Application for Individual Life Insurance

Pacific Life Insurance Company
750 Main Street, Lynchburg, VA 24504
P.O. Box 42000, Lynchburg, VA 24506
(844) 276-5759, Fax (844) 520-1618
www.PacificLife.com

PACIFIC LIFE

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LICENSED INSURANCE PRODUCER CHECKLIST FOR LIFE INSURANCE PART I

Please complete the application properly and ensure that you have satisfied all of our requirements. Follow the submission instructions provided through your marketing distribution channel. We sincerely appreciate your business.

This checklist is not part of the application. Please remove this page before submitting the application to the Insurer.

Be sure to…

- Give the *Notice to Proposed Insured and Owner* to the Proposed Insured or Owner before completing the application.
- Ask all questions and fully and accurately record all given answers – the application will be part of any policy issued.
- Enter the Proposed Insured's SSN, date of birth, address and phone numbers.
- Enter each beneficiary's SSN, date of birth, address and phone numbers – it will help us locate the beneficiary at time of claim.
- Print in dark ink.
- Obtain all necessary signatures.
- Complete and sign the Licensed Insurance Producer's report, located after the application.
- Promptly schedule any required medical exam.
- Obtain proper identification and sufficient information about the customer and source of funds to ensure that money laundering is not involved in the transaction.
- If you accept payment with the application:
  - Accept payment only in the form of currently dated check or money order made payable to the selected insurer.
  - Enter the full amount accepted in Section 7e. on page 2.
  - If the answer to any of the questions is "Yes", the Proposed Insured is not eligible for temporary coverage, and no TIAA form or premium should be accepted.
  - Explain the terms and conditions of the TIAA to the Owner and Proposed Insured and have them sign it. Point out that the date of the policy will be the TIAA date and premiums will be due from that date.
  - Complete and sign the Licensed Insurance Producer's Statement on the TIAA.
  - Give the Owner the COPY of the TIAA. Keep the ORIGINAL with the application.
  - Promptly send the payment and the Application Part I, including the ORIGINAL of the TIAA.
- For Term – explain that for premiums not paid on an annual basis at the beginning of a policy year, we adjust the annual premium by a modal factor to compensate for the lost investment earnings, additional administrative costs, and expected early lapses. These modal factors are available and will be provided on request.

Do Not…

- Use pencil or correction fluid
- Attempt to waive any of our requirements or any information that we request; you do not have the authority to make or modify contracts.
- Promise or imply that we will provide insurance.
- Accept payment in the form of cash/currency or Traveler's checks.
- Accept a check or money order made payable to you or with the payee left blank.
- Accept payment when the amount applied for plus existing insurance with the Insurer exceed $1,000,000.
- Accept payment if the Proposed Insured's age nearest birthday exceeds 70 years.
- Accept payment if any question on the Temporary Insurance Application is answered "Yes" or left blank.

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APPLICATION FOR INDIVIDUAL LIFE INSURANCE — PART I

1. Proposed Insured information

First name | Middle name | Last name *(include maiden name)*

○ Male ○ Female | Date of birth | State/Country of birth | Social security number

Home address | City | State | Zip code

Email address | How long at home address?

• Is the Proposed Insured a United States citizen? ○ Yes ○ No ***If "No,"*** *complete the Resident Alien Supplement form.*

Driver's license number/State | **Marital status** *Select one* ○ Single ○ Married ○ Divorced ○ Widowed

Home phone number | Work phone number | Cell phone number

Occupation *(include duties)*

Employer name and address | How long with employer?

2. Owner information *Complete ONLY if Owner is someone other than the Proposed Insured. If Trust, give full name of trust and date of trust agreement.*

Owner (Full Name)

Address | City | State | Zip code

Relationship to Proposed Insured | Email address

Social security/Tax ID number | Date of birth/Trust

Home phone number | Work phone number | Cell phone number

Owner Type *Select One* ○ Individual ○ Trust ○ Corporation ○ Limited liability company ○ Limited liability partnership ○ General partnership ○ Sole proprietor ○ Other *(Specify)*:

If Owner above is an individual, complete citizenship information below.

• Is the Owner a United States citizen? ○ Yes ○ No State/Country of birth

If "No," complete the *Owner Resident Alien Supplement form.*

If Owner above is a business, complete the business questions below.

Purpose of business | State/country of incorporation/formation | Date of incorporation/formation

Contingent Owner (Full Name)

Address | City | State | Zip code

Relationship to Proposed Insured | Email address

Social security/Tax ID number | Date of birth/Trust

Home phone number | Work phone number | Cell phone number

Contingent Owner Type *Select One* ○ Individual ○ Trust ○ Corporation ○ Limited liability company ○ Limited liability partnership ○ General partnership ○ Sole proprietor ○ Other *(Specify)*:

2. Owner information *continued*

If Contingent Owner above is an individual, complete citizenship information below.

• Is the Contingent Owner a United States citizen? ○ Yes ○ No State/Country of birth

If "No," complete the *Owner Resident Alien Supplement form.*

If Contingent Owner above is a business, complete the business questions below.

Purpose of business | State/country of incorporation/formation | Date of incorporation/formation

3. Beneficiary information *If percentage shares are not given, they will be equal. Use section 12 **REMARKS** to name additional beneficiaries.*

Primary Beneficiary (Full Name)

Address | City | State | Zip code

% Share | Relationship to Proposed Insured | Social security/Tax ID number | Date of birth/Trust

Home phone number | Work phone number | Cell phone number

Primary Beneficiary (Full Name)

Address | City | State | Zip code

% Share | Relationship to Proposed Insured | Social security/Tax ID number | Date of birth/Trust

Home phone number | Work phone number | Cell phone number

Contingent Beneficiary (Full Name)

Address | City | State | Zip code

% Share | Relationship to Proposed Insured | Social security/Tax ID number | Date of birth/Trust

Home phone number | Work phone number | Cell phone number

Contingent Beneficiary (Full Name)

Address | City | State | Zip code

% Share | Relationship to Proposed Insured | Social security/Tax ID number | Date of birth/Trust

Home phone number | Work phone number | Cell phone number

4. Amount and plan of insurance

a. Plan of insurance:

b. Amount of insurance:

$

5. Death benefit (Universal Life only)

○ Level (specified amount only)
○ Increasing (specified amount only)
○ Scheduled Increases (if available)
  ○ Simple ..... %
  ○ Compound ..... %

6. Riders (If available with Plan)

○ Waiver of Premium
○ Waiver of Monthly Deduction
○ Children's Term Insurance: ..... units
○ Other (amount and description)
☐

7. Premiums

a. Payment method: ○ Electronic Funds Transfer (EFT) ○ Direct Bill ○ Other *(Specify)*:

b. Payment mode: ○ Monthly (EFT only) ○ Quarterly ○ Semiannual ○ Annual ○ Single

c. Send Premium Notices to: ○ Insured ○ Owner ○ Other *(Specify)*:

d. Premium source: ○ Salary ○ Investments ○ Savings ○ Gifts/Inheritance ○ Other *(Specify)*:

e. Amount remitted in exchange for Temporary Insurance: $

8. Proposed Insured's tobacco and nicotine use *Additional space for details is available in section 12* ***REMARKS***.

a. Mark the **one** item that best describes your history of tobacco and other nicotine product use:
○ Never used ○ Totally stopped ○ Use now

b. If you have "Totally Stopped," indicate number of **years** since you totally stopped and give date and reason in section 12 ***REMARKS***.
○ Less than 1 ○ 1 or more/less than 2 ○ 2 or more/less than 3 ○ 3 or more/less than 5 ○ 5 or more

9. Proposed Insured's Insurance Needs *Complete either the Personal or Business section. Explain "Yes" answers in section 12* ***REMARKS***.

a. Personal: ○ Income replacement ○ Debt repayment ○ Estate conservation ○ Other .....

1. Personal Finances: Gross annual income $ ..... Total assets $ ..... Total liabilities $

2. Within the past 5 years, have you filed for bankruptcy or had any judgments, collections or liens filed against you? ○ Yes ○ No

b. Business: ○ Buy-Sell ○ Key employee ○ Secure credit ○ Other .....

1. Business Finances: Total assets $ ..... Total liabilities $ ..... Net worth $

2. What percentage of the business do you own? ..... %

3. Your gross annual salary (include bonus) $ .....

4. Is business insurance applied for or in force on other key members of the business? ○ Yes ○ No
(Explain either answer in section 12 ***REMARKS****.)*

5. Within the past 5 years, has the business filed for bankruptcy or had any judgments, collections or liens against it? ○ Yes ○ No

10. Proposed Insured's existing insurance/replacement *Additional space for details is available in section 12* ***REMARKS***.

a. Do you have existing life insurance or annuities? ○ Yes ○ No

b. If "Yes" to Question 10.a., will the insurance applied for in this application replace, end or change any existing life insurance or annuities? *(If "Yes," you may be required to review and sign additional forms.)* ○ Yes ○ No

c. If "Yes" to Question 10.a., list all existing life insurance policies and annuity contracts. *For additional policies/contracts, use section 12* ***REMARKS***.

Full name of company . To be replaced? ○ Yes ○ No

Amount $ Year issued . Beneficiary(ies) .

Full name of company . To be replaced? ○ Yes ○ No

Amount $ Year issued . Beneficiary(ies) .

Full name of company . To be replaced? ○ Yes ○ No

Amount $ Year issued . Beneficiary(ies) .

11. Proposed Insured's History *Explain "Yes" answers in section 12* ***REMARKS***.

a. Do you have any other application or informal inquiry for life insurance pending in any company or society? ○ Yes ○ No

b. Have you ever had an application or reinstatement request for life or disability insurance refused, postponed, limited, withdrawn or cancelled, or have you been asked to pay a higher premium? ○ Yes ○ No

c. Have you ever been convicted of a misdemeanor or felony? ○ Yes ○ No

d. In the past 5 years, have you ever requested or received a Worker's Compensation, Social Security or disability income payment, excluding a pregnancy related payment? ○ Yes ○ No

e. In the past 5 years, has your driver's license been suspended or revoked? ○ Yes ○ No

f. In the past 5 years, have you been convicted of, or pled guilty or no contest to, reckless driving or driving under the influence of alcohol or drugs? ○ Yes ○ No

g. In the past 5 years have you flown, or do you intend within the next 2 years to fly, as a pilot, student pilot, or crew member other than for a scheduled commercial airline? (*If "Yes," complete Aviation Supplement*) ○ Yes ○ No

h. In the past 2 years have you engaged in, or do you intend within the next 2 years to engage in, hang gliding, ultra-light flying, hot-air ballooning, mountain, rock, or ice climbing, motor vehicle or boat racing, or scuba or sky diving? ○ Yes ○ No
(*If "Yes," complete appropriate activities Supplement[s]*)

i. In the next 2 years, do you intend to travel or reside outside of the U.S. for more than 4 consecutive weeks other than for vacation? (*If "Yes," complete Foreign Residence/Travel Supplement*) ○ Yes ○ No

12. Remarks

Please use this section to provide full details to all "Yes" answers from previous sections. **Include question number and section/letter number.**

If beneficiaries are needed beyond those listed in section 3, please provide full details here.

Use application overflow form if additional space is needed.

13. Representations

The application includes the Application – Parts I and II and all approved supplemental forms or amendments the Insurer specifically designates as parts of the application by attaching copies of them to any policy delivered to the Owner. No licensed insurance producer is authorized to: (a) make or modify contracts; (b) waive any Insurer rights or requirements; or (c) waive any information the Insurer requests.

I represent: (1) the statements and answers given in the application are true, complete, and correctly recorded to the best of my knowledge and belief; and (2) the insurance being applied for is suitable for the Owner's insurance needs.

I agree that: (1) I will notify the Insurer if any statement or answer given in the application changes prior to policy delivery; and **(2) except as provided in the Temporary Insurance Application and Agreement, if any, insurance will not begin unless all persons proposed for insurance are living and insurable as set forth in the application at the time a policy is delivered to the Owner and the first modal premium is paid.**

(APPLICABLE ONLY IF THE EMPLOYER OR AN EMPLOYER-CONTROLLED TRUST IS TO BE THE POLICYOWNER OF THIS POLICY) If insurance is being applied for on the life of any non-exempt employee, then I represent such insurance is not prohibited by applicable state law.

If I am an active duty member of the United States Armed Forces (including active duty military reserve personnel), I confirm that this application was not solicited and/or signed on a military base or installation, and I have received from the Producer, whose name appears below, the disclosure required by Section 10 of the Military Personnel Financial Services Protection Act.

No representation is made that, based on information provided in the application, a particular premium rate, risk category, or class will be offered to me. I will review my policy and ask the producer or Pacific Life Insurance Company (PLIC) about the specific premium and risk class referenced in my policy.

The statements and answers in the application are the basis for any policy issued by PLIC, and no information about the applicant will be considered to have been given to PLIC unless it is stated in the application.

I represent that all parties have an insurable interest in the life of the Proposed Insured.

If the policy I am applying for has a No-Lapse Guarantee of at least 20 years, whether specifically requested or automatically attached, then I understand that the policy, if issued, and subject to the No-Lapse Guarantee eligibility requirements, will provide cash values that may be less than a term policy with the same guarantees. In addition, I may be paying for this policy's No-Lapse Guarantee by higher cost-of-insurance charges, lower returns on my investment, or some other pricing method even if there is no separately identified premium for the No-Lapse Guarantee.

14. Authorization to collect and disclose information

Terms

Information

Facts about the Proposed Insured. It includes the Insured's entire medical record, including facts about mental and physical health; prescription drugs; and facts about communicable diseases such as HIV infection, AIDS, tuberculosis, and sexually transmitted diseases. Information also includes facts about other insurance coverage; hazardous activities; character; finances; vocation; and other personal traits. It does not include facts about sexual orientation. Information does not include a mental health professional's Psychotherapy Notes (actual recorded notes of a counseling session that are separate from the rest of a medical record), but Information does include medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress. For New Jersey and Maine, Information does not include facts about previously administered tests for HIV Antibodies, T-Cell Counts, or AIDS.

Source

Medical Physicians; chiropractors; physical therapists; psychologists; drug, alcohol, or mental health counselors; care providers or evaluators; hospitals; clinics; drug or alcohol treatment or consultation facilities; nursing homes; mental health facilities; ambulatory care centers; the Department of Veterans Affairs; facilities or offices staffed or run by care providers; other medical or medically related facilities; medical prescription drug databases; pharmacy or pharmacy benefit manager; insurers; reinsurers; health plans; MIB; consumer reporting agencies; laboratories; financial sources; employers; the Social Security Administration; neighbors; friends; and relatives.

Insurer Pacific Life Insurance Company

Proposed Insured The Proposed Insured is the person whose life is proposed to be insured.

Authorization The Authorization is this Authorization to Collect and Disclose Information.

MIB MIB is the medical information bureau known as MIB, Inc.

Understanding

1. The following parties may need to collect Information in connection with proposed insurance coverage: the Insurer and its reinsurers; MIB; consumer reporting agencies; and these parties' representatives.
2. These parties may disclose collected Information to the following recipient parties: other insurers to which the Proposed Insured has applied or may apply; reinsurers; MIB; or persons or organizations that perform business, professional, or insurance tasks for them.
3. All parties may disclose Information as allowed or required by law. MIB and consumer reporting agencies may disclose Information only as set forth in an agreement with a member company or organization.
4. Some Information may be disclosed to persons or organizations that are not subject to federal health information privacy laws, which means that the information may no longer be protected under such laws. But even if information is disclosed to persons or organizations that are not subject to federal health information privacy laws, those persons or organizations must comply with all other applicable legal requirements governing the protection and redisclosure of information.
5. The Insurer and its reinsurers will use Information to evaluate the application, obtain reinsurance, administer claims, administer coverage, and conduct other activities that are allowed or required by law and that relate to any insurance coverage or proposed insurance coverage with the Insurer.
6. Failing to sign, changing, or revoking the Authorization will impair processing of the application; as a result, the application may be denied.
7. This Authorization will be valid for twenty-four (24) months after the date signed. This time limit complies with the time limit, if any, permitted by applicable law in the state where the policy is issued or issued for delivery.
8. The Proposed Insured or person authorized to act on the Proposed Insured's behalf; (a) may revoke this Authorization by sending written notice to the Insurer at P.O. Box 42000, Lynchburg, VA 24506, Attention: Privacy Official, and (b) may ask to receive a copy of this Authorization.

14. Authorization to collect and disclose information *continued*

Authorization and Acknowledgement

The following parties may need to collect Information in regard to proposed coverage: the Insurer and its reinsurers; MIB; consumer reporting agencies; and all persons authorized to represent these parties. Those parties that may need to collect Information may generally disclose Information to the following: other insurers to which the Proposed Insured has applied or may apply; reinsurers; MIB; or persons who perform business, professional, or insurance tasks for them. They may disclose Information as allowed or required by law. MIB and consumer reporting agencies may disclose Information only as set forth in an agreement with a member company or organization. Certain laws may pertain to some kinds of Information and may further restrict disclosure of that Information. The Insurer and its reinsurers will use Information to evaluate the application.

By signing this Application – Part I, the Proposed Insured or the person authorized to act on the Proposed Insured's behalf: (1) authorizes each Source to give Information when this Authorization is presented; and (2) acknowledges receipt of the Notice to Proposed Insured and Owner. A copy of this Authorization will be as valid as the original. The Proposed Insured or the person authorized to act on the Proposed Insured's behalf may revoke this Authorization by sending written notice to the Insurer. Failing to sign, changing, or revoking this Authorization will impair processing of the application; as a result, the application may be denied.

This Authorization will be valid for the period of time permitted by applicable law, in the state where the policy was delivered or issued for delivery, after the date this Application - Part I is signed. The Proposed Insured or an authorized representative of the Proposed Insured may ask to receive a copy of this Authorization.

Fraud Warning: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Review the answers on the Application carefully. If any of your answers are incorrect or untrue, even if unintentional, the company may have the right to deny benefits or rescind your coverage if the misrepresentation is deemed to be material.

If Proposed Insured or Owner is under age 18, a signature of parent/guardian is required in place of the minor's signature.

State in which owner signed application	State in which policy will be delivered	
.	.	
Signature of Proposed Insured	Date	Signature of Owner *If not Proposed Insured*
X	.	**X**
Life Insurance producer signature	Life Insurance producer name printed	
X	.	
License No.	Managing agency/Brokerage No.	
.	.	
Life Insurance producer signature	Life Insurance producer name printed	
X	.	
License No.	Managing agency/Brokerage No.	
.	.	

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PRODUCER'S REPORT

1. Producer Information

First name | Middle initial | Last name | Producer's company code no.

Last four of social security no./tax ID no. | Phone number | Fax number

a. Does the proposed insured have any existing life insurance or annuity? ◯ Yes ◯ No

Is this insurance applied for intended to replace, end, or change any existing insurance or annuity? ◯ Yes ◯ No

If "Yes," to either question, replacement forms may be required by state law. Include copies of any required forms with the application.

If existing insurance may be replaced, ended or changed, attach a full explanation to the application and explain to the Owner and Proposed Insured that a new suicide and contestable periods may apply.

b. If you accepted money with this application, a Temporary Insurance Application and Agreement (TIAA) is required. Was a TIAA given? ◯ Yes ◯ No

c. Has a medical or paramedical exam been scheduled? *If "Yes," give date and Provider with whom scheduled.* ◯ Yes ◯ No

Date (Mo. Day Yr.) | Provider's name

d. If Proposed Insured is married, amount of insurance on spouse. If spouse is not insured, give reason.

Amount $ | Reason

e. If Proposed Insured is a minor, amount of insurance on parents and any siblings. If parents and siblings are not insured, give reason.

Father | Mother

Siblings (name and amount)

I represent that to the best of my knowledge and belief: (1) the insurance being applied for is suitable for the Owner's insurance needs and financial objectives; (2) the information provided in this report and by the Owner and Proposed Insured in the application is complete, accurate, and correctly recorded; and (3) there is nothing adversely affecting the insurability of the Proposed Insured other than as indicated in the application. I also represent that I gave all required form(s) on or before the date the application was taken.

Life insurance producer signature | Date of signature

X

2. Managing Agency/Brokerage Report

Managing Agency/Brokerage name | Managing Agency/Brokerage No. | Email address | Date

3. Life Insurance Producers to Receive Commission *Complete for each producer to receive commission.*

Total Commission Share(s) to equal 100%. Each producer will share equally unless otherwise indicated.

First name | Middle initial | Last name | **Last four** of social security no./tax ID no.

Address | City | State | Zip code

Email address | Commission share | Company code no.

First name | Middle initial | Last name | **Last four** of social security no./tax ID no.

Address | City | State | Zip code

Email address | Commission share | Company code no.

First name | Middle initial | Last name | **Last four** of social security no./tax ID no.

Address | City | State | Zip code

Email address | Commission share | Company code no.

First name | Middle initial | Last name | **Last four** of social security no./tax ID no.

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APPLICATION FOR INDIVIDUAL LIFE INSURANCE - OVERFLOW FORM

Proposed Insured

a. Full Name (First)	(Middle)	(Last)	b. Date of Birth (Mo./Day/Yr.)	c. Social Security Number

Remarks *(Provide explanations and requested information. Identify applicable item number and letter.)*

I represent that the statements and answers given in the application are true, complete and correctly recorded to the best of my knowledge and belief. I agree that: (1) I will notify the Insurer if any statement or answer given in the application changes prior to policy delivery; and (2) **except as provided in the Temporary Insurance Application and Agreement, if any, insurance will not begin unless all persons proposed for insurance are living and insurable as set forth in the application at the time a policy is delivered to the Owner and the first premium is paid.**

Signature of Proposed Insured | Date signed | Signature of Owner (if other than Proposed Insured)

Signature of Licensed Insurance Producer or Examiner

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NOTICE TO PROPOSED INSURED AND OWNER

DETACH AND LEAVE WITH PROPOSED INSURED(S)

In this disclosure, "we", "us", "our", and "PLIC" refer to Pacific Life Insurance Company, its affiliates, and its subsidiaries. This brief description of our underwriting process is designed to help you understand how an application for life insurance, which may contain long-term care benefits, is handled, the types and sources of information we may collect about you, the circumstances under which we may disclose that information to others and your right, or that of your authorized representative, to learn the nature and substance of that information upon written request. The purpose of the underwriting process is to make sure you qualify for insurance under our rules, and assuming you do, establish the proper premium charge for that insurance. The goal of the underwriting process is to have the cost of insurance distributed equitably among all policyowners, so that each individual pays his or her fair share. To determine your insurability, we must consider such factors as your medical history, physical condition, occupation, and hazardous avocations. We get this information from various sources.

Application and Medical Records – Your application, including the medical history, is the primary source of information in the evaluation process. In addition, we may ask you to take a physical examination or other special test such as an electrocardiogram. We may also ask for a report from your doctor or hospital, another insurance company, or MIB, Inc. ("MIB", see below). When we do so, we will use the Authorization To Obtain Information that you signed. The purpose of MIB is to protect member companies, their policyowners, and insureds from those who would conceal significant facts relevant to their insurability.

MIB, Inc. – Information regarding your insurability will be treated as confidential. PLIC or its reinsurers may, however, make a brief report thereon to MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have about you in its file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB 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 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

PLIC, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

Federal Fair Credit Reporting Act – As part of our underwriting, we may ask that an investigative consumer report be prepared. An independent source known as a consumer reporting agency will prepare the report. The report will typically include information as to your character, general reputation, mode of living and personal characteristics, as well as information obtained from other data sources. ("Mode of living" does not include information related directly or indirectly to your sexual orientation.) The agency may conduct personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted in order to get this information. If you write to us within a reasonable time after you receive this notice, we will tell you whether or not a report was requested. If a report was requested, we will tell you the name, address and telephone number of the agency to whom the request was made. Upon request, the agency will furnish information as to the nature and scope of its investigation. If you would like to inspect and to receive a copy of the report, you may do so by contacting the agency directly.

DISCLOSURE TO OTHERS

Personal information obtained about you during the underwriting process and at other times is confidential and will not be disclosed to other persons or organizations without your written authorization except to the extent necessary for the conduct of our business and only to the extent permitted by applicable state law. Examples of situations where we may share information about you are as follows:

- The Producer may retain a copy of your application, and if a policy is issued will have access to ongoing policy information to better serve your needs.
- If reinsurance is required, the reinsurance company would have access to our application file.
- We may release information to another insurance company to whom you have applied for life, long-term care, or health insurance or to whom you have submitted a claim for benefits, if you have authorized it to obtain such information.
- As stated earlier, we may report information to MIB.
- We will disclose information to government regulatory officials, law enforcement authorities, and others where required by law.

DISCLOSURE TO YOU

In general, you have a right to learn the nature and substance of any personal information about you in our file upon written request. Whenever an adverse underwriting decision is made, we will notify you of the reason(s) for the decision and the source of the information upon which our action is based. Medical record information, however, will normally be given only to a licensed physician of your choice. Please refer to the section on MIB for that organization's disclosure procedure. Should you feel that any information we have is inaccurate or incomplete, please write to: Manager, New Business Services, Pacific Life Insurance Company, P.O. Box 42000, Lynchburg, VA 24506. Your comments will be carefully considered and corrections made where justified. We hope this Notice will help you to understand how we obtain and use personal information in the underwriting process, and the ways you can learn about this information. We are concerned with ensuring privacy as well as lives, and the collection, use, and disclosure of personal information is limited as specified in this Notice.

In Accordance with State Insurance Regulations, the Following Information is provided

The Truth About HIV and AIDS

AIDS is one of the leading causes of death among Americans ages 25 to 44. Many people currently living with HIV, the virus that causes AIDS, did not believe they were at risk. But HIV is serious, and it will be with us for a long time. However, you can prevent HIV infection. This brochure gives you important information about HIV and AIDS that will help you learn to protect yourselves and others.

TRUTH: AIDS is caused by a virus called HIV.
HIV stands for human immunodeficiency virus. It is the virus that causes AIDS - Acquired Immunodeficiency Syndrome. HIV is spread from one person to another through sex and blood-to-blood contact. When someone becomes infected with HIV, the virus attacks that person's immune system (the system that defends the body from illness). A person develops AIDS when his or her immune system becomes so damaged that it can no longer fight off diseases and infections. These diseases and infections can be fatal.

Most people get infected with HIV by having sex or sharing needles with someone who already has the virus.
HIV does not discriminate. Anyone can get HIV.

TRUTH: People infected with HIV may look and feel healthy for a long time.
It may take more than 10 years for people who are infected with HIV to develop AIDS. They may look and feel healthy for years after becoming infected. They may not know they are infected. Even if they don't look or feel sick they can infect others.

TRUTH: When signs of illness do appear, they vary from person to person.
When symptoms do appear, they can be like those of many common illnesses and may include swollen glands, fever, and diarrhea. In some women, recurrent, hard to treat vaginal yeast infections and cervical cancer may be related to HIV infection. Symptoms vary from person to person. None of the symptoms necessarily indicates HIV infection. When people develop AIDS, they may get illnesses that healthy people can usually resist. Only a test can tell if someone is infected with HIV. Only a doctor can diagnose AIDS.

TRUTH: Most people with HIV or AIDS got the virus by having sex or sharing needles with someone who was already infected.
The most common ways in which HIV is spread are–

- Having vaginal, anal, or oral sex with someone who has HIV.
- Sharing needles or syringes with someone who has HIV.
- From a woman with HIV to her baby during pregnancy or childbirth through breast feeding.

HIV can be spread through an infected person's blood, semen, vaginal fluids, or breast milk.

TRUTH: You cannot "catch" HIV like you do a cold or flu.
HIV is not spread through the air or water. HIV is not spread through everyday casual contact.

You can not get HIV from—

- Handshakes.
- Hugs.
- Coughs or sneezes.
- Sweat or tears.
- Mosquitoes or other insects.
- Pets.
- Eating food prepared by someone else.
- Being around an infected person.

Or from using—

- Swimming Pools.
- Toilet seats.
- Phones or computers.
- Straws, spoons, or cups.
- Drinking fountains.

TRUTH: You can protect yourself and others from HIV.
Not having sex is the only sure way to avoid the sexual transmission of HIV. However, if you decide to have sex, you can reduce your risk of infection in several ways:

- Have sex with only one partner who is not infected, who has sex only with you, and who does not share needles or syringes. (Keep in mind that it is difficult to know these things about another person.)
- Avoid contact with your partner's blood, semen, or vaginal fluid.
- When having sex, using a latex condom the right way every time reduces your risk of HIV infection. (See instructions for latex condom use in this brochure.)
- For vaginal or anal sex, use a water-based lubricant with the condom to reduce the risk of breakage.
- For oral sex on a man, use a condom without spermicide or lubricants.

The most effective way to prevent HIV infection through drug use is to stop injecting drugs. People who inject drugs can prevent HIV infection by—

- Using **new**, sterile equipment every time.
- **Never** sharing needles or syringes.

When more effective prevention is not possible, drug equipment may be cleaned with bleach to reduce the risk of HIV infection. Contact your local drug treatment center, health department, or AIDS service organization for more information on how to clean drug equipment.

Producer: Must detach and leave with Proposed Insured in accordance with state regulations

In Accordance with State Insurance Regulations, the Following Information is provided

The Truth About HIV and AIDS

TRUTH: It is impossible for a donor to get HIV from giving blood or plasma.
In the United States, every piece of equipment (needles, tubing, containers) used to draw blood is brand new. It is used only once, then destroyed. **You cannot get HIV from giving blood.**

TRUTH: The chances of getting HIV from a blood transfusion in the United States are now extremely low.
Since 1985, all donated blood and plasma have been tested for signs of HIV. The tests used are more than 99 percent accurate. People who are at risk of being infected with certain germs, including HIV, are not allowed to give blood. If signs of the virus are found in donated blood, the blood is destroyed. Before 1985, some people became infected with HIV through infected blood and certain blood products used for transfusion and for treating diseases such as hemophilia.

TRUTH: There are tests for HIV.
If you think you may be infected with HIV, you are encouraged to seek HIV-antibody testing and counseling. Standard tests look for the presence of HIV antibodies, which are signs of the virus. The body almost always develops antibodies to fight off viruses that enter the blood stream.

Current tests are more than 99 percent accurate. However, it can take up to three months after a person becomes infected before antibodies can be detected by a test. For this reason, if someone was infected recently, the test may not yet show that the person is infected. Contact your local public health department, AIDS service organization, local Red Cross, or doctors office for more information about HIV-antibody testing and counseling.

TRUTH: There is no vaccine for HIV or a cure for AIDS.
Some medicines are now available to help people with HIV live longer, healthier lives. None of these medicines can keep a person from becoming infected with HIV. None of the treatments can cure AIDS. But people can prevent HIV infection by learning the facts and acting on them.

TRUTH: You can help fight the battle against HIV and AIDS by being a volunteer.
Volunteers are always needed. They can answer AIDS hotlines and help teach others about HIV and AIDS. They can help people living with HIV and AIDS by shopping for them or bringing meals to their homes. They can help raise funds to fight this epidemic. Call your local Red Cross or AIDS service organization to learn how you can help.

TRUTH: People with HIV and AIDS need your love and understanding.
You can't get HIV or AIDS from being a friend. People who are living with HIV and AIDS need your support and caring. Ask them how you can help.

What Can I Do to Help?

Know the facts about HIV and AIDS.
Use what you have learned to help protect yourself and others. Share the facts about HIV and AIDS with your family, friends, and co-workers.

Set an example for others.
Show support and caring for people who are living with HIV and AIDS. Remember, you can't get HIV from being a friend.

For more information, contact—

- The National AIDS Information Hotline (toll free): 1(800)342-2437. For Spanish-speaking persons, Línea Nacional de SIDA: 1(800)344-7432. For deaf and hearing-impaired persons, TTY/TDD Hotline: 1(800)243-7889.
- Your doctor or other health care provider.
- Your local or state public health department.
- Your local Red Cross.
- Your local AIDS service organization.
- The American Red Cross Internet Web site: **http://www.redcross.org/hss.**

Red Cross HIV/AIDS Programs

The Red Cross has Basic, African American, Hispanic, and Workplace HIV/AIDS Education programs. Youth materials, including Act SMART and The Party, are also available. Contact your local Red Cross for more information.

Information obtained from the American National Red Cross publication HIV & AIDS, stock #329560 Rev 3/98.

Producer: Must detach and leave with Proposed Insured in accordance with state regulations

15-16882-03 3/01

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

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

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

Unless precluded by law, tests may be performed to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. The HIV antibody test that we perform 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 have applied for with the Insurer, the Insurer may disclose test results to others involved solely in the underwriting process such as its affiliates, reinsurers, employees, or contractors. If the Insurer is a member of MIB, Inc., and if the test results for HIV antibodies/antigens are other than normal, the Insurer will report to MIB, Inc., a generic code which signifies only a non-specific test abnormality. If your HIV test is normal, no report will be made about it to MIB, Inc.. Other test results may be reported to 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 will 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/antigen test results do not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others.

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

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

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

Proposed Insured (Please Print) | Date of Birth

Name and address of designated Physician:

Signature of Proposed Insured or Parent/Guardian | Date | State of Residence

Examiner's Name and Address:

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TEMPORARY INSURANCE APPLICATION AND AGREEMENT (TIAA)

ORIGINAL – Return with the application and the payment. COPY – Give to the Owner only if payment is made at the time the Application – Part I is signed.

1. Notice to Proposed Insured and Owner

Payment of the Amount Remitted may only be made at the same time that both the Application - Part I and this TIAA are completed. If the Insurer does not respond to you within 90 days, notify the Insurer at the above address. **Make the Amount Remitted payable to the Insurer. Do not make it payable to the life insurance producer or leave the payee blank. Do not pay cash.**

2. Temporary Insurance Application *Answer all questions*

Insurer
The Insurer designated in Section 4.a. of the Application - Part I.

Temporary insurance cannot begin and you should make no payment if any question is answered "Yes" or left blank.

1. Is the Proposed Insured less than 15 days old or more than 70 years old (age nearest birthday) on the Date of this TIAA? ◯ Yes ◯ No
2. Is the Policy applied for a joint life insurance policy? ◯ Yes ◯ No
3. Does the total amount of insurance on the Proposed Insured's life in force with the Insurer under any policies, conditional receipts, or temporary insurance agreements exceed $1,000,000? ◯ Yes ◯ No
4. In the past 90 days, has the Proposed Insured been admitted, or medically advised to be admitted, to a hospital or other licensed health care facility, had surgery performed or recommended, or been medically advised to have any diagnostic test (excluding an AIDS-related test) that was not completed? ◯ Yes ◯ No
5. In the past 5 years, has the Proposed Insured been diagnosed, treated, tested positive for, or been given medical advice by a professional health care provider for, heart disease, stroke, cancer, or alcohol or drug dependence or abuse? ◯ Yes ◯ No
6. Has a medical physician diagnosed the Proposed Insured as having Hepatitis C or Acquired Immunodeficiency Syndrome (AIDS)? ◯ Yes ◯ No

I represent that: (1) I have read and received a copy of this TIAA and agree to all of its terms and conditions; (2) I understand and agree that temporary insurance will not begin if any question above is answered "Yes" or left blank; (3) the answers given above are true to the best of my knowledge and belief, and I understand that, if they are false, temporary insurance may be denied or declined; (4) I understand that completing this TIAA does not guarantee that the Insurer will issue a policy on the Proposed Insured's life; and (5) I understand that the licensed insurance producer is not authorized to change or waive the terms of this TIAA.

⚠ **Signature of Proposed Insured**	Date of this TIAA	⚠ **Signature of Owner** *If other than Proposed Insured*
X	▪	**X**

3. Temporary Insurance Agreement

Agreement. Subject to the terms of the policy applied for and this TIAA, the Insurer agrees to pay the Limited Amount to the beneficiaries listed in the Application - Part I upon receipt of due proof that the Proposed Insured died while temporary insurance was in effect. The consideration for temporary insurance is the Temporary Insurance Application and payment of an amount equal to the first modal premium for the plan applied for.
Limited Amount. The Limited Amount is the lesser of: (1) the Amount of Insurance applied for in the Application - Part I; and (2) $1,000,000 minus the amount of any insurance on the Proposed Insured's life in force with the Insurer under any policies, conditional receipts, or temporary insurance agreements.
Start Date. Temporary insurance equal to the Limited Amount will begin on the Start Date subject to the terms of this TIAA. The Start Date is the Date of this TIAA.
Stop Date - 90 Day Maximum. Temporary insurance automatically ends on the Stop Date and the entire amount remitted will be returned without interest to or for the benefit of the Owner. The Stop Date is the earliest of the following: (1) the date the Owner withdraws the application; (2) 45 days after the Start Date if the Insurer has **not** received a properly completed and signed Application Part II – Medical History and all medical examinations and tests required by the Insurer as set forth in its Initial Submission Guidelines; (3) the date the Owner refuses to accept any policy issued or offered; (4) the date the Insurer sends notice to the Owner at the address shown in the Application - Part I that the Insurer has declined to issue insurance; and (5) 90 days after the Start Date.
Policy Date. The Policy Date of any policy issued will be the Start Date unless the policy is backdated at the Owner's request. The Amount Remitted will be applied to the first modal premium for the policy. Upon policy delivery, the policy will replace this TIAA and coverage will continue under the policy without interruption.
Other Limitations. The Insurer's liability will be limited to a return of the Amount Remitted if: (1) any part of the life insurance application or this TIAA contains a misrepresentation material to the Insurer; or (2) the Proposed Insured dies by suicide.

4. Life Insurance Producer's Statement

Amount remitted	Person from whom received
$	▪

On the Date of this TIAA, I received the Amount Remitted in exchange for this TIAA. The TIAA bears the same date as the Application - Part I. I agree that I am not authorized to change or waive the terms of this TIAA and represent that I have not attempted to do so. I have read and explained the terms of this TIAA to the Proposed Insured and Owner. I have left the Copy with the Owner.

⚠ **Signature(s) of Life Insurance Producer(s)**	Life Insurance Producer Number(s)
X	▪

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PACIFIC LIFE

IMPORTANT NOTICE: REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

Original to Insurer

Replacement Information

The Pacific Life Insurance Company listed above is referred to as "we" in this document.

The owner is referred to as "you" and "your."

This document must be signed by you and the producer, if there is one, and a copy left with you.

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interest. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the last page of this form.

Both questions to the right must be answered.

If either of the answers is "Yes," provide the information noted below and complete the producer replacement sales certification on page 2.

Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract?
◯ Yes ◯ No

Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract?
◯ Yes ◯ No

The existing policy or contract is being replaced because:

.

If you answered "Yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

Insurer name	Contract/policy number
Insured/annuitant name	*Select one* ◯ Replaced ◯ Financing
Insurer name	Contract/policy number
Insured/annuitant name	*Select one* ◯ Replaced ◯ Financing
Insurer name	Contract/policy number
Insured/annuitant name	*Select one* ◯ Replaced ◯ Financing

Make sure you know the facts. Contact your existing company or your producer for information about the old policy or contract. If you request one, an in-force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the producer in the sales presentation. Be sure that you are making an informed decision.

15-46070-00 11/2016

Signature

I certify that the responses herein are, to the best of my knowledge, accurate:

Owner signature | Owner printed name | Date

X . .

If you are a Trustee, Attorney-in-Fact, Guardian, or other fiduciary, indicate the capacity in which you are acting.

◯ Trustee ◯ Attorney-in-Fact POA
◯ Guardian ◯ Title/Office .....
◯ Other .....

Joint Owner signature | Joint Owner printed name | Date

X . .

◯ Trustee ◯ Attorney-in-Fact POA
◯ Guardian ◯ Title/Office .....
◯ Other .....

Producer signature | Producer printed name | Date

X . .

I do not want this notice read aloud to me. *Applicants must initial only if they do not want the notice read aloud.*

.

*And copies of all sales material were left with the applicant.

I, the producer, certify that: (a) only company-approved sales materials were used in this transaction and they are appropriate for the policy or contract applied for*; (b) if used, any company-approved electronic sales materials will be printed and provided to the policy or contract owner prior to or at policy or contract delivery; (c) this sale conforms with the company's replacement policy (set forth below).

Producer must sign at right.

Producer signature | Date

X .

Important Notice

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or producer that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts.

You should discuss the following with your producer to determine whether replacement or financing your purchase makes sense:

Premiums
Are they affordable? Could they change? You're older—are premiums higher for the proposed new policy? How long will you have to pay premiums on the new policy? On the old policy?

Policy values
New policies usually take longer to build cash values and to pay dividends. Acquisition costs for the old policy may have been paid, you will incur costs for the new one. What surrender charges do the policies have? What expense and sales charges will you pay on the new policy? Does the new policy provide more insurance coverage?

Insurability
If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down. You may need a medical exam for a new policy. Claims on most new policies for up to the first two years can be denied based on inaccurate statements. Suicide limitations may begin anew on the new coverage.

If you are keeping the old policy as well as the new policy
How are premiums for both policies being paid? How will the premiums on your existing policy be affected? Will a loan be deducted from death benefits? What values from the old policy are being used to pay premiums?

If you are surrendering an annuity or interest sensitive life product
Will you pay surrender charges on your old contract? What are the interest rate guarantees for the new contract? Have you compared the contract charges or other policy expenses?

Other issues to consider for all transactions
What are the tax consequences of buying the new policy? Is this a tax free exchange? (See your tax advisor.) Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code? Will the existing insurer be willing to modify the old policy? How does the quality and financial stability of the new company compare with your existing company?

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PACIFIC LIFE

IMPORTANT NOTICE: REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

Copy to Applicant

Replacement Information

The Pacific Life Insurance Company listed above is referred to as "we" in this document.

The owner is referred to as "you" and "your."

This document must be signed by you and the producer, if there is one, and a copy left with you.

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A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interest. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the last page of this form.

Both questions to the right must be answered.

If either of the answers is "Yes," provide the information noted below and complete the producer replacement sales certification on page 2.

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◯ Yes ◯ No

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◯ Yes ◯ No

The existing policy or contract is being replaced because:

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If you answered "Yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

Insurer name Contract/policy number

. .

Insured/annuitant name *Select one*

. ◯ Replaced ◯ Financing

Insurer name Contract/policy number

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Insured/annuitant name *Select one*

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Insured/annuitant name *Select one*

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15-46070-00 11/2016

Signature

I certify that the responses herein are, to the best of my knowledge, accurate:

Owner signature | Owner printed name | Date

X . .

If you are a Trustee, Attorney-in-Fact, Guardian, or other fiduciary, indicate the capacity in which you are acting.

◯ Trustee ◯ Attorney-in-Fact POA
◯ Guardian ◯ Title/Office .....
◯ Other .....

Joint Owner signature | Joint Owner printed name | Date

X . .

◯ Trustee ◯ Attorney-in-Fact POA
◯ Guardian ◯ Title/Office .....
◯ Other .....

Producer signature | Producer printed name | Date

X . .

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Producer must sign at right.

Producer signature | Date

X .

Important Notice

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Premiums
Are they affordable? Could they change? You're older—are premiums higher for the proposed new policy? How long will you have to pay premiums on the new policy? On the old policy?

Policy values
New policies usually take longer to build cash values and to pay dividends. Acquisition costs for the old policy may have been paid, you will incur costs for the new one. What surrender charges do the policies have? What expense and sales charges will you pay on the new policy? Does the new policy provide more insurance coverage?

Insurability
If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down. You may need a medical exam for a new policy. Claims on most new policies for up to the first two years can be denied based on inaccurate statements. Suicide limitations may begin anew on the new coverage.

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DISCLOSURE STATEMENT FOR ACCELERATED DEATH BENEFIT FOR TERMINAL ILLNESS

Rider Benefit

This Rider provides for the early payment of part of the Policy's Death Proceeds. The Accelerated Death Benefit does not qualify as long term care insurance nor is it intended to qualify as such. We will make this Accelerated Death Benefit payment to the Owner of the Policy upon receiving proof that the Insured's life expectancy does not exceed twelve months.

The Owner may make only one request for an accelerated payment. We must receive, in writing, acknowledgement of and Consent for payment under this Rider from any irrevocable beneficiary and any collateral assignee of the Policy before making any payment.

There is no premium or cost of insurance charge for this Rider; however, an administrative fee is deducted before payment.

Consequences of Receiving Accelerated Death Benefit Payment

This Accelerated Death Benefit was not designed for any specific type of favorable tax treatment; such payment may be considered taxable income. A payment may also adversely affect the recipient's eligibility for Medicaid benefits or other state or federal government benefits or entitlements. The Owner should contact a qualified tax advisor and the appropriate government agencies before electing to receive a payment.

Amount of Benefit Available

The Owner requests the amount of Accelerated Death Benefit. Generally, the largest amount available is the benefit maximum minus any Loan Balance. This benefit maximum is the lesser of (a) and (b) where (a) is the amount equal to any Loan Value of the Policy plus 75% of the difference between the Death Proceeds of the Policy and any Loan Value and (b) is $500,000. The benefit maximum can vary by state, however, and is defined by the Rider.

We will deduct an administrative fee from the Accelerated Death Benefit prior to payment to the Owner.

Effect of an Accelerated Death Benefit Payment

The Accelerated Death Benefit will be treated as a lien against the Death Proceeds of the Policy. This lien will limit the availability of any surrender benefit and of any future policy loans or withdrawals under the Policy.

We will charge interest on the lien. We will charge interest at the policy loan interest rate(s), if any, stated in the Policy on the portion of the lien amount equal to any Loan Value. We will charge interest on the portion of the lien amount that exceeds any Loan Value at a rate not exceeding the greater of: (a) the current yield on a 90-day treasury bill; and (b) is the maximum fixed annual rate of 8% or a variable rate determined in accordance with the NAIC Model Policy Loan Interest Rate Bill, model #590.

Policy and rider premiums will not be reduced after an Accelerated Death Benefit payment and will remain payable.

No matter how long the Insured lives, the Policy will not terminate as a result of a payment under this Rider unless the lien equals or exceeds the Death Proceeds. The Owner may repay all or part of the lien subject to the terms of the Rider.

Sample Illustration

Below is a sample illustration of the effect of an Accelerated Death Benefit payment. This illustration shows the effect on the Death Proceeds immediately after the Accelerated Death Benefit payment has been made and 3 months after payment of the Accelerated Death Benefit.

This sample illustration assumes: (1) $800,000 Primary Death Benefit; (2) $0 loan value; (3) no policy loans or Loan Balance; (4) the maximum Accelerated Death Benefit is elected; (5) the policy loan interest rate is 4.00%; (6) the lien interest rate is 8.00%; and (7) the quarterly premiums are $500.

Before Accelerated Death Benefit Payment:

Primary Death Benefit	$800,000
less: Loan Value	$0
	$800,000
Maximum Accelerating Percentage	X 75%
(a)	$600,000
(b) plus: Loan Value	$0
Min of (a+b, $500,000)	$500,000
less: Loan Balance	$0
Maximum Accelerated Death Benefit Available	$500,000
less: Administration Fee	$250
Amount of Accelerated Death Benefit Payment	$499,750

Immediately After Payment of Accelerated Death Benefit:

Amount of Accelerated Death Benefit Payment	$499,750
plus: Administration Fee	$250
Lien Amount	$500,000
Primary Death Benefit	$800,000
less: Lien Amount	$500,000
less: Loan Balance	$0
Payment upon Death	$300,000

3 Months After Payment of Accelerated Death Benefit:

Amount of Accelerated Death Benefit Payment	$499,750
plus: Administration Fee	$250
plus Accrued Lien Interest (3 months)	$9,713
plus: Premiums due and unpaid	$500
(c) Lien Amount	$510,213
(d) Loan Balance	$0
(e) Primary Death Benefit	$800,000
Payment upon Death (e-d-c)	$289,787

PACIFIC LIFE

PACIFIC LIFE INSURANCE COMPANY
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AUTHORIZATION FOR PAYMENT - ELECTRONIC FUNDS TRANSFER (EFT) AND/OR CREDIT CARD (INITIAL PREMIUM)

Instructions: Complete this form in its entirety to authorize Pacific Life Insurance Company (PLIC) to collect the life insurance premium set forth below by EFT and/or credit card. This form is to be returned to PLIC along with your application for life insurance. Retain a copy of this form for your records.

1. Policy/Application Information

Name of Proposed Insured

Policy/Application Number (if applicable)

2. Premium Payment Information

A. Premium payment frequency: ☐ **Monthly** ☐ **Quarterly** ☐ **Semi-Annual** ☐ **Annual**

B. Check all that apply below:

☐ **Initial Premium authorized payment method** (Check only one): ☐ EFT ☐ Credit Card (**MasterCard®** or **Visa only®**)
The amount authorized from your account will be equivalent to the amount of premium necessary to pay the policy to current date. If the policy was back-dated, or delivery has exceeded standard time frames, this amount may be greater than one standard payment.

☐ **Recurring Premium authorized payment method** (EFT only)
Recurring drafts will begin on the first available draft date after the policy is in force.

3. Checking Account Information (Complete for EFT only)

Bank Account Holder Name

Additional Bank Account Holder Name (if applicable)

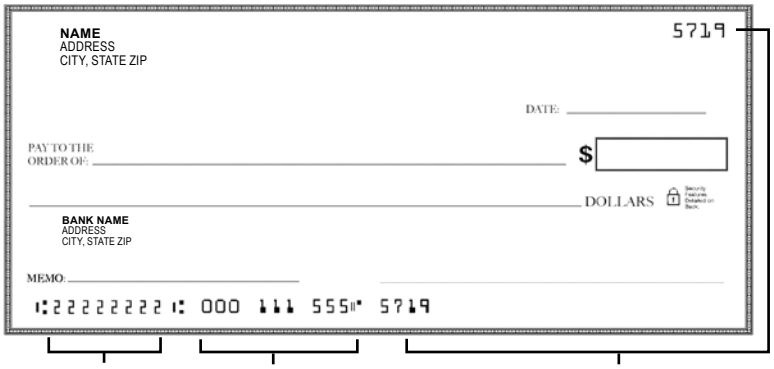
Bank Account Holder Address | City | State | Zip Code

Financial Institution Name

Financial Institution Address | City | State | Zip Code

Bank Routing Number (9 digits)

Checking Account Number



15-47602-00 05/2017

4. Credit Card Information (Complete for Initial Premium only. Not available in **Nevada**, **New York**, or **Pennsylvania**.)

Name of Credit Card Holder (as it appears on the card)

Credit Card Holder Billing Address | City | State | Zip Code

Credit Card Number (**MasterCard® or Visa® only**) | Expiration Date

5. Acknowledgments

By signing below, the signer understands and accepts these term and conditions:

A. Electronic Funds Transfer Payment:

- PLIC is authorized to initiate debit (credit) entries from the above account.
- The origination of ACH transactions must comply with the provisions of the U.S. law.
- PLIC will only allow EFT debit (credit) requests from authorized U.S. financial institutions.
- If I want to cancel or change this authorization, I must contact PLIC at least three business days before a scheduled premium payment.
- PLIC has the right to end withdrawals at any time and bill me directly either quarterly or less frequently for premiums due.
- The financial institution's draft date may vary from the policy's draft date and I further understand that PLIC is not responsible for any bank fees incurred as a result of this variance.
- If an EFT request is not honored by the financial institution upon presentation, PLIC will not consider the payment to be made as a premium. No insurance will be effective. PLIC may, in its sole discretion, resubmit the withdrawal request to the financial institution. PLIC is not responsible for any bank fees incurred by me as a result of insufficient funds or overdraft charges.

B. Credit Card Payment:

- This authorization pertains to the initial premium only. Any amount collected under this authorization that exceeds the initial premium by $2.00 or more will be refunded to me.
- Any refund of premium from credit card will be made directly to me or credited to my account.
- If I want to cancel or change this authorization, I must contact PLIC at least three business days before a scheduled premium payment.
- The use of credit cards may be limited to specific products and cannot be used for premiums paid after policy delivery.
- If a credit card payment request is not honored upon presentation, PLIC will not consider the payment to be made as a premium. No insurance will be effective. PLIC may, in its sole discretion, resubmit the credit card request. PLIC is not responsible for any credit card fees incurred by me as a result of the credit card payment request.

6. Signatures

- By signing below, the signer authorizes PLIC to collect the Initial and/or Recurring premium stated above by the payment method I have selected.
- Signing this authorization does not mean that the policy is effective.
- This Authorization for Payment does not, in any way modify or change the terms of the life insurance policy/contract.

X Authorized Bank Account Holder's Signature (for EFT authorization) | Date

X Credit Card Holder's Signature | Date

X Policyowner Signature | Date

Print Policyowner Name (if different than proposed insured)