PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY

DISCLOSURE NOTICE

By my signature affixed hereto, I verify that I have been provided an Outline of Coverage describing the Policy for which I have applied on this date. I verify that the agent representing Philadelphia American Life Insurance Company discussed, in detail, the coverage as explained in the Outline of Coverage. In addition, the agent explained and I understand the following provisions:

1. The coverage for which I have applied will become effective only when the application is approved by the Home Office and only on the Effective Date assigned by the Company.

2. If I am approved and my Certificate is issued, my coverage will begin immediately on the assigned Effective Date.

3. No benefits will be payable for any sickness or injury due to a Pre-Existing Condition. Pre-existing Condition means a condition for which medical treatment was rendered or recommended by a Physician or for which drugs or medicine was prescribed within 12 months prior to a Covered Person's Effective Date. A condition shall no longer be considered a Pre-Existing Condition after the date a person has been covered under this policy for 12 consecutive months.

4. I understand that a claim for benefits may not be payable under the new Policy due to the above-mentioned Pre-existing Condition waiting period; whereas, the same claim might have been payable under my present coverage, if any, had it remained in force.

5. I understand that until the coverage has been approved and issued, Philadelphia American Life Insurance Company has absolutely no liability to me other than to refund my initial premium if my Application is not approved. Any injury or sickness which may develop between now (today) and the date my coverage is effective will be a Pre-existing Condition, and depending on extent and severity, such injury or sickness may render me (or a dependent) ineligible for coverage.

6. I have read or have been read to me and answered the questions on my Application on behalf of myself and my dependents. I also understand that disclosure of health information is important and any omission may bar the right to recover under the Policy if such answer materially affects the acceptance of the risk or hazard assumed. My Policy, if issued, will contain a photocopy of this document along with the Application for Coverage.

DATE: ______________________ APPLICANT'S SIGNATURE: ____

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

According to information you have furnished, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by Philadelphia American Life Insurance Company. For your own information and protection, you should be aware of and seriously consider certain facts which may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.

3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on any application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force.

DATE: ______________________ APPLICANT'S SIGNATURE: ____________________________________

I have provided a copy of this Notice with the applicant or a copy will be mailed.

DATE: ______________________ AGENT'S SIGNATURE: ______________________________________