



First Great-West Life & Annuity Insurance Company

POLICY CHANGE APPLICATION

USE THIS FORM FOR THE FOLLOWING:

SECTION

REMOVE BENEFIT RIDER	2
CHANGE IN SMOKING STATUS	5
DIVIDEND OPTION CHANGE	4
INCREASE IN FACE/SPECIFIED AMOUNT	2
MISCELLANEOUS POLICY CHANGES	2
REINSTATEMENT	1
REVIEW OF EXTRA RATING	3
STATEMENT OF HEALTH	6,7
TERM CONVERSION	8

PLEASE NOTE:

PART B - Smoking Questionnaire, Statement of Health & HIPAA - MUST BE COMPLETED for the following requests: Reinstatement, Review of Extra Rating, Non-Smoker Discount, Increase in Face Amount or any change that would result in additional risk to the Company.

INSTRUCTIONS:

- Mark the box for each change or service you are requesting.
- This form and all signatures must be in ink.
- SIGNATURE REQUIREMENTS: The owner's signature is required for all requests. If a Corporation is Owner, signatures and titles of two officers, or one officer under Corporate Seal, are required. Witness must be of majority age with no interest in the contract.
- For Addition of Child Rider, complete Form No. 59.
- For Child Policy, complete Form No. 17, Juvenile Non-Medical Form.

Home Office: White Plains, NY

POLICY INFORMATION – Please Complete

Policy No.

POLICY OWNER INFORMATION:

Name
Address
Social Security Number or Tax I.D. No.
<input type="checkbox"/> Check here if new address

INSURED INFORMATION:

Name	
Address	
Social Security Number	
Date of Birth	Place of Birth
<input type="checkbox"/> Check here if new address	

PART A

1 REINSTATEMENT

Please reinstate this policy according to its terms.

2 POLICY CHANGE/INCREASE

Request is hereby made to change or increase existing policy to that specified below:

For UNIVERSAL LIFE Plans Only

Change to Option: A (Increasing) B (Level) Increase/Decrease: \$

New Billed Amount (or minimum required, if greater): \$

Automatic Payment \$ Remove

For NON-UNIVERSAL LIFE Plans Only

Decrease Face Amount : \$ ECO Face Amt. \$

Annual Premium PUA Rider Paid Up Remove

Waiver of Premium: Remove

Please Remove the Following Benefits(s) / Rider(s):

Accidental Death Benefit: \$

Term Rider (Specify Type): \$ Type:

Guaranteed Insurability Rider:

Other Insured Rider / Spouse Rider

Other (Please Specify):

Please change Premium Mode to: Annual Semi-Annual Quarterly PAC/EFT

Add to existing PAC/EFT under Policy No. New PAC/EFT Form Attached

3 REVIEW OF EXTRA RATING/ NON SMOKER DISCOUNT

Please review the existing additional rating on this policy for possible reduction / removal

Please review the policy for application of the non-smoker discount.

4 DIVIDEND OPTION

Please change to or include the following dividend option:

Paid-Up Additions Cash Reduce Premium (not available with PAC/EFT)

Accumulate at Interest Repay Policy Loan Purchase One-Yr. Term (Bal. of div. to be)

Other (Specify)

Please apply existing dividend credits to this option. Withdraw existing dividend credits

Leave dividend credits under existing option. Other

PART B

5 SMOKING QUESTIONNAIRE (Specimen may be required)

A Do you currently use tobacco? Yes No

If "YES," give type: Cigarettes; Cigar; Pipe; Other (Specify):

How long have you been using tobacco? Quantity per day:

B If you are not currently smoking cigarettes, have you ever smoked them? Yes No

If "YES," date on which you stopped smoking:

Length of time you smoked: Why did you stop?

If on the advice of a physician, provide full name and address:

6 STATEMENT OF HEALTH (The Company may require additional Evidence of Insurability)

Proposed Insured:	Occupation:	Relationship to Owner:
Date of Birth: <input type="text"/> / <input type="text"/> / <input type="text"/>	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Height: <input type="text"/> Weight: <input type="text"/> lbs.
Weight Gain/Loss in last year? If "Yes," how much? <input type="text"/> lbs. Reason: <input type="text"/>		

	Yes	No
A During the last two years have you been absent from work for a continuous period of two weeks or more because of illness or injury? If "Yes," give details below.	<input type="checkbox"/>	<input type="checkbox"/>
B Is any other application for insurance or your life pending at this time? If "Yes," give details below. INDICATE TOTAL LIFE and AD&D CURRENTLY IN FORCE.	<input type="checkbox"/>	<input type="checkbox"/>
C Do you participate in any type of flying or gliding, other than as a fare-paying passenger? If "Yes," please complete an aviation questionnaire (Form 24).	<input type="checkbox"/>	<input type="checkbox"/>
D Do you participate in sky or scuba diving, or racing of any kind? If "Yes," please complete an avocation questionnaire (Form 56).	<input type="checkbox"/>	<input type="checkbox"/>
E Do you travel or have you made plans to travel outside the U.S.A. and Canada within the next year? If "Yes," where <input type="text"/> how long <input type="text"/> and why <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
F Do you now or have you ever used alcohol? If "Yes," have you received treatment or belonged to an organization because of alcohol use? If "Yes," give details below. Alcohol Use: Amount per week: <input type="text"/> Type: <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
G Have you ever had your driver's license restricted, revoked or suspended in the last three years? If "Yes," give details below.	<input type="checkbox"/>	<input type="checkbox"/>
H During the past 5 years, have you used heroin or other narcotics, hallucinogenic or other habit forming drugs, including cocaine and marijuana? If "Yes," give details below	<input type="checkbox"/>	<input type="checkbox"/>
I Have you ever had an application for life or disability insurance declined, postponed, rated, or modified? If "Yes," give details below.	<input type="checkbox"/>	<input type="checkbox"/>
J To the best of your knowledge and belief, have you:		
1. Ever been diagnosed or treated by a medical professional for heart disorder, high blood pressure, stroke, cancer, diabetes, alcoholism, or liver or kidney disease?	<input type="checkbox"/>	<input type="checkbox"/>
2. Ever been diagnosed or treated by a medical professional for a respiratory disorder, gastrointestinal disorder, nervous disorder, sexually transmitted disease, except for AIDS and/or ARC, elevated cholesterol or triglycerides, arthritis, or bone or joint disorders?	<input type="checkbox"/>	<input type="checkbox"/>
3. Ever been treated by a medical professional for significant weight loss, fever, night sweats, persistent diarrhea or swollen lymph nodes?	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever been diagnosed as having or treated by a medical professional for any disease or disorder of the immune system except for AIDS and/or ARC?	<input type="checkbox"/>	<input type="checkbox"/>
5. Had medical or surgical treatment during the past five years for any ailment, injury or sickness not named in connection with your prior answers?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever been diagnosed or treated for AIDS and/or ARC?	<input type="checkbox"/>	<input type="checkbox"/>

7. Details of "YES" Answers. Identify Question Number and Individual and Circle Applicable Items. Include diagnoses, dates, duration and names and addresses of all attending physicians and medical facilities. (If more space is needed, please attach an additional sheet of paper.)

AGREEMENT

The undersigned hereby declare(s) that to the best of his/her knowledge and belief the foregoing statements and answers are complete and true. I/We agree that this application and any evidence of insurability required by the Company in connection with the change requested shall be considered an amendment and supplement to the original application and shall form a part of the policy. I/We also agree that the change or reinstatement requested shall not take effect until it has been approved at the Home Office and any required premium has been paid while the facts concerning the insurability of the Proposed Insured are the same as described in this application. The owner believes that the life insured is in good health and is not afflicted with any disease or disorder, external or internal, except as may be disclosed in Part B of this Policy Change Application and in any other statement forming part of this application. No agent can modify this agreement or waive any of the Company's rights or requirements. I have received a copy of: 1) the Medical Information Bureau Notice; and 2) the Notice required by the Federal Fair Credit Reporting Act.

AUTHORIZATION: I understand and authorize the following:

- A. to determine eligibility for insurance for the Proposed Insured, I authorize the release of information concerning;
 - 1. the diagnosis, treatment or prognosis of any past or present physical, mental, drug, or alcohol condition; and
 - 2. any non-medical data which relates to insurability;
- B. the parties authorized to release such information are:
 - 1. any physician or medical practitioner;
 - 2. any hospital, clinic, or other medically related facility;
 - 3. any insurance or reinsurance company;
 - 4. the Medical Information Bureau or any consumer reporting agency; and
 - 5. any employer of the Proposed Insured,
- C. the information may be released to:
 - 1. First Great-West Life & Annuity Insurance Company (First Great-West);
 - 2. the reinsurers of First Great-West; and
 - 3. the legal representative of First Great-West; and
- D. any data obtained will not be released by First Great-West to any person or organization except:
 - 1. to reinsuring companies;
 - 2. to the Medical Information Bureau;
 - 3. to persons performing business or "at services in connection with my application";
 - 4. to any physician named in my medical declarations (as required for my medical care);
 - 5. as required by law; or
 - 6. as I further authorize.

I agree that a photocopy of this authorization will be as valid as the original. I know that I may request a copy of this authorization. I agree that this authorization shall be valid for two years from the date shown below. I know that I may revoke this authorization at any time except to the extent that action is taken in reliance on it.

Signed at this day of , 20

Witness
Witness
Witness
Witness
Witness
Witness

Insured
Additional Insured, if any
Policy Owner, if other than Insured
Policy Owner, if other than Insured
Assignee or Irrevocable Beneficiary, if applicable
Insured

FEDERAL FAIR CREDIT REPORTING ACT NOTIFICATION

THE FEDERAL FAIR CREDIT REPORTING ACT REQUIRES THAT YOU BE GIVEN A COPY OF THIS NOTICE

This is to inform you that as part of First Great-West Life & Annuity Insurance Company's procedure for processing your insurance application an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your: character; general reputation; personal characteristics; and mode of living. You have the right to inspect and receive a copy of the report. You have the right to make a written request within a reasonable period of time to receive additional, detailed information about the nature and scope of this investigation.

NOTICE REGARDING THE MEDICAL INFORMATION BUREAU

Information regarding your insurability will be treated as confidential. First Great-West Life & Annuity Insurance Company or our reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a nonprofit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim of benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. (Medical information will be disclosed only to your attending physician.) If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (866) 692-6901 TTY (866-346-3642)

First Great-West Life & Annuity Insurance Company or our reinsurers may also release information in our files to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

FIRST GREAT-WEST LIFE & ANNUITY INSURANCE COMPANY INFORMATION PRACTICES

This notice is provided to give you a brief description of our information practices. If you would like a more detailed description, please write to us at the address shown below.

One of our important objectives is to see that our insurance coverages are priced in a way that is fair to all policyholders. To do this, we need personal information about you and your family members proposed for coverage under your policy. You are the prime source of that information, but we may also obtain information from other sources such as physicians, hospitals, the Medical Information Bureau and consumer reporting agencies. You may request to be interviewed in connection with the preparation of a consumer report and you are entitled to obtain a copy of the report on request.

The information about you which we obtain and keep in our files, will not be disclosed to others without your authorization except to the extent necessary to conduct our business. For example, some may be disclosed for research study purposes, but no report of such studies would include identification of individuals.

You have a right of access to information we maintain in our files about you (medical information is normally disclosed only to a physician of your choice) and to request correction of any information you believe to be incorrect. Should you wish further details about your right of access or our information practices, write to: First Great-West Life & Annuity Insurance Company, P.O. Box 2305, Buffalo, NY 14240-2305.

PLEASE MAINTAIN A COPY OF THIS PAGE FOR YOUR RECORDS.

Home Office: White Plains, NY