

**DISCLOSURE & COMPARISON OF PRODUCTS
CERTAINTYSELECT® ANNUITY - MINNESOTA**

EquiTrust Life Insurance Company®

7100 Westown Parkway, Suite 200
West Des Moines, Iowa 50266-2521
(866) 598-3692 Fax: (515) 226-5103

www.EquiTrust.com

Mailing Address: PO Box 14500
Des Moines, Iowa 50306-3500

This form must be submitted for each contract/policy being replaced (including partial and penalty-free transfers) in addition to any state-required replacement form(s). Do not leave any item unanswered. If any information requested is unavailable, not applicable or unknown, that must be indicated.

1. Owner Name _____ Joint Owner Name _____
2. Replaced Company Name _____ Replaced Product Name _____
3. Replaced Contract Number _____ Contract Effective Date (mm/dd/yyyy) _____
4. Estimated Dollar Amount of Surrender Loss \$ _____
5. Replacement Withdrawal Type Full Partial Partial Penalty Free Withdrawal

If the replaced product is an annuity, complete the information in the chart below. If the replaced product is life insurance, please begin with the Life Insurance section on the next page.

	Existing Annuity	Proposed Replacement Annuity
Generic Contract Type (Fixed, Index, Variable)		<input type="checkbox"/> Index <input checked="" type="checkbox"/> Fixed
Remaining Surrender Charge Schedule, by year		
Accumulation Value	\$	
Current Cash Surrender Value	\$	
Premium Bonus Percentage	%	0%
Penalty Free Withdrawal Percentage	%	Interest Only
Minimum Guaranteed Interest Rate	%	See Product Disclosure
Death Benefit	\$	Full Accumulation Value
CONTRACT FEATURES		
Contract Fees (Asset Fees, Rider Fees, etc.) Do NOT include IBR Fees		None
Market Value Adjustment	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Return of Premium	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Nursing Home Rider	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Terminal Illness Rider	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
INCOME BENEFIT RIDER INFORMATION		
	Rider Being Replaced	EquiTrust Rider Elected
Does the Contract have an Income Benefit Rider (IBR)?	<input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", complete remainder of chart. If "No", continue to Additional Information section	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Is the client taking payments from the IBR now?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Value of Benefit or Enhanced Withdrawal Base	\$	
Benefit Base Calculation (example: roll-up rate, bonus, etc.)		
IBR Rider Charge		
Provide explanation for loss of benefit base and/or income payments and how this meets current and future needs		

Life Insurance Replacement Section

	Existing Life Insurance Policy
Generic Policy Type (Whole life, UL, Indexed UL, VUL)	
Face Amount	\$
Cash Surrender Value	\$
Please list all Special Riders with this policy	

ADDITIONAL INFORMATION

1. Please explain why you have chosen to replace your existing life insurance or annuity contract. (Give specific reasons)

2. Is the agent assisting you with this transaction the agent on the contract that is being replaced? Yes No

3. **Excluding this replacement**, have you replaced any annuity contracts within the past 60 months? Yes No

If Yes, please provide the following information, if No, proceed to signature section

3a. Provide details about the other replacements within the past 60 months.

3b. Is the agent assisting you with this transaction the same agent who replaced those contracts? Yes No

SIGNATURES

OWNER(S): Do not sign this form if any item has been left unanswered. Please carefully review the information recorded and confirm that it is true and correct to the best of your knowledge.

Owner Signature _____

Date _____

Joint Owner Signature _____

Date _____

Agent/Producer Signature _____

Date _____

NOTICE TO MINNESOTA RESIDENTS AGE 65 AND OLDER

Note: For Minnesota residents age 65 and older, this form must be completed for each product being replaced, in addition to any state-required replacement forms. When explaining the substantial financial benefit, please provide *specific* reasons. Examples of specific reasons may include the addition of new riders or features; greater flexibility in premium payments or pay-out options; or the desire to move away from market risk inherent in an existing variable product.

Attach additional forms, if needed.

1. Name of company being replaced _____ Contract Number _____

2. Please explain the reason(s) this transaction will provide you with a substantial financial benefit, over the life of the contract, including full details: _____

Owner Printed Name _____

Owner Signature _____

Date _____

Joint Owner Printed Name _____

Joint Owner Signature _____

Date _____

Agent/Producer Printed Name _____

Agent/Producer Signature _____

Date _____