One Forethought Center
Batesville, IN 47006
Phone: 888-606-6372
Interview: 800-737-6972
Fax: 877-432-1646

FORE THOUGHT®

FAX

TO: Forethought Life Insurance Company

Agent:

Fax #: 1-877-432-1646

Date:

Phone: 1-888-606-6372

Agent Fax #:

Re: Forethought® Freedom℠ Application(s)

Total Pages:

FAX APPLICATION TRANSMITTAL FORM

Comments: Legibly print the name of the applicant, premium collected, agent's name, agent's writing number, agent's fax and phone number, and the number of pages being faxed including the fax application transmittal form. **Be sure to include the required HIPAA form along with the application.** Fax a maximum of 5 applications at one time including a copy of the premium check. If initial payment is not an Electronic Funds Transfer, mail the check to:

Forethought Life Insurance Company
P.O. BOX 148
BATESVILLE, IN 47006

AGENT'S NAME: _____

AGENT'S NUMBER: _____ AGENT'S PHONE NUMBER: _____

APPLICANT'S NAME	PREMIUM COLLECTED	DO NOT USE – PROCESSING CENTER ONLY	DO NOT USE – PROCESSING CENTER ONLY

FORE THOUGHT®

APPLICATION FOR LIFE INSURANCE
PART 1

Reference Number _____

Forethought Life Insurance Company One Forethought Center Batesville, IN 47006-0148

1. PROPOSED INSURED *(Please Print Using Black Ink)*

First Name	Middle Initial	Last Name		
☐ Male ☐ Female	Date of Birth (mm/dd/yyyy)	Age	State of Birth	Social Security Number - -
Are You a U.S. Citizen ☐ Yes ☐ No IF NO, PROVIDE PERMANENT RESIDENT CARD NUMBER OR VISA TYPE				
Mailing Address			Residential Address (if different than Mailing Address)	
City	State	Zip Code	Occupation	
Phone Number (home) ( )	Phone Number (work) ( )	E-mail Address		
Have you smoked cigarettes in the last 12 months? ☐ **Yes** ☐ **No**				

2. OWNER *(Complete only if the Owner and Proposed Insured are different.)*

First Name	Middle Initial	Last Name	
☐ Male ☐ Female	Relationship to Proposed Insured		Social Security Number - -
Are You a U.S. Citizen ☐ Yes ☐ No IF NO, PROVIDE PERMANENT RESIDENT CARD NUMBER OR VISA TYPE			
Mailing Address		Residential Address (if different than Mailing Address)	
City	State	Zip Code	
Phone Number (home) ( )	Phone Number (work) ( )	E-mail Address	

3. BENEFICIARY INFORMATION *(Beneficiary proceeds will be split equally if no percentages are provided.)*

Primary

First Name	Middle Initial	Last Name	
Age	Relationship to Proposed Insured	Social Security Number - -	Percentage

First Name	Middle Initial	Last Name	
Age	Relationship to Proposed Insured	Social Security Number - -	Percentage

Contingent

First Name	Middle Initial	Last Name	
Age	Relationship to Proposed Insured	Social Security Number - -	Percentage

First Name	Middle Initial	Last Name	
Age	Relationship to Proposed Insured	Social Security Number - -	Percentage

4. INSURANCE PLAN INFORMATION

Plan of Insurance:
- ☐ **Level Death Benefit**
- ☐ **Graded Death Benefit**
- ☐ **Return of Premium**

Billing Mode:
- ☐ **Annual**
- ☐ **Semi Annual**
- ☐ **Quarterly**
- ☐ **Monthly EFT**

Face Amount $ _____

Riders: ☐ _____ ☐ _____ ☐ _____

Initial Premium $ _____

- ☐ **Check with Application**
  Make check payable to Forethought Life Insurance Company
- ☐ **Draft First Premium**
  Draft EFT account for initial premium on _____

5. BANK DRAFT AUTHORIZATION – *Please attach a voided personal check*

Electronic Funds Transfer (EFT)
- ☐ **Checking**
- ☐ **Savings**

Custom Date _____ **(1st thru 28th of the month)**

Account # _____

ABA Routing/Transit # _____

_____ **( )** _____

Name of Financial Institution **Phone # of Financial Institution**

_____

Social Security Number of Account Holder

Automatic Payment Authorization – *Must be completed for EFT*

I authorize Forethought Life Insurance Company ("FLIC") to charge/deduct my insurance premium from my account. This authorization is to remain in effect until I revoke my automatic monthly premium payment by notifying FLIC.

_____

Payor's Signature – ***as it appears on the bank account*** Date

6. REPLACEMENT INFORMATION

1. **Does the proposed insured currently have any life insurance in force?** ☐ **Yes** ☐ **No**
2. **Will this insurance replace any life insurance in force?** ☐ **Yes** ☐ **No**
   If Yes, complete #3 and you will be given the Ohio Notice Regarding Replacement and a Replacement form to be completed on your current insurance.
3. **Company Name** **Face Amount** **Policy Number**

_____ _____ _____

_____ _____ _____

7. ELIGIBLE GRANDCHILDREN *(to be covered by Grandchildren's Benefit)*

Grandchild's Full Name	Date of Birth	Grandchild's Full Name	Date of Birth

8. STATE REQUIRED NOTICES

OH Residents

A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

9. AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I, the Proposed Insured, authorize Forethought Life Insurance Company to obtain protected health information including prescription history, for the purpose of determining my eligibility for insurance, from any licensed physician, medical practitioner, hospital, clinic, the Veteran's Administration, laboratory, other medical or medically related facility, any pharmacy, pharmacy benefit manager, the Medical Information Bureau, Inc. (MIB), insurance companies, consumer reporting agencies and authorize said persons, firms or entities to furnish such information to Forethought Life Insurance Company.

Health information will not be re-disclosed without my authorization, unless permitted by law, in which case it may not be protected under federal privacy rules.

A photographic copy of this authorization shall be as valid as the original. I have a right to receive a copy of this authorization upon request. This authorization shall be valid for two years from the date of my signature below, and may be revoked by sending written notice to Forethought Life Insurance Company at the address listed above.

10. AGREEMENT

I agree that no insurance shall be in effect until: (a) a policy has been issued, and (b) the first premium is paid while I am living and my insurability remains unchanged and then only if I am actually in the state of health represented in this application.

I state that the answers set forth in this application are full, complete and true to the best of my knowledge and belief. The answers are the basis of any insurance issued.

I acknowledge that I have received the Notice of Information Practices and the MIB disclosure notice.

I agree that a verbal confirmation may be requested for this application during a telephone interview, and that my verbal confirmation is as valid as my written signature.

All statements made by me or on behalf of me shall be deemed to be representations and not warranties.

Proposed Insured Signature	Date	Signed At (City, State)
Owner Signature (if other than Proposed Insured)	Date	Signed At (City, State)
Licensed Agent Signature	Date	Signed At (City, State)

11. AGENT DECLARATIONS AND SIGNATURES

Primary Agent Name (Print)			
Address	City	State	Zip Code
Phone Number (home) ( )	E-mail Address		
Business or Institution Name	Business or Institution Phone Number ( )		
License Number	Agent Number		

I declare that: (a) the application was signed and dated by the Proposed Insured and by the Owner, if not the Proposed Insured, after all answers and information were recorded herein; and (b) I have truly and accurately recorded on this form all of the information provided by the Proposed Insured and the Owner, if not the Proposed Insured.

1. Did you personally see the Proposed Insured? ☐ **Yes** ☐ **No**
   If yes, what type of photo ID was used to verify identity?
   ☐ **Drivers license** ☐ **Passport** ☐ **Other** _____
2. Will this policy replace or change any existing life insurance or annuities? If yes, complete the appropriate state Replacement form and submit it with the application. ☐ **Yes** ☐ **No**
3. Did you give the Proposed Insured a copy of the Information Practices and MIB Disclosure? ☐ **Yes** ☐ **No**

If the Owner is other than the Proposed Insured, what type of photo ID was used to verify the Owner's identity?

☐ **Drivers license** ☐ **Passport** ☐ **Other** _____

What is the best time and phone number to contact the Proposed Insured?

Time _____ Phone Number (_____)_____ Time Zone _____

Mail completed policy to: ☐ **Agent** ☐ **Policyowner**

Primary Agent Signature	Date	Signed At (City, State)
Print Name	Commission %	
Agent Signature	Date	Signed at (City, State)
Print Name	Commission %	Agent Number

FORETHOUGHT LIFE INSURANCE COMPANY HOME OFFICE USE ONLY

Application for Life Insurance

Forethought Life Insurance Company
One Forethought Center
P.O. Box 148
Batesville, IN 47006-0148

DISCLOSURES

TO BE GIVEN TO THE PROPOSED INSURED
DO NOT SEND TO HOME OFFICE

MEDICAL INFORMATION BUREAU ("MIB") NOTICE Information regarding your insurability will be treated as confidential. FLIC or its reinsurers may, however, make a brief report thereon to the 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 in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your 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. FLIC, or its reinsurers, may also release information in its file 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. Information for consumers about MIB may be obtained on its website at www.mib.com.

NOTICE OF INFORMATION PRACTICES This application is our major source of information about the Proposed Insured. As part of our routine underwriting procedure, we will occasionally obtain an investigative consumer report which will provide applicable personal information concerning character, general reputation, personal characteristics, and mode of living. This information may be obtained through other parties, including personal interviews with your friends, neighbors, and associates. In some circumstances, this information may be disclosed to third parties without your specific authorization, but only for certain limited purposes related to the conduct of our business with respect to this application. You have the right of access and correction with respect to all personal information collected, and a full notice of your rights will be furnished upon request.

ELECTRONIC FUNDS TRANSFER Effective March 31, 2002, the NACHA Operating Rules, the Electronic Funds Transfer Act, and Federal Reserve's Regulation E were modified to permit the conversion of a paper check to electronic data. By sending a check for payment on your policy, you will be authorizing the use of the information on your check to make a one-time electronic debit from the account on which the check is drawn. This electronic debit, which may post to your account as early as the date your check is received, will be only for the amount of your check. The transaction will appear in the electronic payment area of your checking account or credit union statement. Your paper check will not be returned. It will be imaged and the original destroyed as required by the above regulation. An image of the check will be available upon request.

Important Notice

Part 2 – Medical Questionnaire is now included in **all** application packets. Part 2 should **only be completed if your client does not agree to voice signature**. If your client agrees to a voice signature and you are submitting the application with your client, **you do not need to complete Part 2.**

FORE THOUGHT®

APPLICATION FOR LIFE INSURANCE
PART 2 MEDICAL QUESTIONNAIRE

Reference Number _____

Forethought Life Insurance Company One Forethought Center Batesville, IN 47006-0148

1. PROPOSED INSURED *(Please Print Using Black Ink)*

Name (First, Middle Initial, Last)		Date of birth (mm/dd/yyyy)
Mailing Address		
City	State	Social Security Number - -

2. HEALTH QUESTIONS

1. What is your current Height? _____ ft _____in: Weight? _____ lbs

2.	**Do you require assistance in performing the Activities of Daily Living (ADL's) of eating, bathing, toileting, transferring or dressing or are you confined to a wheelchair?**	☐ Yes ☐ No
3.	**Are you currently:**	
	a. Hospitalized or confined to a bed, nursing home, psychiatric facility, receiving home health care or hospice care or are you currently incarcerated?	☐ Yes ☐ No
	b. Receiving kidney dialysis, chemotherapy or radiation, or using oxygen equipment to assist in breathing (other than for sleep apnea)?	☐ Yes ☐ No
4.	**Have you:**	
	a. Been medically diagnosed as having a life expectancy of 12 months or less?	☐ Yes ☐ No
	b. Had a heart, lung, liver or kidney transplant or has one been recommended to you?	☐ Yes ☐ No
	c. Within the last 12 months, been advised to have any medical procedure, diagnostic test (excluding HIV and AIDS) or surgery that has not yet been done or for which the results have not been received?	☐ Yes ☐ No
	d. Been diagnosed or treated by a medical professional for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related complex (ARC)?	☐ Yes ☐ No
	e. Tested positive for Human Immunodeficiency Virus (HIV)?	☐ Yes ☐ No
5.	**Have you been medically diagnosed, treated for, advised to have treatment for, taken medication, or been prescribed medication for:**	
	a. Alzheimer's disease, dementia, chronic memory loss?	☐ Yes ☐ No
	b. Lou Gehrig's disease (ALS), kidney or liver failure, or end stage kidney disease?	☐ Yes ☐ No
	c. Congestive heart failure or cardiomyopathy within the last 24 months?	☐ Yes ☐ No
6.	**In the last 12 months have you been medically diagnosed, treated for, advised to have treatment for, taken medication or been prescribed medication for:**	
	a. Coronary artery disease, heart attack, angina, heart surgery (including bypass, angioplasty and stent placement) or heart valve replacement?	☐ Yes ☐ No
	b. Stroke or transient ischemic attack (TIA), carotid artery surgery or aneurysm?	☐ Yes ☐ No
7.	**In the last 24 months have you been medically diagnosed, treated for, advised to have treatment for, taken medication or been prescribed medication for:**	
	a. Any internal cancer, brain tumor, leukemia, melanoma, Hodgkin's disease or other lymphoma, cirrhosis of the liver or alcohol or drug dependency?	☐ Yes ☐ No
	b. Diabetes with complications including, eye or kidney disorders, diabetic coma, insulin shock or amputation due to disease?	☐ Yes ☐ No
8.	**Do you have diabetes in combination with a stroke, TIA, or heart disease (including heart attack and heart surgery); have you had multiple strokes, TIA's or heart attacks, or do you have heart disease with a history of a stroke or TIA?**	☐ Yes ☐ No

9.	**In the last 24 months have you been medically diagnosed, treated for, advised to have treatment for, taken medication or been prescribed medication for:**	
	a. Coronary artery disease, heart attack, angina, heart surgery (including bypass, angioplasty and stent placement) or heart valve replacement?	☐ **Yes** ☐ **No**
	b. Stroke or transient ischemic attack (TIA), carotid artery surgery, aneurysm or any irregular heartbeat, such as atrial fibrillation (including a pacemaker or defibrillator)?	☐ **Yes** ☐ **No**
	c. Depression, bipolar disorder, schizophrenia or other psychosis?	☐ **Yes** ☐ **No**
	d. Parkinson's disease, multiple sclerosis or chronic hepatitis?	☐ **Yes** ☐ **No**
	e. Emphysema, chronic obstructive pulmonary disease (COPD), asthma or chronic bronchitis?	☐ **Yes** ☐ **No**
10.	**Do you have diabetes that has required insulin treatment within the last 5 years?**	☐ **Yes** ☐ **No**
11.	**In the last 12 months, have you had a seizure or convulsion?**	☐ **Yes** ☐ **No**
12.	**Have you been hospitalized 2 or more times in the last 12 months for any reason?**	☐ **Yes** ☐ **No**

3. AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I, the Proposed Insured, authorize Forethought Life Insurance Company to obtain protected health information including prescription history, for the purpose of determining my eligibility for insurance, from any licensed physician, medical practitioner, hospital, clinic, the Veteran's Administration, laboratory, other medical or medically related facility, any pharmacy, pharmacy benefit manager, the Medical Information Bureau, Inc (MIB), insurance companies, consumer reporting agencies and authorize said persons, firms or entities to furnish such information to Forethought Life Insurance Company.

Health information will not be re-disclosed without my authorization, unless permitted by law, in which case it may not be protected under federal privacy rules.

A photographic copy of this authorization shall be as valid as the original. I have a right to receive a copy of this authorization upon request. This authorization shall be valid for two years from the date of my signature below, and may be revoked by sending written notice to Forethought Life Insurance Company at the address listed above.

4. AGREEMENT

I agree that no insurance shall be in effect until: (a) a policy has been issued, and (b) the first premium is paid while living and my insurability remains unchanged and then only if I am actually in the state of health represented in this application.

I state that the answers set forth in this application are full, complete and true to the best of my knowledge and belief. The answers are the basis of any insurance issued.

I acknowledge that I have received the Notice of Information Practices and the MIB disclosure notice.

I agree that a verbal confirmation may be requested for this application during a telephone interview, and that my verbal confirmation is as valid as my written signature.

All statements made by me or on behalf of me shall be deemed to be representations and not warranties.

A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Proposed Insured Signature

Date

Proposed Insured Printed Name

Examiner/Interviewer Signature

ACCELERATED DEATH BENEFIT DISCLOSURE

The policy you are considering contains an Accelerated Death Benefit. Before purchasing this policy, you need to be aware of some facts concerning this benefit.

There is no premium charge for this benefit.

After this policy is in force, You may elect to receive the Accelerated Death Benefit Amount immediately if the expected death is the result of an accident or after 30 days if the expected cause of death is illness.

If elected, We will pay You the Accelerated Death Benefit Amount shown in the Schedule of Benefits, Premiums and Fees on Page 3 of Your policy, less the Accelerated death Benefit Administration Fee shown on Page 3 of Your policy, and less any Loan Balance. Our current benefit amount is 97% of the Face Amount and currently there is no administration fee.

Payment of the Accelerated Death Benefit is subject to the following conditions:

1. You claim this benefit by Written Notice to us, including a statement from a Licensed Physician that the Insured has been diagnosed with a Terminal Condition;
2. The Terminal Condition is not the result of intentionally self inflicted injuries or attempted suicide, whether sane or insane; or
3. If the Policy is subject to an irrevocable Beneficiary designation or an assignment, except to Us as security for a policy loan, You must provide Us with written consent by any such Beneficiary or assignee to any payments under this benefit.

At Our option and cost, We may get a second Licensed Physician's opinion regarding the Insured's Terminal Condition. In our sole discretion, We will decide whether the Insured has a Terminal Condition.

We will pay no other benefits under this policy or any attached rider after We pay the Accelerated Death Benefit. The policy will be terminated and may not be reinstated.

You should consult a personal tax advisor if You are considering electing an Accelerated Death Benefit payment. Benefits will be reduced as described above upon receipt of an Accelerated Death Benefit payment. Receipt of Accelerated Death Benefit payments may be taxable or may affect your eligibility for benefits under state or federal laws.

This benefit is not intended to provide coverage primarily for long term care benefits or for confinement in a nursing home.

By signing below, you acknowledge that you have been provided a copy of this Disclosure.

_____ _____

Signature of Applicant Signature of Agent

Forethought Life Insurance Company
One Forethought Center
Batesville, Indiana 47006

Authorization to Release Confidential Medical Information

Records and information obtained will be disclosed to Forethought Life Insurance Company so that it can: 1) evaluate my application for insurance; 2) obtain reinsurance; 3) determine or fulfill responsibility for coverage and provision of benefits; 4) and administer coverage.

I, the undersigned, hereby authorize any and all medical practitioners, physicians, pharmacists, hospitals, clinics, nurses, records custodians, the MIB, Inc., the Veterans Administration, other insurance companies, or anyone else to release any and all records and information to be exchanged between Forethought Life Insurance Company and its agents, reinsurer(s), contractors, employees, representatives, and affiliates, and it assigns as necessary to fulfill the purpose of this disclosure.

I hereby authorize you to release any and all records and information within your possession, custody or control regarding me pursuant to this Authorization. Any and all records and information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition are to be released. Such records and information to be released may include, but not be limited to, testing, treatment, or advice for the following: alcohol abuse, drug abuse, psychiatric and psychological disorders, heart disease, mental disease, genetic disorders, pharmacy prescriptions, HIV or AIDS, sexually transmitted diseases, hepatitis, and Sickle Cell Anemia.

I understand that when information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the insurance company and may no longer be protected by the same rule that applied in the first instance. I understand Forethought Life Insurance Company may report information to MIB, Inc. or to other insurance companies to which I have or may apply. I understand this Authorization will remain in effect a maximum of two (2) years from my date of signature below. I understand I may revoke this Authorization in writing, at any time, by sending a written request for revocation to Forethought Life Insurance Company at the address listed above, unless action has already been taken in reliance upon it, or during a contestability period under applicable law. I understand a photocopy of this Authorization will be treated in the same manner as the original.

I understand that if I refuse to sign this Authorization to release complete medical records, Forethought Life Insurance Company may not be able to process my application. I understand that I or my authorized representative may request a copy of this Authorization.

Name of Proposed Insured (please print)	Name of Proposed Insured B (please print)
Signature of Proposed Insured	Signature of Proposed Insured B
Date	Date

RETURN TO COMPANY

FORETHOUGHT LIFE INSURANCE COMPANY
ONE FORETHOUGHT CENTER
BATESVILLE, INDIANA 47006
INSURANCE – 800/331-8853
ANNUITIES – 877/244-7526

IMPORTANT NOTICE

REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

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

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 interests. 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 this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or other wise terminating your existing policy or contract? ❑ Yes ❑ No

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

   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 or annuitant, 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 OR POLICY #	INSURED OR ANNUITANT	REPLACED (R) OR FINANCING (F)
1.			
2.			
3.			

Make sure you know the facts. Contact your existing company or its agent 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 agent in the sale presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because_____

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

Applicant's Signature	Printed Name	Date
Producer's Signature	Printed Name	Date

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

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 agent 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 agent 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?