



DISCLOSURE TO CALIFORNIA RESIDENTS AGE 65 OR OLDER

The sale or liquidation of any stock, bond, IRA, certificate of deposit, annuity, or other asset to fund the purchase of an annuity or life insurance product may have tax consequences, early withdrawal penalties, or other costs or penalties.

We recommend that you consult independent legal or financial advice before selling or liquidating any assets to fund the purchase of life or annuity products. An annuity may not be sold to a senior if its purpose is to affect Medi-Cal eligibility.

NOTICE REGARDING STANDARDS FOR MEDI-CAL ELIGIBILITY AND RECOVERY

If you or your spouse are considering purchasing a financial product based on its treatment under the Medi-Cal program, read this important message! You or your spouse do not have to use up all of your savings before applying for Medi-Cal.

RECOVERY

An annuity or life insurance product purchased on or after September 1, 2004 shall be subject to recovery by the state upon the annuitant's or insured's death under the regulations of the Medi-Cal Recovery Program. Income derived from the contract must be used to meet the annuitant's or insured's share of costs and, if the annuitant or insured is married, the income derived from the contract may impact the minimum monthly maintenance needs of the community spouse. An annuity or life insurance policy purchased by a community spouse on or after September 1, 2004, may also be subject to recovery if that spouse is the recipient of past or future Medi-Cal benefits.

UNMARRIED RESIDENT

An unmarried resident may be eligible for Medi-Cal benefits if he or she has less than the resource allowance established annually by the State Department of Health Services in countable resources. The Medi-Cal recipient is allowed to keep from his or her monthly income a personal allowance of the amount established annually plus the amount of any health insurance premiums paid. The remainder of the monthly income is paid to the nursing facility as a monthly share of the cost.

MARRIED RESIDENT

Community Spouse Resource Allowance: If one spouse lives in a nursing facility, and the other spouse does not live in a facility, the Medi-Cal program will pay some or all of the nursing facility costs as long as the couple together does not have more than the allowable amount.

Minimum Monthly Maintenance Needs Allowance: If a spouse is eligible for Medi-Cal payment of nursing facility costs, the spouse living at home is allowed to keep a monthly income of at least his or her individual monthly income or the minimum monthly maintenance needs allowed, whichever is greater.

FAIR HEARINGS AND COURT ORDERS

Under certain circumstances, an at-home spouse can obtain an order from an administrative law judge or court that will allow the at-home spouse to retain additional resources or income. The order may allow the couple to retain more than the allowance in countable resources. The order also may allow the at-home spouse to retain more than the monthly maintenance needs allowance in monthly income.

REAL AND PERSONAL PROPERTY EXEMPTIONS

Many of your assets may already be exempt. Exempt means that the assets are not counted when determining eligibility for Medi-Cal.

See Reverse Side



REAL PROPERTY EXEMPTIONS ONE PRINCIPAL RESIDENCE

One property used as a home is exempt. The home will remain exempt in determining eligibility if the applicant intends to return home someday. The home also continues to be exempt if the applicant's spouse or dependent continues to live in it. Money received from the sale of a home can be exempt for up to six months if the money is going to be used for the purchase of another home.

REAL ESTATE USED IN BUSINESS OR TRADE

Real estate used in a trade or business is exempt regardless of its equity value and whether it produces income.

PERSONAL PROPERTY USED IN A TRADE OR BUSINESS

One motor vehicle. Irrevocable burial trusts or irrevocable prepaid burial contracts. There may be other assets that may be exempt.

This is only a brief description of the Medi-Cal eligibility rules. For more detailed information, you should call your county welfare department. Also, you are advised to contact a legal services program for seniors or an attorney who is not connected with the sale of this product.

I understand that I am entitled to a 30-day cancellation period after receipt of my contract. If I decide to cancel, I am entitled to a refund of the account value or premiums paid, whichever is greater.

I have read the above notice and have received a copy.

Applicant's Signature

Date

Printed Name

Spouse (if applicable)

Legal Representative (if applicable)

Agent's Name



**ADVANCE NOTICE FOR
CALIFORNIA SENIOR CITIZENS (AGE 65 AND OLDER)
IN-HOME INSURANCE SOLICITATION**

Pursuant to Section 789.10 of the California Insurance Code, this notice is required to be given to you no more than 14 days, and at least 24 hours, prior to a scheduled visit to discuss insurance in your home. If you ask the agent to visit you the same day, the agent must provide this notice upon his or her arrival.

1. I am a licensed insurance agent. My purpose for coming to your home is to sell, discuss, and/or deliver one of the following (agent: indicate all that apply):
 - ☐ life insurance
 - ☐ annuities
 - ☐ other insurance products (specify): _____
2. You have the right to have other persons present at the meeting, including family members, financial advisors or attorneys.
3. You have the right to end the meeting at any time.
4. You have the right to contact the California Department of Insurance for information, or to file a complaint. The consumer assistance telephone number at the Department is 800-927-HELP or 213-897-8921.
5. The following individuals will be coming to your home:

Agent Name on License

Insurance License No.

Agent Name on License

Insurance License No.

Agent Name on License

Insurance License No.

Agent Name on License

Insurance License No.



Each of these individuals will give you their business card upon entering your home.



Date of Delivery

Agent's Name

Senior's Name

Agent's Address

Senior's Address

City, State, ZIP Code

City, State, ZIP Code

Agent's Telephone Number

Name of Insurer

Section 1	Proposed Insured Name (First, Middle, Last)		SSN (Required)		Date of Birth (mm/dd/yyyy)		Age	Gender: <input type="checkbox"/> M <input type="checkbox"/> F
	Proposed Insured Street Address		City		State	Zip	Telephone	
	Owner Name (First, Middle Last) (if different from Proposed Insured)		SSN (Required)		Relationship to Insured			
	Owner Street Address (where to send policy information)		City		State	Zip	Telephone	
Section 2	1) In the last 12 months, has the Proposed Insured: been confined to a hospital; received hospice care; or been informed by a member of the medical profession that he/she has a terminal illness or life expectancy of 12 months or less?? <input type="checkbox"/> Y <input type="checkbox"/> N							
	2) In the last five years, has the Proposed Insured been diagnosed with or treated by a member of the medical profession for any of the following: cancer; heart disease; congestive heart failure; stroke; COPD; emphysema; Alzheimer's/dementia; insulin-dependent diabetes; alcohol or drug dependency; AIDS or AIDS-related complex (ARC); renal insufficiency; kidney failure; cirrhosis of the liver; Multiple Sclerosis; Parkinson's disease; or Amyotrophic Lateral Sclerosis (ALS)? <input type="checkbox"/> Y <input type="checkbox"/> N							
	If the Proposed Insured answers "Yes" to Question 1, a life insurance policy will not be issued. If the Proposed Insured: applies for a 3Y, 5Y or 10Y Payment Plan; and answers "No" to both health questions; and signs the application, full coverage will be issued. If the Proposed Insured: answers "No" to Question 1 and "Yes" to Question 2; or does not sign the application; or is applying for a 1Y or Single Payment Plan, a policy with a limited death benefit for one or two years will be issued.							
Section 3	\$ _____ \$ _____ Face Amount Premium Amount		Payment Plans: <input type="checkbox"/> Single <input type="checkbox"/> 1Y <input type="checkbox"/> 3Y <input type="checkbox"/> 5Y <input type="checkbox"/> 10Y Billing Type: <input type="checkbox"/> APA (Section 9) <input type="checkbox"/> Coupon Book Multi-Pay Premium Mode: <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semiannual <input type="checkbox"/> Annual					
			Total premiums paid over the life of the agreement will equal the modal premiums times the number of payments. The total premiums paid could be more than the death benefit.					
	Will any policy applied for have any portion of the initial or future premiums paid, or otherwise provided, by anyone other than the Owner? <input type="checkbox"/> Y <input type="checkbox"/> N If yes, please provide name, address, and relationship: _____							
	Section 4 Do you have any existing life insurance policies or annuity contracts? <input type="checkbox"/> Y <input type="checkbox"/> N Is the insurance applied for intended to replace or change any existing life insurance or annuity coverage? <input type="checkbox"/> Y <input type="checkbox"/> N (If "Yes," to either question, please provide the required replacement form(s), if applicable in your state.)							
Section 5	Secondary Addressee Name (First, Middle, Last) (Multi-Pay - where to send copies of premium lapse notices)						Telephone	
	Street Address		City		State	Zip Code		
Section 6	Important Information: If Beneficiary Information is left blank, the default Beneficiary will be the Proposed Insured's estate.							
	Beneficiary Name (First, Middle, Last)		SSN		Telephone		Relationship to Insured	
	Street Address		City		State	Zip Code		
Section 7	Agreement: The above information is true and complete to the best of my knowledge and belief. I understand that the falsity of any statement in the application shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by Forethought. I understand no coverage shall be in effect until the first premium has been paid, a contract has been issued while the Proposed Insured is living, and the Proposed Insured's insurability remains unchanged. I have read and understand the Fraud Warnings and State Notices given to me with this application. I certify that: 1) Owner has an insurable interest in the Proposed Insured's life; 2) I have not entered into any agreement or arrangement to make a future sale of this life insurance policy; and 3) I have not entered into any agreement by which I am to receive consideration in exchange for procuring this policy.							
	Signature of Proposed Insured (if legal representative/guardian, attach legal documentation)				City and State (where signed)		Date (mm/dd/yyyy)	
	X Policyholder/Owner Signature (if different)				City and State (where signed)		Date (mm/dd/yyyy)	
	X							
Section 8	To the best of my knowledge, the applicant has an existing life insurance policy or annuity contract. <input type="checkbox"/> Y <input type="checkbox"/> N							
	Is the insurance applied for intended to replace or change any existing life insurance or annuity? <input type="checkbox"/> Y <input type="checkbox"/> N							
	I certify that I have truly and accurately recorded herein the information supplied by the Owner and Proposed Insured.							
	Signature of Agent		Date (mm/dd/yyyy)		Agent Telephone		Agent Email Address	
X								

Section 9	Automated Payment Authorization <i>(please attach a voided check)</i>		
	Name of Financial Institution	Routing Number	Account Number
	<input type="checkbox"/> Checking <input type="checkbox"/> Savings		
	Draw Date: <input type="checkbox"/> Standard Date <i>(about 30 days after issue of coverage)</i> <input type="checkbox"/> Custom Draw Date _____ <i>(Select 1-28)</i> <input type="checkbox"/> Deduct first payment only		
	I authorize Forethought Life Insurance Company to withdraw from my account the amount of premium due and request that the institution honor such withdrawals. I agree that the Institution's rights shall be the same as if it were a check drawn and signed by me. I further agree that if any withdrawal fails or is disallowed neither the Institution nor Forethought Life Insurance Company shall be under any liability whatsoever. This authorization shall continue until the Institution receives written notification from me or the contract is paid in full.		
	Electronic Check Disclosure: When you provide a check as the initial payment, you authorize us to either use information from your check to make a one-time electronic fund transfer from your account or to process the payment as a check transaction. You will not receive your check back from your financial institution.		
	Signature of Account Holder	Printed Name of Account Holder	Date (mm/dd/yyyy)
	X		
Section 10	Fraud Warnings & State Notices		
	California Residents – Reg. 789.8: The sale or liquidation of any asset in order to buy insurance, either life insurance or an annuity contract, may have tax consequences. Terminating any life insurance policy or annuity contract may have early withdrawal penalties or other costs or penalties, as well as tax consequences. You may wish to consult independent legal or financial advice before the sale or liquidation of any asset and before the purchase of any life insurance or annuity contract.		

This form is only required when applying for a multi-year payment plan that provides full first-day insurance coverage.

It allows Forethought to obtain medical records needed to investigate death claims that occur within two (2) years of policy issuance, as provided under the terms of your policy. This authorization becomes null and void after two years.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, the Veterans Administration, or any other medical facility having information as to diagnosis, treatment or prognosis with respect to my physical condition, to release and disclose the entire medical record and any other protected health or other information concerning me within the past five (5) years, without restrictions, to Forethought. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the treatment of alcohol, drug and tobacco abuse, and mental illness and treatment. This excludes psychotherapy notes. Information relating to HIV test results will only be disclosed as permitted by applicable state law.

I understand that the protected information is to be disclosed under this authorization so that Forethought may administer claims, determine or fulfill responsibility for coverage and provision of benefits, and conduct other legally permissible activities that relate to any coverage I have, or have applied for, with Forethought. Any protected information obtained will not be released by Forethought.

I understand that this authorization shall remain in force for **twenty-four (24) months** from the date shown below if used in connection with an application for an insurance policy, an application for reinstatement of an insurance policy, a request for change in policy benefits, or for the duration of a claim if used for the purpose of collecting information in connection with a claim for benefits under a policy.

I understand and agree that a copy of this authorization is as valid as the original and that I or my authorized representative will receive a copy of this authorization with my policy. I understand and agree that this authorization may be revoked by me at any time in writing, by sending a written notice of revocation to One Forethought Center, Batesville, IN 47006, attention to New Business. I agree that Forethought shall be fully protected if it acts in reliance on this authorization prior to receiving notice of revocation or to the extent that Forethought has a legal right to contest a claim under an insurance contract. Any information that is disclosed pursuant to this authorization may be redisclosed as provided herein or as required or authorized by law and may then no longer be covered by federal rules governing privacy and confidentiality of health information.

I understand that if I refuse to sign this authorization to release my complete medical records, Forethought may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments.

Signature of Insured or Legal Representative		Date (mm/dd/yyyy)	
Primary Care Physician		Telephone	
Street Address	City	State	Zip Code

IMPORTANT INFORMATION**READ CAREFULLY**

This information applies to Forethought Life's Simple Protection Plan policies, which may be used to help offset the cost of funeral or other final expenses ("at-need expenses") of the insured. Upon death of the insured, the proceeds of your policy will be paid directly to the person you named as beneficiary under the policy. The beneficiary may use the proceeds for the payment of the insured's at-need expenses but is not required to do so. Your policy does not guarantee that the proceeds will be used for the insured's at-need expenses or that the proceeds will be sufficient to cover any particular merchandise or service upon the insured's death.

Your policy is not issued in connection with or as payment or a guarantee for any funeral contract or prearrangement for goods and services to be provided upon the insured's death. As such, your policy does not guarantee or entitle you to any particular funeral services or merchandise upon the insured's death or guarantee or entitle you to any particular price for funeral services or merchandise upon the insured's death.

Any discussion of or reference to the current price of funeral goods and services by your licensed insurance agent is intended only to give you an idea of the cost of a typical funeral in your area as a means of estimating the cost of possible at-need expenses. Any particular services or merchandise identified were merely a statement of your current preferences for purposes of estimating at-need expenses. The price of any services or merchandise identified represents a current estimate and is not guaranteed. The price for services or merchandise, if any, selected upon the insured's death will be determined based on the current retail price at the time of delivery.

Cancellation and Refunds

If you have made a list of at-need preferences, you may cancel or change those selections at any time. Cancellation of funeral preferences does not cancel your Forethought Life insurance, which may only be terminated in accordance with its terms and conditions. If you cancel your Forethought insurance more than thirty days after receipt, you will receive the cash value. In the early years, the cash value may be substantially less than the premiums paid.

The person who assists you in completing the application is a licensed insurance agent. The agent may receive a sales commission from the insurance company in connection with the sale of your policy.



Section 1: Policy Information

Insured	Policy Number
Owner (if other than Insured)	

Section 2: Acknowledgements and Signatures

Effective 45 days from the date Forethought Life Insurance Company (Forethought) receives this form (Effective Date), I hereby irrevocably assign ownership of this Policy to the Forethought Insurance Trust (Trust). This transfer, once effective, is made for the purpose of obtaining favorable consideration of the Policy for purposes of any applicable state or federal public assistance program.

I understand and acknowledge that by irrevocably transferring ownership of this Policy to the Trust, as of the Effective Date:

- 1) The Trustee of the Trust becomes vested with all of the legal rights and incidents of ownership that I had in the Policy and shall take possession of and hold and administer the Policy in accordance with the terms of the Trust;
- 2) The change of ownership is permanent and irrevocable and I renounce my power to control ownership of the Policy;
- 3) I give up any remaining right to cancel the Policy and receive a return of premium under the Right to Cancel provision;
- 4) I waive all rights under the Policy to surrender it for cash, or to obtain a loan against the Policy;
- 5) The Trustee may assent to my request for a change of the designated beneficiary of a policy after assignment, but is not obligated to do so;
- 6) It is my personal obligation to pay all premiums due on this Policy (if any) directly to Forethought, and if my failure to pay premiums results in the lapse of the Policy, the Trustee will have no further obligation with respect to the Policy;
- 7) The Trustee of the Trust will have no obligation to pursue a claim against Forethought for Forethought's refusal or failure to pay policy proceeds. The designated beneficiary at the time of death of the Insured, or the Insured's estate if no beneficiary is so designated, shall be vested with such rights in the event that a claim for policy proceeds is denied;
- 8) The Trust provides that the Trustee of the Trust is not liable to any beneficiary for breach of trust to the maximum extent allowed by law. This means the Trustee will not be liable for a breach of trust unless the breach was caused by the Trustee's wanton, reckless, or intentional conduct. My signature below, transferring ownership of the Policy to this Trust, indicates that I have either consulted with independent legal counsel about the effect of this provision of the Trust (or any questions relating to this provision) or have voluntarily declined to do so.
- 9) **This is not a contract for prepaid funeral services or merchandise under state law and the Policy does not, and is not intended to, fund any preneed or prepaid funeral contract. The Policy is not a funeral policy or a policy with any similar designation;**
- 10) **The Policy being assigned does not entitle the policyholder or any other person to prepaid funeral services or merchandise or any other services or merchandise;**
- 11) **The Policy being assigned is not guaranteed to be exempt as a resource in determining eligibility for Medicaid under state law, and does not guarantee Medicaid eligibility. Medicaid eligibility determinations are made in accordance with applicable Medicaid laws and policies;**
- 12) **Forethought makes no representation with respect to whether this irrevocable assignment is sufficient to remove any Policy from the Owner's estate or the Insured's estate for Federal estate tax purposes or any State estate or inheritance tax purposes or for purposes of qualifying for Medicaid benefits or excluding assets from the reach of creditors;**
- 13) **A sales commission may be paid to the agent who sold the Policy;**
- 14) I may obtain a full copy of the Trust, at any time, upon written request to Forethought Life Insurance Company, P.O. Box 151, Batesville, IN 47006-2016.

Section 2: Acknowledgements and Signatures (continued)
2.1: For Applicant (To be used for only for purposes of making assignment effective immediately)

I understand that by initialing below, I hereby elect to make this irrevocable assignment effective immediately. I understand that by making this election I waive the 45 day election period provided in Section 2 and thereby give up all rights to cancel the Policy and receive a return of premium under the Right to Cancel provision of the Policy.

To waive 45-day election period and make this assignment effective immediately, please initial here: _____
 Initials

2.2: For Agent

I, _____ (Agent Name) certify that on _____ (Date) I have explained to this applicant that by initialing the above line in Section 2.1, he/she is waiving their right to cancel the Policy and assert that he/she is aware of the consequences of immediate transfer. I understand that this option should only be used if there is an **immediate** need for Medicaid qualification.

2.3: Signatures

Signature of Owner	Date (mm/dd/yyyy)
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Medicaid rules, as well as their interpretation and application, vary by state and the ability to qualify for a state and/or federal public assistance program IS NOT guaranteed. You should always consult an elder-law attorney or a financial advisor who is knowledgeable in this area on your state's specific rules pertaining to Medicaid eligibility, and on using irrevocable assignments of life insurance policies as a means to protect your assets. Importantly, even if your life insurance policy is excluded from consideration as a resource because of the irrevocable assignment, it may still be subject to Medicaid transfer penalties, which could delay Medicaid eligibility up to several months if you apply for Medicaid within five years of the transfer. The applicant's individual circumstances at the time of application for government assistance will, in part, determine whether or not the policy will count as a resource. The judgment of the caseworker handling the application will also be a factor.

This Irrevocable Assignment of Ownership to Forethought Insurance Trust form can be submitted as follows:
U.S. Mail

Forethought Life Insurance Company
 P.O. Box 151
 Batesville, IN 47006

Via Fax:

Please fax to (800) 320-3291

Questions? Please Call: (800) 331-8853

Private Express Carrier:

Forethought Life Insurance Company
 One Forethought Center
 Batesville, IN 47006

Via Email

Please email to preneed@gafg.com



REPLACING YOUR LIFE INSURANCE POLICY?

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

Are you thinking about buying a new life insurance policy or annuity and discontinuing or changing an existing one? If you are, your decision could be a good one - or a mistake. You will not know for sure unless you make a careful comparison of your existing benefits and the proposed benefits.

Make sure you understand the facts. You should ask the company or agent that sold you your existing policy to give you information about it.

Hear both sides before you decide. This way you can be sure you are making a decision that is in your best interest.

We are required by law to notify your existing company that you may be replacing their policy.

List below the identification of policies which are involved in the replacement transaction.

Existing Policy Information on:

Name of Insured

Information on Present Policies *(If more policies are involved, use additional sets of forms)*

	Company Name	Type of Policy	Policy # Number	Date of Issue	Face Amount of Basic Policy	Type of Optional Benefits
1						
2						

Proposed Policy Information on:

Name of Insured

	Company Name	Type of Policy	Face Amount of Basic Policy	Type of Optional Benefits
1				
2				

ATTENTION CONSUMER. THIS NOTICE IS REQUIRED. PLEASE READ IT CAREFULLY BEFORE SIGNING.

I have received all sales material used in conjunction with this sale. It is my understanding that upon review of this material, should I have any questions, I can contact either my producer or Forethought for further clarification.

Applicant's Signature and Printed Name

Agent's Signature

Date (mm/dd/yyyy)

Joint Applicant's Signature and Printed Name

Address

Date (mm/dd/yyyy)

City

State

Zip

Telephone #

License #



Mailing Address: **Forethought Life Insurance Company**
One Forethought Center
P.O. Box 216
Batesville, IN 47006

Insured Name	Owner Name <i>(if different than Insured)</i>
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To electronically receive and sign documents related to your Forethought Life insurance or annuity application, you must read and agree to the following terms and conditions.

You have applied for coverage with us and indicated your desire to electronically receive and sign documents related to your application. This Electronic Document Disclosure and Consent ("Disclosure") applies to those forms, disclosures and notices required to be given to you and in some cases signed and returned to us as part of the application. By agreeing to the terms and conditions of this Disclosure, you are agreeing to receive, read, acknowledge and/or sign these documents electronically.

The words "we," "us," and "our" means the specific underwriting company identified in your quote and in the documents we provide to you, including your life insurance policy/certificate or annuity contract. The words "you" and "your" means the individual(s) who has/have applied for the policy/certificate/contract and who is/are identified as an Owner in the policy/certificate/contract.

Documents Provided Electronically: The types of electronic documents you are consenting to receive, read, acknowledge and/or sign includes, but is not limited to the following and will be referred to as "Documents" in this Disclosure:

- Legal and regulatory disclosures, forms, notices and communications associated with the purchase and/or payment of your policy/certificate/contract.
- Required forms, notices and/or disclosures relating to contract limits, coverage choices, selections and rejections.
- Authorization forms relating to this coverage.
- Any other notice that must be delivered to or acknowledged or signed by you when purchasing your coverage.

Method of Providing Documents to You Electronically: All Documents we provide to you electronically will be provided either by (1) email; or, (2) accessing a website identified in an email we send to you.

Withdrawing Consent: You may withdraw your consent to receive Documents in electronic form by contacting us at ask.us@gafg.com. At our option, we may treat an invalid email address or malfunction of a previously valid address that you provided, as a withdrawal of your consent to receive electronic Documents. We will not charge a processing fee for withdrawing your consent to receive electronic Documents; however, if a discount is given now or in the future for conducting business electronically, withdrawing consent may result in the loss of any such discount. Withdrawing your consent to receive electronic Documents will be effective only after we have a reasonable period of time to process your request.

Updating Your Records: It is your responsibility to provide us with a true, accurate and complete email address, contact, and other information related to this Disclosure and your policies/certificates/contracts, and to maintain and promptly update any changes in this information. You can update information (such as your email address) by contacting us at ask.us@gafg.com.

Hardware and Software Requirements: In order to access, view, sign and retain electronic Documents we make available, your device (i.e. PC, Mac, tablet, pad) must meet the following minimum criteria:

- Internet connection with access to your valid email account
- Browser: Microsoft Internet Explorer 9.0 or later; Mozilla Firefox v7.0 or later; Google Chrome v14 or later; or, Safari v5 or later
- Operating System: Windows Vista or later; iOS 5 or later; or, Android OS2 or later
- Adobe® Acrobat® Reader® 9.5.2 or later
- Sufficient electronic storage capacity on your device
- Printer connected to your device for printing PDF documents

We will update you if there are any changes to the hardware or software requirements that could impact your receiving or signing electronic Documents.

Requesting Paper Copies: We will not send you paper copies of electronic Documents, unless you request it or we otherwise deem it appropriate to do so. You can obtain a paper copy of any electronic Document we provide to you by printing it yourself or requesting we mail a paper copy to you. Requests for paper copies must be made within a reasonable time after we first provided the electronic Document(s) to you. To request a paper copy, contact us at ask.us@gafg.com. There is no charge associated with requesting a paper copy of an electronic Document we send you. We reserve the right, but assume no obligation, to provide a paper (instead of electronic) copy of any Document you have authorized us to provide electronically.

Documents in Writing: All Documents, electronic or paper format, from us to you will be considered "in writing." A copy of all electronic Documents, this Disclosure and any other document that is important to you should be printed or downloaded by you for your records.

Applicable Law: You acknowledge and agree that your consent to electronic Documents is provided in connection with a transaction affecting interstate commerce subject to applicable federal and/or state law governing electronic document delivery and execution, and that you and we both intend that such law govern such transaction to the fullest extent possible to validate our ability to conduct business with you by electronic means.

Termination/Changes: We reserve the right, in our sole discretion, to discontinue the provision of your electronic Documents, or to terminate or change the terms and conditions on which we provide electronic Documents. We will provide you with notice of any such termination or change as required by applicable law.

By selecting "I agree", electronically signing this form as an example of your e-signature, you are agreeing to the terms and conditions set forth in this Disclosure, and you are confirming that you are able to receive the electronic Documents as specified in the hardware and software requirements listed in this Disclosure.

Insured	Owner
<input type="checkbox"/> I Agree <input type="checkbox"/> I Decline	<input type="checkbox"/> I Agree <input type="checkbox"/> I Decline
Insured Signature X	Owner Signature X

Note: your e-signature may be made by signature pad, touchscreen signature, or by selecting a unique font and typing your name in the above signature field. If using a unique font, the same font **must** be used on all documents signed.

Insured and Owner (if applicable) must check one of these boxes to continue with the electronic application.

If Insured or Owner (if applicable) does (do) not agree, then Documents must be printed, signed and submitted in paper format.