

(if "Yes" submit Temporary Insurance Agreement)

2. Billing Method

☐ Regular

☐ Penn Check add to existing account no. _____

☐ Salary Allotment add to existing account no. _____

Billing Mode ☐ Single ☐ Annual ☐ Semi-annual ☐ Quarterly ☐ Monthly (Penn Check and Salary Allotment only)

Billing Premium _____

Initial Additional Premium Deposit _____ ☐ 1035X ☐ Other

3. ADPUA ☐ Yes ☐ No If Yes, Lump Sum _____ Scheduled Amt. _____

4. Will any part of the premium be paid from funds that are borrowed or otherwise financed? ☐ Yes ☐ No

If "Yes" details _____

G. PENN CHECK ACCOUNT INFORMATION

Complete only if Penn Check mode is selected and this is a new account. Also attach a Void Check

1. Bank Name	2. Bank Routing and Account No.
3. Account Type ☐ Checking ☐ Savings ☐ Pershing ☐ Other	4. Draw Date: ☐ 1st ☐ 8th ☐ 15th ☐ 22nd
5. Bank Address (Street, City, County, State, Zip)	
6. Name (First, Middle, Last) of First Depositor	7. Name (First, Middle, Last) of Second Depositor

H. OWNER

*1-9: Complete **only** if Owner is other than Proposed Insured 1. If Trust, give name of Trust, Trustee and date of Trust*

10-12: Complete requested information.

***Note:** If Owner is a Trust or Insured's business **omit** questions 4, 9, 10, 11, 12.*

1. Name(s) (First, Middle, Last) of Owner(s) or Complete Name of Entity			2. Relationship to Proposed Insured
3. Address (Street, City, County, State, Zip)			
4. Date of Birth	5. Soc. Sec. # / Tax ID — —	6. Telephone # ( )	7. Name of Trustee
8. Date of Trust	9. Occupation		
10. Household Net Income	11. Tax Bracket %	12. Liquid Net Worth (Exclude Primary Residence)	

I. SUITABILITY

This section must be completed for the Owner and is to be completed for all business as stated below.

For HTK Producers:
Complete this section for all Traditional Life Plans. For Variable Life Plans, complete the HTK Account Agreement in lieu of this section.

For Non-HTK Producers:
This section must be completed for both Traditional Plans as well as Variable Life Plans.

1. Prior Investment Experience (check one only)

- ☐ None - No investment experience. Previous holdings were generally limited to bank savings accounts and CD's
- ☐ Average - Invests in securities on an infrequent basis. Has 1-2 years experience investing in securities. Has a general knowledge of the risks and rewards of investing in securities.
- ☐ Above Average - Invests in securities on a frequent basis. Has a number of years experience investing in securities. Has a general knowledge of the risks and rewards of investing in securities.
- ☐ Active - Invests in securities on a frequent basis. Has a number of years experience investing in securities. Has extensive knowledge of the risks and rewards of investing in securities.

2. Primary Source of Funds (for this transaction, check one only)

- ☐ Current Income
- ☐ Gift/Inheritance
- ☐ Proceeds from sale of mutual funds
- ☐ Savings
- ☐ Other _____
- ☐ Rollover from pension/retirement fund
- ☐ Proceeds from sale of stocks or bonds
- ☐ Policy Values from existing life/annuity contract
- ☐ Surrender of life insurance/annuity contract
- ☐ Personal Loan

3. Financial Needs/Benefits (check all that apply)

- ☐ Death Benefit/Enhanced Death Benefit
- ☐ Asset Rebalancing
- ☐ Retirement Funding
- ☐ Estate Planning
- ☐ Tax Deferral/Tax Advantage
- ☐ Debt Protection
- ☐ Charitable Giving
- ☐ Savings, Accumulation
- ☐ Diversification of Investments
- ☐ Education/College Funding
- ☐ Business Purposes
- ☐ Annuitization Options
- ☐ Current Income
- ☐ Other _____

4. Risk Profile (Variable Life only, check one only)

- ☐ Conservative-Accepts a low return potential. Maintain a low degree of risk
- ☐ Moderate-Accepts fair degree of risk including lack of liquidity, in order to pursue the potential for a modest return
- ☐ Aggressive-Accepts high degree of risk, including a limited loss of principal, in order to pursue the potential for a higher return
- ☐ Very Aggressive-Accepts maximum degree of risk, including total loss of principal, in order to pursue the maximum possible return

5. Primary Investment Objective (Variable Life only, check one only)

- ☐ Safety of Principal –Preservation of investment Principal
- ☐ Income-Regular, current income stream. May need investment principal within next five years.
- ☐ Growth and Income-Moderate growth. Current Income Stream. May need investment principal within next five years
- ☐ Growth-Grow assets moderately or slightly above rate of inflation. Will not need investment principal for at least ten years
- ☐ Aggressive Growth-Desire to grow assets substantially. Will not need investment principal for at least ten years. Reinvestment of income
- ☐ Speculation-Grow assets substantially In short time frame. Higher than average possibility of total loss of principal. Will not need investment principal for at least ten years

J. PAYOR

Complete only if Payor is other than the Proposed Insured or Owner or if a different address is requested. If Payor is a trust or Insured's business, omit questions 5, 6 and 7.

1. Name(s) (First, Middle, Last) of Payor(s)

2. Relationship to Proposed Insured

3. Address: (Street, City, State, Zip)

4. Mailing Address (if different from above): (Street, City, State, Zip)

5. Occupation

6. Annual earned income from occupation

7. Other Income & Source

8. Soc. Sec # or Tax ID #
— —

K. PRIMARY BENEFICIARY

Note: If no beneficiary survives the insured, proceeds revert to the Estate of the Insured.

1. Name of Primary Beneficiary(ies). (If Trust, give Name, Date of Trust and Name of Trustee)

2. Relationship to Proposed Insured

3. Soc. Sec # or Tax ID #
— —

L. CONTINGENT BENEFICIARY

1. Name of Contingent Beneficiary

2. Relationship to Proposed Insured

3. Soc. Sec # or Tax ID #
— —

M. RIDER BENEFICIARY

If no beneficiary is named or survives insured, proceeds revert to the owner.

1. Name of Rider Beneficiary

2. Relationship to Proposed Insured

3. Soc. Sec # or Tax ID #
— —

N. LIFE INSURANCE IN FORCE OR PENDING

	Proposed Insured 1	Proposed Insured 2
1. Have you ever applied for life, health or disability insurance and been declined, postponed or charged an increased premium?	☐ YES ☐ NO	☐ YES ☐ NO
2. Do you have any applications pending with any other life insurance company now?	☐ YES ☐ NO	☐ YES ☐ NO
3. Have you been involved in any discussion about the possible sale or assignment of this policy to a Life Settlement, Viatical or other secondary market provider?	☐ YES ☐ NO	☐ YES ☐ NO
4. Have you in the past 2 years sold a policy to a Life Settlement, Viatical or other secondary market provider?	☐ YES ☐ NO	☐ YES ☐ NO

If answered "Yes" to above questions, please give details for each Proposed Insured.

Proposed Insured 1 _____

Proposed Insured 2 _____

N. LIFE INSURANCE IN FORCE OR PENDING (continued)

5. List all Insurance In Force on any Proposed Insured. **If none, check this box.** ☐

Insured's Name & Company	Face Amount	Policy Number	Issue Year	Is this Policy being Replaced or Changed?	Check if 1035 Exchange
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	

O. REPLACEMENT AND 1035 EXCHANGE INFORMATION

1. a) Are you considering stopping premium payments, surrendering, replacing, forfeiting, assigning to the insurer or reducing your benefits under an existing policy or contract? ☐ YES ☐ NO

b) Are you considering using or borrowing funds from your existing policies or contracts to pay premiums due on the new or applied for policy? ☐ YES ☐ NO

If answered "Yes" to either question, please complete and sign all required replacement forms.

2. If 1035 Exchange, will loan be carried over? ☐ YES ☐ NO If Yes, amount $ _____

Details _____

P. TOBACCO AND/OR NICOTINE USE

1. Has any person proposed for coverage **ever** used tobacco or nicotine products in any form? PI1 ☐ Yes ☐ No PI2 ☐ Yes ☐ No

2. If "Yes": **PI1** Type _____ Frequency _____ Date Last Used _____

PI2 Type _____ Frequency _____ Date Last Used _____

Q. PERSONAL INFORMATION

Complete for all Proposed Insureds

Provide details to any yes answers in the "Details" section

	PI1	PI2
1. Annual earned income from occupation (After deduction of business expenses)	$	$
2. Other income (State source in "Details")	$	$
3. Net Worth	$	$

4. Has any Proposed Insured declared bankruptcy? (If "Yes" has it been discharged and date of discharge)

Declared Bankruptcy YES ☐ NO ☐ Discharged YES ☐ NO ☐ Date of Discharge _____

Details _____

Q. PERSONAL INFORMATION (Continued)

Complete for all Proposed Insureds.

Provide details to any yes answers in "Details" Section

	PI 1		PI 2	
	YES	NO	YES	NO
5. Does any Proposed Insured intend to reside or travel outside the United States within the next 24 months? (If "Yes" complete foreign travel questionnaire)	☐	☐	☐	☐
6. Is any Proposed Insured a member, or intending to become a member, of any armed forces or military reserve?	☐	☐	☐	☐
7. Within the past three years, has any Proposed Insured:				
(a) Flown or taken instruction as a pilot or crew member or intend to do so? (If "Yes", complete Aviation Supplement)	☐	☐	☐	☐
(b) Engaged in any kind of racing, scuba or sky diving, hang gliding, rock climbing, or other hazardous avocation or intend to do so? (If "Yes", complete appropriate questionnaire)	☐	☐	☐	☐
(c) Been convicted of a moving violation or had their driver's license suspended or revoked?	☐	☐	☐	☐
8. Has any Proposed Insured ever:				
(a) Used amphetamines, barbiturates, hallucinogens, marijuana, cocaine, narcotics, or other controlled substances, except as prescribed by a physician?	☐	☐	☐	☐
(b) Been counseled or treated for use of alcohol or drugs?	☐	☐	☐	☐
9. Within the past ten years, has any Proposed Insured been convicted of a felony?	☐	☐	☐	☐
10. Is there any family history of cancer, diabetes, heart disease, Huntington Chorea, neuromuscular disorder before the age of 60?	☐	☐	☐	☐

Details_____

R. PERSONAL PHYSICIAN

Name and address of Personal Physician(s): GIVE DATE AND REASON LAST CONSULTED.
(If no personal physician, list physician last consulted, date and reason last consulted)

1. Proposed Insured 1: Physician Name	2. Phone No. ( )	3. Date Last Seen
4. Address: (Street, City, State, Zip)		
5. Reason Last Seen:		
6. Proposed Insured 2: Physician Name	7. Phone No. ( )	8. Date Last Seen
9. Address: (Street, City, State, Zip)		
10. Reason Last Seen:		

S. MEDICAL HISTORY

Complete for all Proposed Insureds.

Provide details to any yes answers in "Details" Section

	Proposed Insured 1	Proposed Insured 2
1. Height (in shoes)	ft. in.	ft. in.
2. Weight (clothed)	lbs.	lbs.
3. Weight change in last year?	Yes_____ No_____	Yes_____ No_____
If "Yes":	No. of lbs. Reason:	No. of lbs. Reason:
4. Birth weight if under 6 mo. old	lbs.	lbs.

	PI1 YES	PI1 NO	PI2 YES	PI2 NO
5. Are you presently taking medication either prescribed or over the counter? If yes, provide full details including name, dosage, and prescribing physician. (if applicable)	☐	☐	☐	☐
6. Within the past five years, has any Proposed Insured:				
(a) Consulted a physician for any reason, had an electrocardiogram or other diagnostic tests?	☐	☐	☐	☐
(b) Been in a clinic, hospital or medical facility for observation or treatment?	☐	☐	☐	☐
(c) Been advised to have any diagnostic test, hospitalization or surgery which was not done?	☐	☐	☐	☐
7. Has any Proposed Insured ever been treated for, or been diagnosed with:				
(a) Chest pain, high blood pressure, stroke, heart murmur, or other circulatory disorder?	☐	☐	☐	☐
(b) Cancer, cyst, growth, tumor?	☐	☐	☐	☐
(c) Anxiety, depression, dizziness, convulsions, epilepsy or any mental or nervous disorder?	☐	☐	☐	☐
(d) Diabetes, thyroid or other glandular disease?	☐	☐	☐	☐
(e) Colitis, or any liver or gastrointestinal disorder?	☐	☐	☐	☐
(f) Breast, prostate or reproductive disorder?	☐	☐	☐	☐
(g) Kidney, bladder or other genitourinary disorder?	☐	☐	☐	☐
(h) Asthma, emphysema, chronic obstructive pulmonary disease (C.O.P.D.) or other respiratory disorder?	☐	☐	☐	☐
(i) Has any Proposed Insured been treated or been diagnosed by a member of the medical profession for an immune deficiency disorder, AIDS, HIV or AIDS related complex (ARC)?	☐	☐	☐	☐

T. DETAILS FOR MEDICAL HISTORY QUESTIONS

Question No. and Letter	Person	Date	Details (include full names and address of physicians, hospitals, etc.

U. FAMILY HISTORY

** Complete amount of Insurance only if Primary Insured is under age 17.*

1. Proposed Insured 1	Age if Living	State of Health	Amount of Insurance *	Age at Death	Cause of Death
Father					
Mother					
Brothers and Sisters No. Living_____ No. Dead_____					

1. Proposed Insured 2	Age if Living	State of Health	Amount of Insurance *	Age at Death	Cause of Death
Father					
Mother					
Brothers and Sisters No. Living_____ No. Dead_____					

CERTIFICATION OF OWNER'S TAXPAYER ID #

Under penalty of perjury, I the owner certify that:

1. The number shown in this application as my social security number or taxpayer identification number is correct; and
2. I am not subject to backup withholding because I have not been notified by the IRS that I am subject to backup withholding as a failure to report all interest or dividends, or the IRS has notified me that I am no longer subject to backup withholding, or I am exempt from backup withholding.
3. I am a U.S. person (including a U.S. resident alien)

☐ Check this box if you are subject to backup withholding under section 3406(a)(1)(c) of the Internal Revenue Code.

SPECIAL INSTRUCTIONS

NON-CONFORMING ILLUSTRATION ACKNOWLEDGEMENT (NON-VARIABLE ONLY)

I acknowledge that the life insurance policy illustration shown to me differs from the policy application I have completed. I understand that if a policy is issued, an illustration conforming to the policy, as issued, will be provided to me for my signature no later than at the time the policy is delivered.

☐ check if applicable

AUTHORIZATION FOR FUND TRANSFER (VARIABLE ONLY)

The agent/registered representative may request transfers of account values pursuant to my instruction unless I check this box.

☐ check if applicable

PENN CHECK AUTHORIZATION

By completing Section G of this application, I authorize monthly payments from my checking account, or from my Pershing Resource Checking or Pro Cash Plus account to the Penn Mutual Life Insurance Company, its subsidiaries, affiliates, third party administrators and reinsurers (herein Company) for premiums on this policy, beginning with the next periodic payment that comes due under the contract, until such time as a payment cannot be made due to insufficient funds or the Company gives the other parties at least 30 days' advance written notice of the termination of such payment plan. I am able to cancel the payment plan at any time by either calling the Company at 1-800-523-0650 or in writing. Monthly payments will be drawn from my account on or about the date specified in this application.

I further agree that if any such check be dishonored, whether with or without cause and whether intentionally or inadvertently, the Company shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

REPRESENTATIONS	I(we), the Proposed Insured(s), or Applicant(s) if Proposed Insured(s) is(are) age 17 or less, represent that the statements and answers in this part I of the application are written as made by me(us) and are complete and true to the best of my (our) knowledge and belief. I(we) the Proposed Insured(s), or the Applicant(s) if other than the Proposed Insured(s) agree that they will be a part of the contract of insurance if issued; that I(we) will be bound by such statements and answers, and that the Company, believing them to betrue, will rely and act upon them. I(we) also understand and agree that: 1. Subject to the provisions of the temporary insurance agreement attached to this application, no insurance will be in force until the first premium is paid in full and the policy is delivered while the health, habits, occupation and other facts relating to the Proposed Insured(s) and to the Payor, if a Payor Benefit is issued, are the same as described in this Part I of the application, any Part II required by the Company and any amendments or supplements to them. 2. Notice to or knowledge of an agent or a medical examiner is not notice to or knowledge of the Company, and no agent or medical examiner is authorized to accept risks, to pass upon acceptability for insurance or to modify any contract of insurance. 3. Acceptance of any policy issued based on this application will be a ratification of any amendments or corrections noted by the Company in the space headed “Home Office Amendments and Corrections”, except that if required by state statute or regulation, any change in amount, age, plan of insurance, additional benefits or classification must be agreed to in writing.
FRAUD WARNING *Applies to all states except those specifically listed.*	Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a 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. Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, and denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies. District of Columbia: WARNING 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 application containing any false, incomplete, or misleading information is guilty of a felony in 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. Louisiana: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. Maine & Tennessee: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits. New Jersey: Any person who includes 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 in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties. Ohio: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submitts an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. Oklahoma: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds for an insurance policy containing any false, incomplete or misleading information is guilty of a felony. Oregon: Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or a statement of claim containing any materially false information or conceals for the propose of misleading information concerning any fact material may be guilty of a fraudulent insurance act which is a crime and may subject such person to criminal and civil penalties. 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. Virginia: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submit an application or files a claim containing a false or deceptive statement may have violated state law. Vermont: 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 may be proven guilty or fraud. Washington: Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law.

AUTHORIZATION

Write in names of all Proposed Insureds.

I(we),_____
hereby authorize: (a) any physician, health care provider, health plan, medical professional, hospital, clinic, laboratory, pharmacy or other medical or health care facility that has provided payment, treatment or services to me(us) or on my(our) behalf; (b) any insurance company; and, (c) the Medical Information Bureau, Inc. (MIB), to disclose my(our) entire medical record and any other protected health information concerning me(us) to the Underwriting Department of The Penn Mutual Life Insurance Company, its subsidiaries, affiliates, third party administrators and reinsurers (herein Company).

I(we) understand that such information may include records relating to my(our) physical or mental condition such as diagnostic tests, physical examination notes, and treatment histories, which may include information regarding the diagnosis and treatment of human immunodeficiency virus (HIV) infection, sexually transmitted diseases, and mental illness, and the use of alcohol, drugs and tobacco, but shall not include psychotherapy notes.

I(we) acknowledge that any agreements I(we) have made to restrict my(our) protected health information do not apply to the Authorization, and I(we) instruct any physician, health care professional, hospital, clinic, medical facility or other health care provider to release and disclose my(our) entire medical record without restriction.

I(we) understand that this information will be used by the Company to determine eligibility for insurance.

I(we) hereby authorize the Company to disclose any information it obtains about me(us) to the Medical Information Bureau, Inc., or any other life insurance company with which I(we) do business. I understand that the Company will not disclose information it obtains about me(us) except as authorized by this Authorization, as may be required or permitted by law, or as I(we) may further authorize. I(we) understand that if information is redisclosed as permitted by this Authorization, it may no longer be protected by applicable federal privacy law.

I(we) understand that: (a) this Authorization shall be valid for 24 months from the date I(we) sign it; (b) I(we) may revoke it at any time by providing written notice to the Underwriting Department of the Company subject to the rights of any person who acted in reliance on it prior to receiving notice of its revocation; and (c) my(our) authorized representative and I(we) are entitled to receive a copy of the Authorization upon request and (d) a copy of this Authorization shall be as valid as the original.

I(we) acknowledge receiving an MIB, Inc. Notice, a Fair Credit Reporting Act Notice and a Notice of Information Practices and authorize Penn Mutual to obtain an investigative or other consumer report as described in the Fair Credit Reporting Act Notice.

SIGNATURES

Signed and Dated by the Applicant in:

City	State	Month/Day/Year

SIGNATURE OF INSURED - OR PARENT IF INSURED IS UNDER THE AGE OF 18

X	**X**
Proposed Insured 1	Proposed Insured 2

SIGNATURE OF OWNER AND OR APPLICANT - IF OTHER THAN THE PROPOSED INSURED

X	**X**
Owner*	Applicant

*If a Corporation, the signature and title of any authorized officer other than the Proposed Insured(s) is required and the full name of the corporation must be shown. If a Trust, the signature of the Trustee.

SIGNATURE OF PAYOR

X _____
Payor

AGENTS CERTIFICATION

Be sure to check appropriate block.

Each agent present at solicitation must sign.

I certify to the best of my knowledge the answers to the questions in all parts of this application are true and correct. I further certify to the best of my knowledge this policy ☐ **will** ☐ **will not** replace or change any existing life insurance or annuity policy now in force.

X _____ Agent

X _____ Agent

X _____ Agent

X _____ Agent

X _____ Agent

X _____ Agent

HOME OFFICE AMENDMENTS AND CORRECTIONS

Not applicable in Pennsylvania.

The Penn Mutual Life Insurance Company
Philadelphia, PA 19172

Agent's Underwriting Report

A. KNOWLEDGE OF PROPOSED INSURED AND SALE

1. How long and how well have you known the Proposed Insured?

2. Are you aware of any additional factors which might influence insurability? ☐ Yes ☐ No
   If "Yes" give details _____

3. If application taken on a non-medical basis:
   a) Were answers from Proposed Insured obtained personally and in your presence? ☐ Yes ☐ No
   b) If the Proposed Insured is a child, did you see the child? ☐ Yes ☐ No

4. What is the specific need for this coverage? _____

5. Will any part of the premium for this policy be paid for by funds that are borrowed or otherwise financed? ☐ Yes ☐ No

6. Have you had any discussions about, or do you have any reason to believe that this policy may be sold or assigned to a Life Settlement, Viatical or other secondary market provider? ☐ Yes ☐ No
   If the answer to either question 5 or 6 is "Yes", provide full and complete details _____

B. TRUST OR PENSION PLAN DATA

1. If the policy is being applied for under a Trust or Pension Plan:
   a) Full name of Trust/Plan _____
   b) Type of Plan
      ☐ Qualified Pension or Profit Sharing Plan
      ☐ Non-Qualified Pension or Profit Sharing Plan
      ☐ Other _____

2. To comply with IRS regulations, an Agent's Disclosure Form must be submitted once for each qualified plan unless it is three years from the date of the last Disclosure or there has been a change in the plan; i.e., a different product purchased or a change in the commission rate.
   a) Disclosure Form has been submitted in the last three (3) years that covers the Commission Schedule applicable to this Contract. ☐ Yes ☐ No
   b) Disclosure Form is attached for this contract. ☐ Yes ☐ No

C. SUITABILITY AND COMPLIANCE

1. Have the Fair Credit Reporting Act and MIB, Inc. Notices been given to the Proposed Insured or Applicant if Proposed Insured is a child? ☐ Yes ☐ No
2. I have complied with all state licensing and educational requirements. ☐ Yes ☐ No
3. I have complied with all required Commission Disclosures. ☐ Yes ☐ No
4. If a replacement is involved, all producers associated with this sale certify that replacement is in the best interests of the Proposed Insured. ☐ Yes ☐ No

D. VERIFICATION OF IDENTITY

OWNER	JOINT OWNER
Driver's License ☐ Passport ☐ Birth Certificate ☐	Driver's License ☐ Passport ☐ Birth Certificate ☐
Other Government Issued ID ☐	Other Government Issued ID ☐
ID Number _____	ID Number _____
Issuing Authority _____	Issuing Authority _____
Issue Date: _____	Issue Date: _____
Expiration Date:	Expiration Date:

Review ID and verify that the photograph on the ID is the individual. Record ID information above. If individual does not have a Driver's License, Passport, or unexpired Government Issued photo ID, secure a copy of the individual's birth certificate. ID information must be obtained for ALL owners. For entities (trusts, corporations, partnerships) secure the appropriate documentation (Certification of Trust, Articles of Incorporation, Corporate Resolution, Partnership Agreement)

ADDITIONALY FOR ENTITIES AND TRUSTS AND PARTNERSHIPS: Please obtain ID for each Owner, Trustee, or Partner

E. ASSET BASED COMPENSATION

For Variable Life only, do you want Asset Based Compensation? Yes ☐ No ☐

F. NEW BUSINESS MARKETING INFORMATION

If you used elements of any of these marketing programs or tools to support your sale please check all that apply.

- ☐ Penn Mutual Marketing Brochures
- ☐ BBP – The Business Building Partners Program
- ☐ BOSS - Business Owner Success Strategies Small
- ☐ Business, Big Mistakes
- ☐ Seminar Marketing
- ☐ Women's Niche Marketing Program
- ☐ The Healthcare Niche Marketing Program
- ☐ Referral Marketing
- ☐ Email Concepts
- ☐ Newsletters
- ☐ Trade Shows

Please check the sales support services and sales concepts used to acquire the sale:

Sales Support Services Used

- ☐ Marketing Consultation
- ☐ Advanced Sales Support
- ☐ Product Sales Support (Life or Annuity)

Sales Concepts

- ☐ Protection (Death Benefit)
- ☐ Wealth Accumulation (Protection PLUS, Wealth Transfer)
- ☐ Retirement Planning (Retirement Distribution, Stretch IRA)
- ☐ Estate Planning (Charitable Giving, Survivorship Life)
- ☐ Business Continuation (PASS, PASS Plus)
- ☐ Selective Employee Benefits (Deferred Comp, Split Dollar, Executive Bonus, 419 Plans)

G. SIGNATORY SECTION

Each agent on case must sign.

SOLICITING AGENT	DATE (mm/dd/yyyy)
SOLICITING AGENT	DATE (mm/dd/yyyy)
SOLICITING AGENT	DATE (mm/dd/yyyy)
SOLICITING AGENT	DATE (mm/dd/yyyy)
SOLICITING AGENT	DATE (mm/dd/yyyy)
SOLICITING AGENT	DATE (mm/dd/yyyy)

H. AGENT INFORMATION

AGENT'S NAME	PML OFFICE CODE (3 DIGIT)	PML AGENT CODE (5 DIGIT)	% OF COMMISSION

PENN CHOICE

Applicants Name:
Policy Number:

Indeterminate Premium Policy Summary for Annually Renewable Term to Age 85 LT-99(TX)

This is an indeterminate premium policy. The initial premium is guaranteed for an initial guaranteed period, which is specified on page 3 of the policy you will receive. After the initial guaranteed period, the premium is subject to change, and may change each year, thereafter. The premium will not be greater than the maximum premium listed on the Additional Specifications page. Premiums are set by Penn Mutual subject to the Table of Maximum Premiums contained in the policy. Penn Mutual reserves the right to charge the maximum premium beginning with any policy year after the initial guaranteed period.

This policy is a Renewable Term to Age 85 Life Insurance Policy. It is an Indeterminate Premium Policy. The policy can be renewed each year until the Expiration Date by payment of the premium for the renewal year.

This is a participating policy. Dividends will be paid only if declared by Penn Mutual. However, Penn Mutual does not anticipate paying dividends on this policy in the foreseeable future.

_____

Signature of Applicant

_____

Date

Penn Mutual
A better way of life

The Penn Mutual Life Insurance Company
Philadelphia, PA 19172

Supplemental Application for Flexible Premium Adjustable Variable Life Insurance

A. Owner Name(s) (Must Agree with Application) _____

B. Premium Allocation and Dollar Cost Averaging (DCA)

For Premiums only - Please select (1a) OR (1b)

☐ **(1a)** I elect to allocate the net initial and subsequent premiums according to the Ibbotson Portfolio selection indicated below. (If this option is selected, DCA selection is not available.)

☐ **(1b)** I elect to specify the allocation of the net initial and subsequent premiums in Column A on the chart below. **Do NOT use increments of less than 1%.**

INVESTMENT OPTIONS	INVESTMENT MANAGERS	COL A INITIAL & SUB. PMTS.	COL B DCA	COL C DCA from 12 month (not available for VMAX II and VUL 3)	COL D AAR	COL E Mo. Deduction Allocation (not available for VMAX II and VUL 3)
VIP Equity Income	Fidelity Investments	%	$	%	%	%
VIP Growth	Fidelity Investments	%	$	%	%	%
VIP Asset Manager	Fidelity Investments	%	$	%	%	%
Money Market	Independence Capital Management, Inc.	%	**N/A** $	%	%	%
Limited Maturity Bond	Independence Capital Management, Inc.	%	$	%	%	%
Quality Bond	Independence Capital Management, Inc.	%	$	%	%	%
International Equity	Vontobel Asset Management, Inc.	%	$	%	%	%
AMT Balanced	Neuberger Berman Management Inc.	%	$	%	%	%
Mid Cap Value	Neuberger Berman Management Inc.	%	$	%	%	%
Small Cap Value	Goldman Sachs Asset Management, L.P.	%	$	%	%	%
Mid Cap Growth	Turner Investment Partners, Inc.	%	$	%	%	%
Growth Stock	T. Rowe Price Associates, Inc.	%	$	%	%	%
High Yield Bond	T. Rowe Price Associates, Inc.	%	$	%	%	%
Flexibly Managed	T. Rowe Price Associates, Inc.	%	$	%	%	%
UIF Emerging Markets Equity (Int'l)	Van Kampen	%	$	%	%	%
Index 500	Wells Capital Management Incorporated	%	$	%	%	%
Small Cap Growth	Bjurman, Barry & Associates	%	$	%	%	%
REIT	Heitman Real Estate Securities LLC	%	$	%	%	%
Large Cap Growth	ABN AMRO Asset Management, Inc.	%	$	%	%	%
Large Cap Value	Lord, Abbett & Co. LLC	%	$	%	%	%
Strategic Value	Lord, Abbett & Co. LLC	%	$	%	%	%
Fixed Interest	The Penn Mutual Insurance Company	%	$	%	**N/A**	%
12-Month DCA Account	The Penn Mutual Insurance Company	%	**N/A**	**N/A**	**N/A**	**N/A**
TOTALS		**100%**	**$**	**100%**	**100%**	**100%**

NOTE: Mortality and expense risk asset charges will continue to be deducted pro-rata for Column E.

For DCA only - (Select one box) Annual premium must be at least $600

☐ I elect to transfer the funds from the 12-month DCA Account in twelve monthly installments according to the Ibbotson Portfolio selection below (not available for VMAX II and VUL3)

☐ I elect to specify the allocation of funds from the 12-month DCA Account in twelve monthly installments as indicated in Column C on the chart above (not available for VMAX II and VUL3)

☐ I elect the DCA option using the Money Market fund. Please transfer $_____ ($50.00 minimum) monthly from the Money Market fund into the funds selected in Column B in the chart above. **NOTE: Ibbotson allocations are not available with this selection.**

☐ I decline the DCA option.

Ibbotson's The Asset Allocation Decision

☐ Income Portfolio - Short-term time horizon; slight risk tolerance.
☐ Short-term Growth Portfolio - Short-term time horizon; average risk tolerance.
☐ Intermediate Growth Portfolio - Intermediate time horizon; average risk tolerance.
☐ Long-term Growth Portfolio - Long-term time horizon; above average risk tolerance.
☐ Aggressive Long-term Growth Portfolio - Long-term time horizon; high risk tolerance.

C. DCA Disclosures

Any residual funds in the Money Market (less than the minimum) will automatically transfer to the allocation on record.

Any residual funds in the 12-month DCA Account will automatically transfer to the allocation on record at the end of each 12-month period.

The first DCA transfer will take place on the 15th of the month after the Free Look period ends.

DCA transfers will continue monthly:
- **anytime the balance in the Money Market fund is above the minimum**

DCA transfers will not take place:
- **if the policy enters a grace period**

DCA transfers will continue until:
- **the company receives a written or telephone request from the owner to terminate DCA or**
- **five years from the start date of the first DCA transfer from the Money Market fund or the following date selected _____**

D. Automatic Asset Rebalancing (AAR): (Select one box) the Money Market fund is not available with AAR if the DCA option is selected. Minimum contract value of $1,000 is required to activate AAR.

☐ I elect to have the total of the assets in all funds automatically rebalanced each calendar quarter according to the Ibbotson Portfolio selection on page 1.

☐ I elect to have the total of the assets in all funds automatically rebalanced each quarter as indicated in Column D of the chart on page 1. Please use whole percentages. Totals must equal 100 percent. **NOT AVAILABLE IF FIRST BOX UNDER SECTION B IS SELECTED.**

☐ I decline the AAR option.

AAR will continue quarterly until:
- **The company receives a written or telephone request from the owner to terminate AAR.**

E. Disclosure

(a) Did the owner receive the prospectus? Yes _____ No _____

(b) Does the owner understand that:
- THE DEATH BENEFIT MAY INCREASE OR DECREASE DEPENDING ON INVESTMENT EXPERIENCE? Yes _____ No _____
- THE CASH VALUE MAY INCREASE OR DECREASE DEPENDING ON THE INVESTMENT EXPERIENCE? Yes _____ No _____
- THE POLICY WILL LAPSE IF THE CASH SURRENDER VALUE BECOMES INSUFFICIENT TO COVER POLICY CHARGES? Yes _____ No _____

(c) Does the owner believe that this policy will meet insurance needs and financial objectives? Yes _____ No _____

F. Signatures

I, the owner, represent that the statements and answers in this supplemental application are complete and true to the best of my knowledge.

Date _____ _____
Signature of Owner

at _____ , _____ _____
CITY STATE Signature of Registered Representative

CHECK BOX OF APPLICABLE COMPANY

☐ **The Penn Mutual Life Insurance Company**
Philadelphia, PA 19172

☐ **The Penn Insurance and Annuity Company**
Philadelphia, PA 19172

Confidential Financial Statement

Instructions:

To be submitted with Application for $1,500,000 and up or at Underwriting Department discretion.
For amounts over $4,999,999 an inspection report will be required. Please be sure to advise the proposed insured of this requirement.

For amounts of $3,000,000 or more also submit Financial Statements for the last two years (Personal or business, depending on the purpose of the insurance)*.

* For personal insurance, a year-end review by the personal accountant; for business insurance, such documents as income statments, profit and loss statements, balance sheets, and year-end financial reviews.

_____ Proposed Insured

_____ Date of Birth

PART I - Personal Insurance

Purpose of Insurance:

☐ Family Protection ☐ Estate Conservation

☐ Debt Repayment (give details such as loan amt. and duration)_____

☐ Other (specify)_____

Personal Income:

$ _____ Annual Earned Income $ _____ Other Income $_____ Total Income

Bankruptcy: Have you been involved in any kind of bankruptcy in past 7 years?

☐ Yes ☐ No (If yes, give full details including type and date discharged.)

Personal Worth:

	Assets		**Liabilities**
$_____	Cash	$_____	Bank Loans
$_____	Investments	$_____	Taxes Due
$_____	Real Estate (residence)	$_____	Mortgage (residence)
$_____	Other Real Estate	$_____	(Other Mortgages
$_____	Business Equity	$_____	Business Indebtedness
$_____	Notes/Acct. Receivable	$_____	Notes/Acct. Payable
$_____	Life Ins. (cash value)	$_____	Insurance Loans
$_____	Automobiles	$_____	Other (specify)
$_____	Other (specify)		
$_____	**Total Assets**	**$_____**	**Total Liabilities**

Net Worth: **$_____ Total Assets**

(minus) **$_____ Total Liabilities**

$_____ Net Worth

_____ Date

_____ Signature of Proposed Insured

OVER FOR BUSINESS COVERAGE

PART II - Business Insurance

(For amounts of $3,000,000 or more you must submit Financial Statements)

Business Details:

Name of Business _____

Nature of Business _____

How long has business been in operation? _____

When did proposed insured join the business? _____

What percentage of the business is owned by the proposed insured? _____

Type of organizaiton: ☐ Corporation ☐ Sole Proprietorship ☐ Partnership ☐ Other _____

Business Valuation:

$ _____ Book Value $ _____ Market Value

Proposed Insured's % of ownership of business _____ %

How was Market Value determined? _____

Profits:

$ _____ year-before-last $ _____ last year $ _____ this year (est.)

Purpose of Coverage:

☐ Key-Person ☐ Buy-sell/stock redemption ☐ Business Loan

☐ Other (explain) _____

If Business Loan, complete the following:

Name of Lender _____

Address _____

Amount of loan _____ Date of loan _____

Purpose of loan _____ Repayment Terms _____

Are other business members being similarly insured?

Name	Amount	Company
_____	$_____	_____
_____	$_____	_____
_____	$_____	_____
_____	$_____	_____

_____ _____

Date Signature of Proposed Insured