

APPLICATION FOR LIFE INSURANCE

This packet includes an application for all plans of life insurance. Also included are the Notice of Insurance Information Practices, Authorization form, and PreAuthorized Bank form.

Forward this packet to the Home Office intact. Do not separate.

A separate AIDS Informed Consent/Questionnaire form is required. Always utilize the appropriate form for your state.

Please be sure:

- (1) The Notice of Insurance Information Practices is delivered to the proposed insured before completion of the application.
- (2) The Temporary Life Insurance Agreement Receipt is given to the premium payor whenever settlement is collected in advance.
Do not accept settlement if the proposed insured has been treated for heart disease, stroke or cancer within the past 2 years.
Do not accept settlement if the application is not completed in its entirety.
- (3) The proposed insured, and applicant if a different person, sign the form where indicated.
- (4) If the proposed insured is under age 18, the application is signed by a parent or guardian.
- (5) All sections of the application required for the coverage requested are completed.
- (6) The signed authorization remains attached to the application when forwarded to the Home Office.
- (7) Taxpayer Identification number and Certification form is completed and remains with the application when sent to the Home Office.
- (8) To complete the Personal History Interview form included herein. The information portion is to remain with the application. The notice portion is to be detached and given to the proposed insured.

NON MEDICAL AND PARAMEDICAL LIMITS

In all instances non medical and paramedical limits must be observed. Do not initiate paramedicals or medicals when lesser requirements suffice.



A Stock Insurance Company
U.S. Financial Life Insurance Company
An AXA Financial Company
10290 Alliance Road -- PO Box 429560
Cincinnati, OH 45242
513-686-2000
www.usfli.com

NOTICE OF INFORMATION PRACTICES
This Notice Must Be Given To Proposed Insured

(Including Medical Information Bureau Notice and Fair Credit Reporting Act Notice)

In considering your application, information from various sources will be considered. These include your statements, the results of your physical examination (if required), and reports we get from doctors or medical facilities which have attended you. Information about your insurability will be treated as confidential. We, or our reinsurers, may, however, make a brief report of this to the Medical Information Bureau, a nonprofit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file. Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is P.O. Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660.

We, or our reinsurers, may also release information to other life insurance companies to whom you apply for life or health insurance, or to whom a claim is submitted.

In addition, we may get an investigative report from a consumer reporting agency. This report requires personal interviews with your neighbors, friends, or other acquaintances for information as to your general reputation, personal characteristics and mode of living. As part of your application, you have authorized us to do this. You have the right to be personally interviewed and to make a written request within a reasonable period about the nature and scope of this investigation. Upon written request you will be told if such a report has actually been ordered, and if it has, we will give you the name and address of the consumer reporting agency. You may contact this consumer reporting agency and ask for a copy of such report.

Unless a legitimate business need exists or we are required to do so by law, the information we get in this report, as well as any other information which we later acquire, will not be disclosed to anyone else without your consent. You may request a copy of all information acquired by us and have a right to correct any personal information which you feel is inaccurate. We will, if required by law, give you a more detailed notice of the types of personal information which we get in considering your application, as well as any additional rights which you may have.

U.S. Financial Life Insurance Company
An AXA Financial Company

PART 1 - Application For Life Insurance

Application No. _____

Please Print Using Dark Ink

Policy No. _____

Section I

Proposed Insured #1

Name (Last First M)			Date of Birth M D Y			Place of Birth	Social Security No.		
Home Address			City			State	Zip	How Long?	
Sex*	Marital Status*		Occupation			Employer			
Business Address			City			State	Zip	How Long?	

Section II

Proposed Insured #2

Name (Last First M)			Date of Birth M D Y			Place of Birth	Social Security No.		
Home Address			City			State	Zip	How Long?	
Sex*	Marital Status*		Occupation			Employer			
Business Address			City			State	Zip	How Long?	

Section IIA

Dependent Children

Name (Last First M)	Sex	Date of Birth			Place of Birth	Height		Weight
		M	D	Y		ft	in	

Section III

Applicant (Owner or Payor)

Name of Applicant/Owner (if other than Proposed Insured) (Applicant must sign Page 6)				Relationship		Social Security No. or Taxpayer I.D. No.	
Address				City		State	Zip

If Proposed is a minor, ownership will pass to Proposed Insured at age, ____ (If no designation is made, ownership will pass to Proposed Insured at age 21)
 All notices and reports will be sent to the Owner unless otherwise specified in Special Requests section, Page 4

Section IV

Policy Specifications

Plan of Insurance	Face Amount	If UL, indicate	<input type="checkbox"/> Option 1- Specified Amount
			<input type="checkbox"/> Option 2- Specified Amount in addition to Cash Value Death Benefit.
Additional Benefits			
<input type="checkbox"/> Waiver of Premium	<input type="checkbox"/> Children's Insurance Benefit		
<input type="checkbox"/> Waiver of Stated Monthly Amount (UL)	<input type="checkbox"/> Additional Insured Person Rider		
<input type="checkbox"/> Waiver of Monthly Deduction (UL)	<input type="checkbox"/> Other: _____		
<input type="checkbox"/> Accidental Death			

Section V Premium

Premium Frequency: Annual Semiannual Quarterly PAC Single Cash with Application \$ _____

Send premium notices to: Home Business (Give any special mailing address here.)

Name _____

Address _____ City _____ State _____ Zip _____

*For Informational Purposes Only

Section VI Beneficiary For Proposed Insured #1	PRIMARY BENEFICIARY: Full Name	Percent	Relationship
		%	
		%	
	CONTINGENT BENEFICIARY: Full Name	Percent	Relationship
	%		
	%		
If more than one, then equally to the survivors unless otherwise stated.			

Section VI-A Beneficiary For Proposed Insured #2	PRIMARY BENEFICIARY: Full Name	Percent	Relationship
		%	
		%	
	CONTINGENT BENEFICIARY: Full Name	Percent	Relationship
	%		
	%		
If more than one, then equally to the survivors unless otherwise stated.			

Section VII Life Insurance In Force and Pending on All Proposed Insureds, Including Business Insurance: (If none insert "None.")

Existing and Pending Insurance	Name of Insured	Company	Type of Coverage	Life Amount	Accidental		Year Issued
					Death	Death	
				\$	\$		

- Regarding all Proposed Insureds:** (If any "Yes," give name, date and details in Remarks below.)
- | | | |
|--|--------------------------|--------------------------|
| | Yes | No |
| (a) Has any life or health insurance been applied for without it being received exactly as requested? | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) Is the policy applied for to replace any existing insurance or annuity in this or any other company? | <input type="checkbox"/> | <input type="checkbox"/> |
| (If "Yes," forward Replacement Forms.) | | |
| (c) Has any life insurance lapsed, been surrendered or otherwise terminated in the last 24 months? | <input type="checkbox"/> | <input type="checkbox"/> |

Section VIII Special Activities	Has any Proposed Insured:	Yes	No
	(a) Flown as a Student, Private, Commercial or Military pilot in the past two years, or are any such flights planned in the future? (If "Yes," complete Aviation Questionnaire, Page 9.	<input type="checkbox"/>	<input type="checkbox"/>
	(b) Engaged in any form of racing, sky diving, underwater diving, or other hazardous activity in the past two years? (If "Yes," complete Avocation Questionnaire, Page 10)	<input type="checkbox"/>	<input type="checkbox"/>
	(c) Belong to or intend joining any active military, naval or aeronautic organization?	<input type="checkbox"/>	<input type="checkbox"/>
	(d) Contemplate travel or residence outside the United States or Canada?	<input type="checkbox"/>	<input type="checkbox"/>

Section IX Tobacco Use	Has Primary or Additional Proposed Insured:	Yes	No
	(a) Smoked tobacco within the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
	If "Yes," and not presently smoking, when did Primary Proposed Insured quit? _____ When did Additional Proposed Insured quit? _____		
	(b) Used tobacco in any other form?	<input type="checkbox"/>	<input type="checkbox"/>
	If "Yes," what type? _____		

Section X Driving	(a) Has Primary Proposed Insured and/or Additional Proposed Insured had their driver's license restricted or revoked, or been cited for more than 3 moving violations within the last 3 years?	Yes	No
		<input type="checkbox"/>	<input type="checkbox"/>

Special Requests and Remarks:

PART II -- NON-MEDICAL SECTION

Application No. _____

- 1 (a) Proposed Insured #1: Height ft in Weight lbs Weight change in past year none loss gain lbs
 (b) Do you have a personal doctor? Yes No (If "Yes," give name, address and telephone number.)

- 2 (a) Proposed Insured #2: Height ft in Weight lbs Weight change in past year none loss gain lbs
 (b) Do you have a personal doctor? Yes No (If "Yes," give name, address and telephone number.)

Please answer all Questions for Each person to be insured

3. Have you been diagnosed or treated by a member of the Medical Profession in the last 10 years for:
 (Circle conditions to which "Yes" answer applies and give details below.)
- (a) Convulsions, epilepsy, paralysis, mental or nervous disorders?
 - (b) Chest pain, high blood pressure, heart murmur, heart attack, stroke, or other disorder of the heart or circulatory system?
 - (c) Asthma, emphysema, bronchitis, tuberculosis, or chronic respiratory disease?
 - (d) Jaundice, intestinal bleeding, ulcer, chronic colitis, diverticulitis, or other liver or gastro-intestinal disorder?
 - (e) Complicated pregnancy, hysterectomy, disorder of breast or female organs?
 - (f) Disease of kidney, bladder, prostate, or sugar or protein in urine?
 - (g) Loss of vision, amputation, deformity, arthritis or any disorder of muscles, bones or joints?
 - (h) Cancer, tumor, diabetes or glandular disorder?

Proposed Insured #1		Proposed Insured #2		Children	
yes	no	yes	no	yes	no
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. To the best of your knowledge have you or has any other Proposed Insured:
 (Circle conditions to which "Yes" answer applies and give details below.)
- (a) Other than above, had examination, treatment or consultation with a doctor, or been hospital confined during the past 5 years?
 - (b) Been on, or are now on, any medication or prescribed diet?
 - (c) Been treated for drug addiction, alcoholism or been a member of Alcoholics Anonymous?
 - (d) Ever used narcotics, hallucinogens, barbiturates, heroin or any other drug not prescribed by a physician?
 - (e) In the past 10 years have you been treated for or been diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS) ?
 - (f) Ever received disability benefits?
 - (g) Been advised to have any diagnostic test, hospitalization or surgery which has not been completed?
 - (h) Had a parent, brother or sister who had cancer, diabetes, heart disease, or who committed suicide? (Please show age at onset and/or date of death)

yes	no	yes	no	yes	no
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Person's Name	Question Number	Details or Reasons	Duration	Name, Address and Telephone # of Attending Doctor and Hospital (if applicable)

HOME OFFICE ENDORSEMENTS

(Not to be used where prohibited by Statute or Insurance Department ruling)

DECLARATIONS

I (We) represent that all statements and answers made in all parts of this application are full, complete and true to the best of my (our) knowledge and belief. It is agreed that:

- (1) All such statements and answers shall be the basis for and a part of any policy issued on this application.
- (2) No agent or medical examiner can accept risks or make or change contracts or waive U.S. Financial's rights or requirements.
- (3a) Any prepayment made with this application will be subject to the provisions of the Temporary Life Insurance Agreement;
- (3b) If there is no prepayment made with this application, the policy will not take effect until both:
 - (I) the first premium is paid during the lifetime of the proposed insured and while his/her health and the facts and other conditions affecting his/her insurability are as described in Part I and Part II of this application;
 - (II) and until the policy is delivered to the proposed owner.
- (4) No one except the President, Vice President or the Secretary can make, alter or discharge contracts or waive any of the Company's rights or requirements.
- (5) Acceptance of the policy by the Owner shall constitute ratification of any changes made by U.S. Financial under "Home Office Endorsements."

NOTICE - 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.

Dated _____

Signature of Proposed Insured #1

Signed At _____
City and State

Signature of Proposed Insured #2

Signature of Additional Insured
(If 18 years old or older, otherwise, parent's signature needed.)

Signature of Applicant/Owner,
if Other than Proposed Insured
(If a corporation, state name)

Signature of Children's Benefit Insured
(If 18 years old or older, otherwise, parent's signature needed.)

Witnessed by Agent

By _____
Signature of Corporate Officer

**U.S. Financial Life Insurance Company
An AXA Financial Company**

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I authorize U.S. Financial Life Insurance Company and/or its reinsurer(s) to obtain medical and other information on me or my minor children. This includes information about drugs and alcohol and about diagnosis, treatment and prognosis of any physical or mental condition, as well as any other non-medical information.

I authorize the release of this information to U.S. Financial Life Insurance Company and/or its reinsurers. This information can be released by doctors including medical practitioners and pharmacists. It can also be released by any hospital, clinic or other medical or medically related facility, including facilities run by the Veteran's Administration. Information can also be released by insurers, reinsurers, the Medical Information Bureau (MIB), employers and consumer reporting agencies.

I also authorize all the above sources (except the MIB) to give such records or information to any consumer reporting agencies employed by U.S. Financial to collect and transmit such information.

I acknowledge that the information obtained by this authorization will be used by U.S. Financial to determine eligibility for insurance applied for, and may be used to determine eligibility for benefits under an existing policy. Any information obtained will only be released by U.S. Financial to reinsurers, the MIB, or other persons or organizations performing business or legal services in connection with my application or a claim. The information may also be released if U.S. Financial is required to do so by law, or if I authorize its release.

This authorization shall be valid for 30 months from the date shown below. I may obtain a copy of this if I ask for it. A photographic copy shall be as valid as the original.

I authorize U.S. Financial Life Insurance Company to obtain one or more investigative consumer report(s) on me.

I have received a copy of the Notice of Information Practices.

Date: _____

Signature of Proposed Insured #1

Signature of Additional Insured
(If 18 years old or older, otherwise,
parent's signature needed.)

Signature of Proposed Insured #2

Signature of Children's Benefit Insured
(If 18 years old or older, otherwise
parent's signature needed.)

Signature of Parent or Legal Guardian,
(if minor child(ren) proposed for insurance)

THIS AUTHORIZATION MUST BE SIGNED BEFORE APPLICATION CAN BE PROCESSED

AGENT'S REPORT - PLEASE COMPLETE IN FULL

SECTION A - General Information

1. Do you have knowledge of or reason to believe that replacement or change of existing life insurance or annuities may be involved? yes no

(If "Yes," supply details Section VII, Page 4.)

2. What is purpose of insurance applied for? _____

3. a. How long and how well have you known each proposed insured? _____

b. Are you related?

4. Were you present with the Proposed Insured and Other Insured(s) when this application was completed?

(If "No," Explain) _____

5. If Proposed Insured's name was changed for any reason, state previous name and date changed _____

6. Is a paramed or Medical Examination required for: Proposed Insured

If "Yes," fill in below Other Insured

Name of Insured	Date of Exam	Type of Exam	Examiner Paramedical Service Name	Special Studies

7. Have you any information about health, character, habits, residence, mode of life, contemplated travel, or occupation affecting this risk which is not fully explained in this report or in the application? (If "Yes," give details in Remarks section) ...

8. If the Proposed Insured or Other Insured is Under age 15:

(a) Applicant's relationship to the child: _____

(b) Amount of insurance on life of : Father \$ Mother \$

(c) Did you see the child?

(d) Age of brothers and sisters of the child and amount of insurance in force on each of their lives:

Age	Insurance	Age	Insurance	Age	Insurance	Age	Insurance

9. Primary Insured: Earned Income: \$ _____ Unearned Income: \$ _____ Net Worth: \$ _____

Other Insured: Earned Income: \$ _____ Unearned Income: \$ _____ Net Worth: \$ _____

SECTION B Business Information (Complete only if insurance is for business purposes)

1. (a) What is approximate net worth of business? \$ _____

(b) What is approx. net yearly business income? \$ _____

(c) What is Market Value of business? \$ _____

2. (a) Is it a partnership corporation sole proprietorship

(b) What percentage of business does Proposed Insured own or control; _____ %

3. Business insurance applied for and in force on any proposed insured and any Partners, Officers, or Key Person: (If "None," explain in Remarks Section).

Name	Title & Interest	Amount	Company

SECTION C - Agent's Remarks Section

Except as set forth below, I hereby represent that I know nothing affecting the insurability of any person applying for insurance which is not fully set forth in these papers.

Signature of Soliciting Agent _____

Print full name as signed above _____

COMPLETE FOR PROPER PRODUCTION CREDIT

Agency	Code Number	Address	Phone Number

Agent	Code Number	Address	Phone Number	
				%

Agent	Code Number	Address	Phone Number	
				%

U.S. Financial Life Insurance Company
An AXA Financial Company

AVIATION QUESTIONNAIRE

Name of Proposed Insured Date of Birth

Section I For Pilots, Students and Crew Members:
Hours Flown Total of Solo Hours Flown Total Hours Flown In Past 12 Months: Estimated Hours Flying In Next 12 Months:

Section II
Pilot Certificate Private Student Airline Transportation Rating (ATR) Instrument Flight Rating (IFR) Commercial Flight Instructor

Have you ever been grounded or had your license revoked? Yes No (If Yes, give details in Remarks below.)

Section III
Type of Flying Pleasure Flying Personal Business Crop Dusting Employer Aircraft or Employee Transportation Freight Carrying or Passenger Service Instructor Other (Give details in Remarks below.)

Section IV
Military Flying (a) Military Branch or Organization
(b) Type Aircraft Date of Last Flight
(c) If not pilot, specify capacity in which you fly

Section V
Other Flying (a) Have you ever flown or do you intend to fly: Yes No
Ultralight, Biplane, Prototype, experimental or personally built or assembled aircraft?
(If Yes, complete Avocation Questionnaire, Page 10.)
(b) Have you within the past 12 months, or do you contemplate flying in the Civil Air Patrol?
(c) Do you contemplate a change from your present flying to commercial or military flying?
(If Yes, give details in Remarks below.)

Section VI
Aviation Rates Should you not qualify for full coverage at standard rates, do you desire: Yes No
(a) Full coverage with extra premium, if available?
(b) Restricted aviation coverage without extra premium, if available?

Remarks:

The above statements and answers are complete and true to the best of my knowledge and belief and will be the basis for and a part of any policy issued based on them.

Signed at _____ City and State _____ Signature of Proposed Insured _____
Date _____

**U.S. Financial Life Insurance Company
An AXA Financial Company**

AVOCATION QUESTIONNAIRE

Name of Proposed Insured: Date of Birth

m	d	y

Section I Auto, Motorcycle, Snowmobile, Motorboat:

Type: midget stock hotrod drag sportscar snowmobile cycle boat other

Racing Vehicle or boat: make & model _____ Class & category _____

Sports Displacement _____ Horsepower _____

Timing 1/2 "of": vehicle vs. vehicle vehicle vs. clock Maximum speed attained _____ mph

Location: oval track closed circuit drag strip hill climb other

Have you ever had a racing accident? Yes No (If "Yes," explain details in Remarks below)

Racing Organizations affiliated with _____

Races supervised by _____

Frequency (Number of Races)	Last 12 Months <input style="width: 50px;" type="text"/>	1 to 2 Years Ago <input style="width: 50px;" type="text"/>	Estimate Next 12 Months <input style="width: 50px;" type="text"/>
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Section II

Type: scuba skin snorkel Purpose: recreation rescue salvage

Locations: oceans lakes rivers pools quarries caves other

Underwater Have you received formal diving training? Yes No (If "Yes," give details in Remarks below)

Sports Do you use the "buddy system"? Yes No

Depth.	Average Time	Number of Dives Last 12 Months	Number of Dives 1 to 2 Years Ago	Number of Dives Est. Next 12 Months
0-75 ft.	Mins.	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
76-125 ft.	Mins.	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
Over 125 ft.	Mins.	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>

Section III Please Identify Which of the Activities You Participate In:

sky diving hang gliding ultralights biplaning parachuting ballooning other

Sky If sky diving: Yes No If ballooning: Yes No

Sports Delayed jumping done? Yes No Gas ballooning? Yes No

Any stunting or baton passing? Yes No Hot air ballooning? Yes No

Are you a member of a club? Yes No

What class of license do you hold? _____

Usual location or type of terrain? _____

Have you been in an accident connected with this avocation? Yes No

(If "Yes," give details in Remarks below)

Number of flights or jumps: Last 12 Mos. _____ 1 to 2 Years ago _____ Est Next 12 Mos. _____

Average height _____ Maximum height _____

Average distance _____ Maximum distance _____

Average duration _____ Maximum duration _____

Remarks or Other Avocations (Include details regarding nature, location, frequency, and degree of participation.)

The above statements and answers are complete and true to the best of my knowledge and belief and will be the basis for and a part of any policy issued based on them.

Signed at _____
City and State

Signature of Proposed Insured

Date _____

PERSONAL HISTORY INTERVIEW TELEPHONE INFORMATION

Insured's Name _____

Telephone number you would like us to call:

Home _____ Business _____
(Area) (Number) (Area) (Number) (Ext.)

The best time for us to call you is: _____ a.m. _____ p.m. Time Zone

(Agent's Name)

(Agency or Office)

PLEASE DETACH HERE AND GIVE THIS PART TO THE PROPOSED INSURED,
PERSONAL HISTORY INTERVIEW NOTICE

As part of your application you have been given and acknowledged receipt of the "Notice of Insurance Information Practices". This "Notice" has informed you of the necessity of information required about you and other persons who may be proposed for insurance. The "Notice" also informed you about the Medical Information Bureau and any investigative consumer report which may be requested.

In order to offer insurance at the lowest possible cost U.S. Financial Life Insurance Company has specially trained employees that may call you to discuss information contained in your application or to ask questions related to the underwriting of your insurance. Whether they call depends upon the amount of insurance applied for. We will attempt to conduct this telephone interview at your convenience and at a number you designate. The information portion of this form contains the data needed to complete such a call. Your cooperation in supplying this information is appreciated and will greatly assist in the prompt underwriting of the insurance applied for.



A Stock Insurance Company
U.S. Financial Life Insurance Company
An AXA Financial Company
10290 Alliance Road -- PO Box 429560
Cincinnati, OH 45242
513-686-2000
www.usfli.com

REQUEST FOR PAYORS' TAXPAYER IDENTIFICATION NUMBER AND CERTIFICATION

Enter your taxpayer identification number in the appropriate box. For most individuals, this is your Social Security Number.

SS#

Tax I.D.#

Certification-Under penalties of perjury, I certify that:

1. The number shown on this form is my correct Taxpayer Identification Number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding either because I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of failure to report all interest or dividends, or the IRS has notified me that I am no longer subject to backup withholding.

Certification Instructions:

You must cross out item (2) above if you have been notified by IRS that you are subject to backup withholding because of underreporting interest or dividends on your tax return. However, if after being notified by IRS that you were subject to backup withholding you received another notification from IRS that you are no longer subject to backup withholding, do not cross out item (2).

Please sign here _____
(Signature of applicant, Trustee/Employer) (Date)

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 Application # _____ is made for

Life Insurance on _____

Name of Proposed Insured(s)

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 the Agreement.

TERMS AND CONDITIONS

AMOUNT OF COVERAGE \$100,000 MAXIMUM FOR ALL APPLICATIONS OR AGREEMENTS

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, 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) \$100,000. In no event shall the total benefit payable under this Agreement and under any other Temporary Insurance Agreement with the Company exceed \$100,000 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 Part I and Part II of the Application have been completed on the same date or prior to the date of this Agreement and at least one month's premium for the policy applied for, but not less than \$20.00, is received on the date of this Agreement.

DATE COVERAGE TERMINATES -- 60 DAYS MAXIMUM

Temporary Life Insurance under this Agreement will terminate automatically on the earliest of:

- (a) 60 days from the date of this Agreement, or
- (b) the date that insurance takes effect under the policy applied for, or
- (c) the date a policy, other than as applied for, is offered to the Applicant, or
- (d) the date the Company mails notice of termination of coverage to the premium notice address designated in the Application. The Company may terminate coverage at any time.

SPECIAL 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 if 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.
- * No one is authorized to accept money on Proposed Insureds under 15 days of age or over age 70 (nearest birthday) on the date of this Agreement, nor will any coverage take effect.
- * If the Proposed Insured dies by suicide, the Company's liability under this Agreement is limited to a refund of the payment made, if we can show the Proposed Insured intended suicide at the time of this Agreement.
- * 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 _____ 20 _____

Applicant (if other than proposed insured)

Signature of Proposed Insured
(If below age 18, parent or guardian must sign)

Signature of Agent

Signature of Additional Proposed Insured

NOTICE: The Applicant should retain a copy of this Agreement; the original will be retained by the Company. If you do not hear from the Company regarding the insurance applied for within 70 days from the date of this Agreement, notify the Company at

10290 Alliance Road, Cincinnati, OH 45242

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 Application # _____ is made for

Life Insurance on _____

Name of Proposed Insured(s)

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 the Agreement.

TERMS AND CONDITIONS

AMOUNT OF COVERAGE \$100,000 MAXIMUM FOR ALL APPLICATIONS OR AGREEMENTS

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, 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) \$100,000. In no event shall the total benefit payable under this Agreement and under any other Temporary Insurance Agreement with the Company exceed \$100,000 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 Part I and Part II of the Application have been completed on the same date or prior to the date of this Agreement and at least one month's premium for the policy applied for, but not less than \$20.00, is received on the date of this Agreement.

DATE COVERAGE TERMINATES -- 60 DAYS MAXIMUM

Temporary Life Insurance under this Agreement will terminate automatically on the earliest of:

- (a) 60 days from the date of this Agreement, or
- (b) the date that insurance takes effect under the policy applied for, or
- (c) the date a policy, other than as applied for, is offered to the Applicant, or
- (d) the date the Company mails notice of termination of coverage to the premium notice address designated in the Application. The Company may terminate coverage at any time.

SPECIAL 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 if 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.
- * No one is authorized to accept money on Proposed Insureds under 15 days of age or over age 70 (nearest birthday) on the date of this Agreement, nor will any coverage take effect.
- * If the Proposed Insured dies by suicide, the Company's liability under this Agreement is limited to a refund of the payment made, if we can show the Proposed Insured intended suicide at the time of this Agreement.
- * 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 _____ 20 _____

Applicant (if other than proposed insured)

Signature of Proposed Insured
(If below age 18, parent or guardian must sign)

Signature of Agent

Signature of Additional Proposed Insured

NOTICE: The Applicant should retain a copy of this Agreement; the original will be retained by the Company. If you do not hear from the Company regarding the insurance applied for within 70 days from the date of this Agreement, notify the Company at

10290 Alliance Road, Cincinnati, OH 45242

AGENT: Do Not Separate FORM MUST BE COMPLETED IN FULL AND ACCOMPANIED
BY A PERSONAL CHECK MARKED "VOID".

**AUTHORIZATION TO U.S. FINANCIAL LIFE INSURANCE COMPANY
TO INITIATE DEBIT ENTRIES ON BANK ACCOUNT**

For the purpose of paying premiums for insurance on the life of

Issued under Application No. _____ or, in force under Policy No. _____

I hereby authorize U.S. Financial Life Insurance Company to initiate debit entries, whether by electronic or paper means, on my
account at the _____ Bank Account No. _____
(Bank)

(City)

(State)

(Zip)

Such authorization to be revocable only upon receipt by U.S. Financial Life Insurance Company of a written revocation.

I agree that the initiation of such debit entries to such bank shall constitute due notice of premiums being due upon the policy.

My Debit Date is the same as the
Policy Date unless indicated below _____ Date _____

Other Date _____ (Signature)

**AUTHORIZATION TO MY BANK
TO HONOR DEBIT ENTRIES ON BANK ACCOUNT**

As a convenience to me, I hereby request and authorize you to honor debit entries, whether by electronic or paper means, with said debits made to my account and drawn by U. S. Financial Life Insurance Company, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to such debit shall be the same as if it were a check drawn on you and signed personally by me. I hereby agree that if any debit is not paid by you for any reason, with or without cause or whether such nonpayment is intentional, inadvertent or otherwise, you shall be under no liability whatsoever, even though such nonpayment results in the forfeiture of insurance. This authorization is to remain in full force and effect until revoked by me upon 30 days written notice, and until you actually receive such notice I agree that you shall be fully protected in honoring any such debit to my account.

Date _____ Signature _____
(As it appears on bank records)



EXAMINER'S NAME AND ADDRESS

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

To determine your insurability, U.S. Financial Life Inc. Co. (the insurer) has requested that you provide a sample of your blood for testing and analysis. All tests will be performed by a licensed laboratory.

Tests may be performed to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. The HIV antibody test is actually a series of tests done by a medically accepted procedure. The HIV antigen test directly identifies AIDS viral particles. These tests are extremely reliable. Other tests which may be performed include determinations of blood cholesterol and related lipids (fats) and screening for liver or kidney disorders, diabetes, and immune disorders.

All test results will be treated confidentially. They will be reported by the laboratory to the insurer. When necessary for business reasons in connection with insurance you have or had applied for with the Insurer, the Insurer may disclose test results to others such as its affiliates, reinsurers, employees or contractors. If the insurer is a member of the Medical Information Bureau (MIB, Inc.), and if the test results for HIV antibodies/antigens are other than normal, the Insurer will report to the MIB, Inc., a generic code which signifies only a nonspecific blood test abnormality. The test results may also be disclosed to any member company that receives an application for health or life insurance on your life. If your HIV test is normal, no report will be made about it to the MIB, Inc. Other test results may be reported to the MIB, Inc., in a more specific manner. The organizations described in this paragraph may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or as authorized by you.

If your HIV test results are normal, no routine notification will be sent to you. If the HIV test results are other than normal, the insurer will contact you. The insurer may also contact you if there are other abnormal test results which, in the Insurer's opinion, are significant. The insurer may ask you for the name of a physician or other health care provider to whom you may authorize disclosure and with whom you may wish to discuss the results.

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

I have read and I understand this Notice and Consent For Blood Testing which may include AIDS Virus (HIV) Antibody/Antigen Testing. I voluntarily consent to the withdrawal of blood from me by needle, the testing of that blood, and the disclosure of the test results as described above. In the event of a positive test result, I authorize U.S. Financial Life Insurance Company to send the test results to the following health care professional for post-test counseling and for Health department reporting purposes:

(Physician's Name)

(Physician's Address)

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

Proposed Insured

Signature of Proposed Insured or Parent/Guardian

Date

Date of Birth

State of Residence



NOTICE OF INFORMATION PRACTICES

(Including Medical Information Bureau Notice and Fair Credit Reporting Act Notice)

THIS NOTICE MUST BE GIVEN TO THE PROPOSED INSURED

In considering your application, information from various sources will be considered. These include your statements, the results of your physical examination (if required), and reports we get from doctors or medical facilities which have attended you. Information about your insurability will be treated as confidential. We, or our reinsurers, may, however, make a brief report of this to the Medical Information Bureau, a nonprofit membership of organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file. Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the bureau's information office is P.O. Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660.

We, or our reinsurers, may also release information to other life insurance companies to whom you apply for life or health insurance, or to whom a claim is submitted.

In addition, we may get an investigative report from a consumer reporting agency. This report requires personal interviews with your neighbors, friends, or other acquaintances for information as to your general reputation, personal characteristics and mode of living. As part of your application, you have authorized us to do this. You have the right to be personally interviewed and to make a written request within a reasonable period about the nature and scope of this investigation. Upon written request, you will be told if such a report has actually been ordered, and if it has, we will give you the name and address of the consumer reporting agency. You may contact this consumer reporting agency and ask for a copy of such report.

Unless a legitimate business need exists or we are required to do so by law, the information we get in this report, as well as any other information which we later acquire, will not be disclosed to anyone else without your consent. You may request a copy of all information acquired by us and have a right to correct any personal information which you feel is inaccurate. We will, if required by law, give you a more detailed notice of the types of personal information which we get in considering your application, as well as any additional rights which you may have.

Disclosure Statement



This Disclosure Statement with all applicable blanks filled in is for your protection. It gives you basic information about the cost of coverage of the insurance being solicited. Read it carefully before signing any agreement to buy life insurance.

This Disclosure Statement shall not be considered as an offer to contract or as altering or modifying any policy or rider that may be issued.

Name of Proposed Insured								Age	Sex					
Name of Agent Preparing Disclosure					Agent Home Address or Agency Address				Agent's Telephone					
Name of Insurer														
Home Office Address of Insurer (City & State)														
Direct all Correspondence to (Insurer's Home or Administrative Office)														
Policy	Descriptive Title of Coverage				Face Amount of Coverage (1) If not applicable, Description of Coverage				Annual Premium If not known, Premium for Mode Quoted (2)					
Rider (s)														
Supplemental Benefit(s) (Built into Policy)														
										The cost is included in the Premium for the policy				
The Face Amount of Coverage Changes as Follows:										For Policy Rider Supplement				
Premium Changes		Ultimate Premium		Ann	S/A	Qtr	Mth	Policy Year (Age)	Or Representative Prem and \$		Ann	S/A	Qtr.	Mth
Pol. Rider Sup.		\$												
Ultimate Premium \$				Ann	S/A	Qtr	Mth	Policy Year (Age)	And					
Retirement Income: Your Policy is designated to pay a guaranteed retirement income of:							Starting Age	Year	For Life			BUT NOT LESS THAN 10 YEARS		
GUARANTEED CASH VALUE, If you continuously pay your premiums on this policy as they come due, you will have the following guaranteed Cash Value for each \$1,000 (or face amount). You may borrow against this Cash Value at an annual interest charge.										Annual Interest Charge %				
Number of years Policy has been in force				\$		10		20		Age 55				
Total Accumulated Cash Value per \$1,000 (or Total Face Amount)														
<p>The prospective insured has not requested an earlier delivery of the index.</p> <p>Upon request either the company or agent will furnish you with additional information about the insurance described, If inapplicable to insurance being offered, section may be deleted entirely or clearly marked "Not Applicable"</p> <p>Certification of Disclosure Statement Delivery</p> <p>I hereby certify that a copy of this written disclosure statement required by Chapter 23 of the Pennsylvania Insurance Department Regulation was given to the applicant at the time that the life insurance application was signed by the applicant.</p>														
Applicant's Name (please print)								Date						
Agent's Signature														
DIS PA (11-90)		Copy One – Applicant			Copy Two – Agent			Copy Three – Home Office						

**Authorization for Release of Health-Related Information
to U.S. Financial Life Insurance Company
This authorization complies with the HIPAA Privacy Rule**

Name of proposed insured/patient (please print)

_____/_____/_____
Date of birth

I hereby authorize the release of information from all doctors and/or facilities, including the following:

Name Address

Name Address

Name Address

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record and any other protected health information concerning me to the U.S. Financial Life Insurance Company (U.S. Financial) and LabOne, Inc., its agents, employees, and representatives. LabOne, Inc. is obtaining this information on behalf of U.S. Financial Life Insurance Company (U.S. Financial) for the express purposes outlined in the third paragraph of this release. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that U.S. Financial may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with U.S. Financial.

This authorization shall remain in force for 30 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to U.S. Financial at 10290 Alliance Road, Cincinnati, OH 45242 Attention: Privacy Official. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that U.S. Financial has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, U.S. Financial may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I acknowledge that I have received a copy of this authorization.

Signature of Proposed Insured/Patient or Personal Representative Date

Description of Personal Representative's Authority or Relationship to Patient

Application Checklist

Help us help you place that case! Listed below are some of the common problem areas on new applications. Please take the time to review your application before submitting it.

1. **BE HONEST AND THOROUGH.** Remember, we are trying to look for reasons to insure your client, but if the client conceals part of their medical history, it is only prudent for us to be concerned about the overall integrity of the case and respond accordingly. Encourage your client to be forthcoming with complete information and we will be able to really work to get the best offer. We can make truly impressive offers where all others have failed.
2. **PAY CLOSE ATTENTION TO SECTION #7 ON PAGE 4.** This question regards other life/health insurance that has been offered as rated, declined or modified. Do not skip this question. An honest answer is required and can go a long way in winning the confidence of your underwriter. On the other hand, an incomplete answer can adversely affect the case.
3. **DO NOT COMPLETE THE TEMPORARY INSURANCE AGREEMENT AND/OR COLLECT MONEY IF THE PROPOSED INSURED ANSWERED QUESTIONS "YES" ON THE TIA, IS OVER AGE 70, OR HAS BEEN DECLINED OR POSTPONED ELSEWHERE.** The money will automatically be sent back to your proposed insured. Except when paid with a properly completed Temporary Insurance Agreement, the initial premium should not be accepted until the time of policy delivery.
4. **ALWAYS SUBMIT 2 SEPARATE APPLICATIONS FOR SURVIVOR LIFE POLICIES.**
5. **NON-MEDICAL SECTION (PARTII) MUST BE COMPLETED.** We use this more than other companies. A detailed Part II can often speed up the underwriting process. **DO NOT** order a paramed exam until **AFTER** we have reviewed the case.
6. **BE SURE TO INDICATE THE REQUESTED PLAN FACE AMOUNT, DEATH BENEFIT OPTION AND MODE OF PAYMENT.**
7. **PAGES 6 AND 7 MUST BE SIGNED AND THE AGENT SECTION ON PAGE 8 MUST BE COMPLETED.**
8. **COMPLETE THE PERSONAL HISTORY INTERVIEW SECTION ON PAGE 11.**
9. **INCLUDE COMPLETE REPLACEMENT PAPERS IF THE CLIENT IS REPLACING CURRENT INSURANCE.**
10. **BE SURE TO INCLUDE A SIGNED NAIC ILLUSTRATION OR ILLUSTRATION STATEMENT FOR THE FOLLOWING STATES: AK, AL, CA, CO, CT, DE, HI, IA, IL,IN, KS, LA, MD, ME, MI, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NV, OH, OK, OR, PA, RI, SC, SD, TX, UT, VA, VT, WA, AND WI.**
11. **PLEASE DIRECT QUESTIONS REGARDING YOUR SUBMITTED BUSINESS TO YOUR GENERAL AGENT.**

We appreciate your business and your cooperation in helping us place your case quicker!