Banner Life® Insurance Company

NOTICE TO PROPOSED INSURED

(Please give to the Proposed Insured)

☐ 1701 Research Boulevard
Rockville, Maryland 20850-3191

☐ 100 Quentin Roosevelt Boulevard
Garden City, New York 11530-9641

Thank you for applying to Banner Life Insurance Company. We greatly appreciate your efforts to complete each part of the application truthfully and accurately. The soliciting insurance broker (broker) should be able to answer any questions you may have. This broker is an independent broker, not an employee of Banner Life Insurance Company, and is not authorized to make or modify contracts or to waive any requirements or any information that we may request.

Underwriting

Once we receive your application, we will begin an evaluation process called underwriting and determine whether you are eligible for insurance and, if so, the rate you should pay for that insurance. We may find that we are unable to give you the insurance you have applied for or that we are able to give it to you only on a modified basis or at a rate greater than our lowest rate. For example, if you have ever used any kind of tobacco or any other nicotine product, you may not be eligible for our lowest rate.

Your application will be our primary source of information; therefore, it must be true, complete, and accurate. You must inform us of a change to any answer in any part of your application before accepting delivery of a policy; in fact, you agree to do so when you sign your application. We may seek information from other sources to help us evaluate the information you give us on your application.

Contestability

We strongly urge you to review the completed application closely for accuracy. A claim may be denied or your coverage may be contested by a lawsuit if the application is incomplete or if it contains fraudulent statements or material misrepresentations. If the lawsuit is successful, the policy will be void and coverage will be lost. Any policy that is delivered to you will indicate when and under what circumstances it may be contested. Please be aware that if the application contains materially fraudulent or deceptive statements or conceals material facts, and you submitted it with the intent to defraud or to facilitate fraud against us, you may also be guilty of insurance fraud, which is a crime.

Replacement of Existing Coverage

If you intend to replace existing coverage, tell the broker of your intention and answer “yes” to the replacement question in the application; state law may require the broker to give you information that will help you compare the policy you are applying for with the policy you intend to replace. If you are undecided about keeping existing coverage, indicating an intention to replace existing coverage may help you get the information you need to make a decision. If you do replace existing coverage, the new policy may contain new suicide and contestable periods. The following would be considered replacement: you stop paying premiums on an existing policy or surrender an existing policy before or shortly after applying to us **or** you borrow from an existing policy to pay premiums for the insurance for which you are applying. State law may define replacement to include other situations. Ask the broker if you are unsure.

Insurance Information Practices

We will rely primarily on information provided by you. We may supplement that information with information from other sources such as medical professionals who have treated you. In some cases, we may ask a consumer reporting agency to collect information and submit an investigative consumer report to us as explained in this Notice under **Federal Fair Credit Reporting Act.** You may request to be interviewed in connection with the preparation of this report.

In certain limited situations, we are allowed by law to disclose necessary items of personal information to third parties without your specific authorization.

You have the right to be told about, and to see and copy if you wish, items of personal information about you that appear in our files, including information contained in investigative consumer reports. You also have the right to seek correction of information you believe to be inaccurate.

We will send you a more detailed explanation of our information practices if you send us a written request. You may send your request to the Director of Underwriting, Banner Life Insurance Company, 1701 Research Boulevard, Rockville, MD 20850-3191.

Federal Fair Credit Reporting Act

As part of our underwriting, we may ask that an investigative consumer report be prepared. An independent source known as a consumer reporting agency will prepare the report. The report will typically include information as to your character, general reputation, mode of living, and personal characteristics. The agency will conduct personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted in order to get this information. If you write to us within a reasonable time after you receive this Notice, we will tell you whether or not a report was requested. If a report was requested, we will tell you the name, address, and telephone number of the agency to whom the request was made. Upon request, the agency will furnish information as to the nature and scope of its investigation. If you would like to inspect and to receive a copy of the report, you may do so by contacting the agency directly.

MIB (Medical Information Bureau) Disclosure

We will treat the information regarding your insurability as confidential. We and our reinsurers may, however, make a brief report to the Medical Information Bureau, Inc. (MIB). MIB is a non-profit membership organization of life insurance companies. It operates an informational exchange bureau on behalf of its members. If you apply to another member company for life, health, or disability insurance, or a claim for benefits is submitted to such a company, MIB, upon request, will supply that company with any information it may have in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in that 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 Post Office Box 105, Essex Station, Boston, Massachusetts 02112. The phone number is (617) 426-3660.

We and our reinsurers may also release information in our files to other insurance companies to whom you may apply for life, health, or disability insurance or to whom a claim for benefits may be submitted.

Banner Life® Insurance Company

☐ 1701 Research Blvd.
Rockville, MD 20850-3191
(Corporate office)

☐ 100 Quentin Roosevelt Blvd.
Garden City, NY 11530-9641

PART I
(Please Print)

SECTION A PROPOSED INSURED

1. Full Name (Include maiden name in parentheses) ☐ M ☐ F	2. Date of Birth Mo. / Day / Yr.	3. State of Birth	4. Social Security Number

5. Home Address: Give No., Street, City, State, and Zip Code	How Long?

6. Previous Addresses within past 5 years	7. Driver's License No. and State of Issue

8. Phone Numbers Home ( ) Work ( )	9. Marital Status ☐ M S ☐ ☐ W D ☐	10. Occupation (Include duties.)

11. Employer's Name and Address and Nature of Business?	How Long Employed?

12. Proposed Insured Internet E-mail Address

SECTION B BENEFICIARY

13. Primary: (Full Name)	Address	Birthdate	SSN or TIN	Rel. to Prop. Ins.	% Share

14. Contingent: (Full Name)	Address	Birthdate	SSN or TIN	Rel. to Prop. Ins.	% Share

If percentage shares are not given, they will be equal.

SECTION C OWNER

(Complete only if the Owner is to be other than the Proposed Insured.)

15. Owner is ☐ Individual ☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Trust

16. Full Name (If trust, give full name of trust and date of trust agreement)	17. Date of Birth Mo. / Day / Yr.	18. SSN or Tax ID No.

19. Address: Give No., Street, City, State, and Zip Code

20. Relationship to Proposed Insured	21. Internet E-mail Address

SECTION D PAYOR

22. Amount remitted with Conditional Receipt (with same number as the Application - Part 1) $___________________________________

23. Frequency of Premium Payment: ☐ Single ☐ Annual ☐ Semi-annual ☐ Quarterly ☐ Pre-authorized Check (PAC)

24. If premium notices are to be sent to someone other than the Owner, give full name, address, and relationship to Owner below.
Name _______________________________________ Address ____
Relationship __________________________________ ____

SECTION E INSURANCE APPLIED FOR

25. Amount and Plan of Insurance: Amount $________________________________ Plan___________________________________

26. Death Benefit Option (if available with Plan): ☐ Increasing Death Benefit ☐ Level Death Benefit

27. If our underwriting indicates that we cannot give you the lowest rate for the Plan of Insurance, will you consider a higher rate? ☐ Yes ☐ No

Additional Benefits (if available)

28. ☐ Waiver of Premium ☐ Other (description and amount) ____

SECTION F OTHER INSURANCE

29. List all of the Proposed Insured's existing life and disability insurance. If None, state NONE.

Full Name of Company	Amount	ADB	Waiver	Issue Yr.	Name of Beneficiary
	$	$	☐ Yes No ☐		
	$	$	☐ Yes No ☐		
	$	$	☐ Yes No ☐		

	Yes	No
30. Will you, or are you likely to, replace, end, or change existing insurance or annuity in any company or society with the insurance for which you are applying? (If "Yes", the broker may be required to provide additional forms for your review and signature.)	☐	☐
31. Have you ever applied for life, health, or disability insurance and been turned down, asked to pay a higher premium, or issued a reduced face amount? (If "Yes", explain in the Remarks section.)	☐	☐
32. Do you have an application or informal inquiry for life, health, or disability insurance pending in any other company or society, or have you ever withdrawn such application or informal inquiry? ("If "Yes", explain in the Remarks section.)	☐	☐

SECTION G TOBACCO USE

33. Has the proposed insured **ever** used any form of tobacco or nicotine-based products? ☐ Yes ☐ No
If "Yes", when did the proposed insured last use tobacco or nicotine-based products? ________________________
(month/year)

Type ____ Quantity ____

SECTION H GENERAL QUESTIONS

(Explain all "Yes" answers in the Remarks section.)

	Yes	No
34. Have you ever requested or received a Worker's Compensation, Social Security, or disability income payment?	☐	☐
35. Have you ever been convicted of a misdemeanor (other than a minor traffic violation) or a felony?	☐	☐
36. In the past 5 years, have you had your license suspended or had 2 or more moving violations or accidents?	☐	☐
37. In the past 5 years, have you been convicted of, or plead guilty or no contest to, driving under the influence of alcohol or drugs?	☐	☐
38. Are you a member, or do you intend to become a member, of the armed forces, including the reserves?	☐	☐
39. Are you a citizen of the United States? If "NO", provide country, type of visa, and expiration date in the remarks section.	☐	☐

SECTION I OTHER ACTIVITIES

	Yes	No
40. Have you in the past 5 years flown, or do you intend to fly, other than as a passenger? (If "Yes", complete Aviation Supplement.)	☐	☐
41. Have you in the past 2 years engaged in, or do you intend to engage in, any hazardous activities or sports such as hang gliding, hot-air ballooning, ultra-light flying, mountain or rock climbing, motor vehicle or boat racing, or scuba or sky diving? (If "Yes", complete Hazardous Activities Supplement.)	☐	☐
42. Have you in the past 5 years traveled or resided, or do you intend to travel or reside, outside of the continental United States for more than 4 consecutive weeks? (If "Yes", explain in the Remarks section.)	☐	☐

REMARKS

43. (Use this section for explanations and special requests. Identify applicable Question numbers.)

44. Home Office Corrections (Not for use for policies issued in MD, KY, PA and WV.)

AUTHORIZATION TO COLLECT AND DISCLOSE INFORMATION

Source Each of the following may be a source of information: care provider; treatment facility; insurer; reinsurer; MIB; consumer reporting agency; financial source; and employer. **Care provider** includes: physicians; chiropractors; physical therapists; psychologists; and drug, alcohol, or mental health counselors. **Treatment facility** includes: hospitals; clinics; drug or alcohol treatment or consultation facilities; nursing homes; mental health facilities; ambulatory care centers; and those facilities or offices staffed or run by care providers.

Information Information means facts about my: mental or physical health; other insurance coverage; hazardous activities; character; general reputation; mode of living; finances; vocation; and other personal traits.

I understand that the following parties may need to collect information in regard to proposed coverage: Banner Life Insurance Company (the Company) and its reinsurers; the Medical Information Bureau, Inc. (MIB); a consumer reporting agency; and all persons authorized to represent these parties. I therefore authorize each source to give information when this Authorization to Collect and Disclose Information (Authorization) is presented. A copy of this Authorization will be as valid as the original. The Company will use the information to decide if I am insurable. The broker may use it to help update and improve my insurance program. Those parties that may need to collect information may disclose the information they collect to: other insurers to which I have applied or may apply; reinsurers; MIB; or those persons who perform business, professional, or insurance tasks for them. They may disclose the information as allowed by law. MIB and consumer reporting agencies may disclose the information only as set forth in a contract with a member company or organization.

This Authorization will be valid for two years after the date I sign the Application - Part I. I understand that I or my authorized representative may ask to receive a copy of this Authorization. I have received the Notice to Proposed Insured.

These statements are made by the Proposed Insured or the person authorized to act on behalf of the Proposed Insured. If an investigative consumer report is prepared, I elect to be interviewed: ☐ yes ☐ no.

IN CONNECTION WITH THIS APPLICATION FOR INSURANCE, IT IS UNDERSTOOD AND AGREED THAT:

The statements contained here and in Part II of this application and any supplements thereto, copies of which shall be attached to and made a part of any policy to be issued, are true to the best of my (our) knowledge and belief and are made to induce the Company to issue an insurance policy. I agree to notify the Company of any changes to the statements and answers given in any part of the application before accepting delivery of any policy.

No agent or other person has power to make, modify, or discharge any contract of insurance or to bind the Company by making promises respecting benefits upon any policy to be issued. No information as to any matter made a subject of inquiry here and in Part II of this application and any supplements thereto, copies of which shall be attached to and made part of any policy to be issued, shall be considered known by the Company unless set out in writing on this application. No broker is authorized to: (a) make or modify contracts; (b) waive any Company rights or requirements; or (c) waive any information the Company requests.

Except as may be provided in a duly issued Conditional Receipt, no insurance shall take effect unless and until the policy has been physically delivered and the first full premium paid during the lifetime of the insured(s) and then only if the person(s) to be insured is (are) actually in the state of health and insurability represented in Parts I and II of this application and any supplements thereto, copies of which shall be attached to and made part of any policy to be issued.

Changes or corrections made by the Company and noted in Part I, Question 44 above are ratified by the Owner upon acceptance of a contract containing this application with the noted changes or corrections. In those states where written consent is required by statute or State Insurance Department regulation for amendments as to plan, amount, classification, age at issue, or benefits, such changes will be made only with the Owner's written consent.

DECLARATION

I (We) have carefully read the receipt and understand and agree to the terms thereof including the conditions under which a limited amount of insurance may become effective prior to policy delivery. I (We) understand that all premium checks are to be made payable to **Banner Life Insurance Company;** checks are not to be made payable to the agent or the payee left blank. I (We) have received the MIB Disclosure and Fair Credit Reporting Act.

______________________________ Signed at ______________________ on _____/_____/_____
Signature of Proposed Insured — City/State

______________________________ Signed at ______________________ on _____/_____/_____
Owner (if other than Proposed Insured) — City/State

By ______________________________
Signature and Title (if applicable)

______________________________ Signed at ______________________ on _____/_____/_____
Signature of Broker — City/State

PERSONAL INFORMATION STATEMENT

COMPLETE ON **ALL** BUSINESS CASES AND **IF REQUIRED** ON NON-BUSINESS CASES
(REFER TO CURRENT UNDERWRITING REQUIREMENTS CHART)

1. a. Personal Finances for each person proposed for insurance:

Name of Proposed Insured	Total Assets	Total Liabilities	Net Worth	Earned Income	Unearned Income

   b. Has any person proposed for insurance ever filed for bankruptcy? ☐ Yes ☐ No
   If "Yes," provide details below.

2. What is the purpose of this insurance? (i.e., Keyman, Stock Redemption, Buy and Sell, Creditor, Estate Liquidity, Other): ____________________

3. How was the face amount determined? ____________________

4. Business Finances (Complete **only** if this is business insurance):

   a. Total Assets $__________ b. Total Liabilities $__________ c. Net Worth $__________

   d. Net Profit After Taxes for Past Two Years: Last Year $__________ Previous Year $__________

   e. Is the business a Corporation, Partnership, or Proprietorship? (circle one)

   f. How long has the business been established? ____________________

   g. What is the nature of the business? ____________________

   h. What is the percentage ownership of this firm? ____________________

   i. Is there business insurance applied for or in force on other key members of this firm? ☐ Yes ☐ No
   If "Yes," provide details below.

   j. Has the proposed insured's company ever filed for bankruptcy? ☐ Yes ☐ No
   If "Yes," provide details below.

5. Are there any special considerations of circumstances relevant to this case? ____________________

6. Details: ____________________

The statements contained in this PERSONAL INFORMATION STATEMENT, a copy of which shall be attached to and made part of any policy to be issued, are true to the best of my knowledge and belief and are made to induce the company to issue an insurance policy.

Signature of Witness	Signature of Proposed Insured
Date	Signature of Other Proposed Insured
Signature of Other Proposed Insured	Signature of Other Proposed Insured

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To be completed for any Proposed Insured who is being considered without a medical examination.

1. Complete for all persons proposed for insurance:

Name of Proposed Insured	Date of Birth (Mo-Day-Yr)	Height	Weight	Change in weight in past 12 months Loss (lbs.) Gain (lbs.) Reason

2. Does any proposed insured have a personal physician? (If Yes, complete the following.) ☐ Yes ☐ No

Name of Proposed Insured	Name, Address and Phone Number of Personal Physician	Date Last Visited, Reason, Results

Give full details if any answer to Questions 3 through 11 is "Yes". Include the name of the proposed insured, dates, nature of illness or injury, number of attacks, duration, severity, treatment, results, names, addresses and telephone number of doctors, hospitals or clinics involved.

	Yes	No	Details
3. Does any person proposed for insurance have any physical defect?	☐	☐	
4. Has any person proposed for insurance:			
a. used barbiturates, heroin, cocaine (including crack), marijuana, LSD, PCP, amphetamines, any derivative of these drugs or any other illegal, restricted or controlled substance except as prescribed by a physician? If Yes, list all substances, when used and how often.	☐	☐	
b. been advised to seek, or received treatment for drug use, or been arrested for drug use or distribution?	☐	☐	
5. Has any person proposed for insurance:			
a. ever used alcoholic beverages? If Yes, how often and how many ounces?	☐	☐	
b. been advised to limit or cease the use of alcoholic beverages?	☐	☐	
c. been counseled, sought help or treatment, or been advised to undergo counseling or treatment for alcohol problems?	☐	☐	
d. attended or joined any organization for alcohol or related problems?	☐	☐	
6. Has any person proposed for insurance ever had:			
a. convulsions, paralysis, neuritis, nervous breakdown, dizziness, fainting spells, loss of consciousness, migraine or chronic headaches, nervous or mental disorders?	☐	☐	
b. high blood pressure, chest pain, palpitation, angina, heart murmur, heart attack, stroke, or other disorder of heart or blood vessels?	☐	☐	
c. asthma, tuberculosis, emphysema, bronchitis, sleep apnea or other disorder of the respiratory system?	☐	☐	
d. shortness of breath, chronic hoarseness or cough, blood spitting?	☐	☐	
e. chronic indigestion, ulcer, hernia, colitis, intestinal bleeding, disorder of stomach, gallbladder, liver, digestive or abdominal organs?	☐	☐	

Continuation of Part II Non-Medical Declarations	Yes	No	Details
6. f. kidney stone, diabetes, sugar, albumin, pus, or blood in urine, disorder of kidneys, bladder, genito-urinary organs?	☐	☐	
g. rheumatic fever, arthritis, gout, disorder of muscles, bones, joints or spine, loss of extremity or deformity?	☐	☐	
h. impairment of vision or hearing or disease of eyes, ears, nose or throat?	☐	☐	
i. tumor, cancer, venereal disease, disorder of blood, skin, thyroid or other glands?	☐	☐	
j disorder of the breasts, prostate, or reproductive organs?	☐	☐	
k. an immune deficiency disorder, AIDS, or positive test results indicating the presence of the AIDS virus?	☐	☐	
l. any other illness, disease, or injury?	☐	☐	
7. Within the past 10 years, has any proposed insured: a. had treatment or observation or been advised to have treatment or observation in any hospital or institution?	☐	☐	
b. had x-rays, electrocardiograms, blood studies or other diagnostic tests other than an HIV test?	☐	☐	
c. treatment or consultations with any physicians or practitioners, other than as stated above? Give details.	☐	☐	
8. Within the past 5 years, has any proposed insured: a. been advised to have or contemplate having a surgical operation?	☐	☐	
b. taken or been advised to take any prescription or non-prescription medication on a daily, weekly, or monthly basis?	☐	☐	
9. Is any person proposed for insurance now pregnant? If so, what is the expected date of delivery?	☐	☐	
10. Is any proposed insured now being treated by or consulting with a physician, psychiatrist or other licensed medical practitioner?	☐	☐	
11. Has any proposed insured's immediate family member (parent, brother, or sister) had heart disease, diabetes, cancer, polycystic kidney disease or other familial disease? If Yes, please identify the proposed insured, relationship of family member, disease or illness, whether living or deceased, and current age or age at death.	☐	☐	

I have carefully read all the above questions; the statements and answers are true to the best of my knowledge and belief.

______________________________ Signed at ______________________ on _____/_____/_____
Signature of Proposed Insured, or parent or legal guardian if Proposed Insured is a minor. — City/State

______________________________ Signed at ______________________ on _____/_____/_____
Signature of Other Proposed Insured — City/State

______________________________ Signed at ______________________ on _____/_____/_____
Signature of Broker — City/State

Banner Life® Insurance Company

1701 Research Boulevard
Rockville, Maryland 20850-3191
(301) 279-4800

CONDITIONAL RECEIPT

NOTICE TO PROPOSED INSURED AND OWNER. No coverage will become effective prior to delivery of the policy applied for unless and until all the conditions of this receipt are met. No agent or broker has the authority to alter the terms or conditions of this receipt. This receipt shall be void if altered or modified.

No payment may be accepted with the application if, within the last 24 months, any person proposed for coverage has been treated for or diagnosed by a member of the medical profession as having: AIDS or any other immunological disorder; heart trouble; stroke; cancer; alcoholism; drug dependency; insulin dependent diabetes; or any blood pressure condition requiring medication.

CONDITIONS WHICH MUST BE MET BEFORE INSURANCE MAY BECOME EFFECTIVE PRIOR TO DELIVERY OF THE POLICY:

1. An amount equal to the modal premium indicated on the application must be submitted; the mode must be either annual, semi-annual, quarterly or pre-authorized check plan (two months' premium required); and
2. All medical examinations, test, x-rays and electrocardiograms initially required by the Company's published rules with regard to age and amount requested must be completed within ninety (90) days from the date of this receipt; and
3. The proposed insureds are, on the Effective Date indicated below, risks acceptable for insurance exactly as applied for on a standard premium basis according to the Company's rules and practices, without modification of plan, premium rate or amount; and
4. On the Effective Date the state of health and all factors affecting the insurability of each person proposed for coverage must be as stated in applications required by the Company, and;
5. Any check or money order given in payment is honored when first presented.

EFFECTIVE DATE. If all the conditions above are met, then insurance, subject to all the terms and conditions of the policy applied for and as if the policy applied for had already been issued and delivered, will become effective on the latest of: (a) the date of application; (b) the date of application - part II; (c) the date of completion of all underwriting requirements stated in (2) above; or (d) the special policy date requested in the application, if any.

MAXIMUM AMOUNT. The total amount of life insurance available under this receipt shall be the amount shown in Part 1, Question 25 of the application. This amount, together with any insurance now applied for or pending issue with the Company, including Accidental Death Benefits, shall not exceed $250,000 to issue age seventy (70).

There is no coverage beyond age seventy (70); there is no coverage for any Last Survivor product applied for.

RETURN OF MONEY. If any of the above conditions is not met, the liability of the Company will be limited to the return of the amount remitted with this receipt. All returns will be made without interest to or for the benefit of the owner.

AGREEMENT. I agree that: (1) the limited amount of insurance that may begin prior to policy delivery will not exceed the Maximum Amount as defined above; (2) this limited amount of insurance will not begin unless all of the CONDITIONS listed above are first met exactly; (3) this receipt will be void if the application or this receipt contains any material misrepresentation or the Proposed Insured dies by suicide; and (4) this receipt will be of no legal effect on and after the earliest of the following: (a) the date the entire amount remitted with this receipt is returned, or (b) the date a policy is delivered to the Owner; and I further agree to any remaining terms, limits, and conditions of the Conditional Receipt and the Agreement in the Application.

______________________________	____/____/____	______________________________
Signature of Proposed Insured	Date of this Receipt	Signature of Owner (if other than Proposed Insured)

BROKER STATEMENT.

Amount Remitted: $_________________________ Person from whom Received: ___________________________________

On the Date of this Receipt, I received the amount indicated above in exchange for this receipt. This receipt bears the same date as the Application - Part 1. I have accurately represented the terms and conditions of this receipt to the Proposed Insured and Owner. I know of no reason why any person to be covered may not be eligible for insurance.

____
Signature of Broker

AGENT'S REPORT

1. Name of proposed insured? ____________________
2. How long have you known proposed insured? ____________ How well? ____________
3. Who first suggested the purchase of this insurance? ☐ Agent ☐ Owner/Applicant ☐ Proposed Insured ☐ Other ________
4. Insured is: ☐ Single ☐ Married ☐ Divorced ☐ Widowed 5. Purpose of Insurance: ____________

		YES	NO
6.	a. Did you personally see the proposed insured?	☐	☐
	b. Was the application signed by the proposed insured after all questions were answered? If either **a** or **b** are answered "No", explain in Number 10.	☐	☐
7.	Are you aware of anything about the health, habits, hobbies, or other factors which might effect the insurability of the proposed insured? If answered "Yes", explain in Number 10.	☐	☐
8.	a. To the best of your knowledge, does the policy applied for involve the replacement of existing life insurance or annuities?	☐	☐
	b. If "Yes", has the proposed insured replaced other life insurance policies in past 5 years?	☐	☐
9.	Is a single case agreement to be submitted for this application?	☐	☐

10. Explanation and Details ____________________

STATEMENTS BY AGENT

I certify that:

- I asked and carefully explained each question to the proposed insured and owner/applicant before recording each answer prior to the application being signed;
- The answers given in this application and Agent's Report are complete and accurate to the best of my knowledge and belief;
- The proposed insured and applicant know that any fraudulent statement or material misrepresentation in the application may result in loss of coverage under the policy;
- I have no personal knowledge of any other factors which may have an effect on the proposed insured's insurability;
- I have given the Notice to Proposed Insured attached to this application to the proposed insured;
- If the insurance applied for will or may replace any existing life insurance policy or annuity contract, I have completed any and all proper state required replacement form(s);
- I have explained to the proposed insured that if money is submitted with this application, conditions of the Conditional Receipt must be met.
- If I become aware of a change in the health or habits of the proposed insured occurring after the date of the application but before the policy is delivered, I promise to inform the Company of the change and agree to withhold delivery of the policy until instructed by the company to do so.

X ____________________ ____________________
Signature of Agent Date

Print name ____________________ Agent # ____________ S.S.# ____________

Address ____________________ Share of commission ____________________

Phone No. ( ) ____________________ Internet e-mail address ____________________

X ____________________ ____________________
Signature of Agent Date

Print additional Agent name ____________________ Agent # ____________ S.S.# ____________

Address ____________________ Share of commission ____________________

Internet e-mail address ____________________

GENERAL AGENT INFORMATION

GA name ____________________ GA #____________ Case manager ____________

Address ____________________ ____________________

Phone No. ( ) ____________ Fax No. ( ) ____________ Internet E-mail address:

AUTHORIZATION TO DRAW CHECKS IN PAYMENT OF LIFE INSURANCE PREMIUMS
(Please type or print all items except signatures.)

ATTACH SAMPLE PERSONAL CHECK

AUTHORIZATION is hereby provided to Banner Life Insurance Company to draw a check each month upon my account at the:

____
Full Name of Bank

____
(Street Address (Not P.O. Box)) (City) (State) (Zip)

for the purpose of paying premiums for insurance on the following named persons:

Name of Insured(s) (Please Print)	Policy Number or Date of Application for insurance if policy has not been issued

(Please DO NOT use felt tip pen for signatures.)

This authorization is revocable only upon receipt by Banner Life Insurance Company of a written revocation signed by me. I hereby agree that the mailing of checks to the designated bank shall constitute due notice of premiums being due upon the policy.

Signed at ______________________ this __________ day of __________ 20______
(city / state) (day) (month) (year)

X ______________________ X ______________________
Bank signature of Premium Payor(s) - Give Both signatures if Joint Account

AUTHORIZATION TO HONOR CHECKS

To ____ Bank

Bank Address ____
(Street Address (Not P.O. Box)) (City) (State) (Zip)

As a convenience to me, I hereby request and authorize you to pay and charge to my account checks drawn on my account by and payable to the order of Banner Life Insurance Company of Rockville, MD, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such check.

I further agree that if any such check be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

Banner Life Insurance Company is instructed to forward this authorization to you. (Please DO NOT use felt tip pen for signatures.)

X ______________________ X ______________________
Bank signature of Premium Payor(s) - Give Both signatures if Joint Account

______________________ ______________________
Date Depositor's Bank Account No.

To: The Bank named above:

So that you may comply with your depositor's request, Banner Life Insurance Company agrees:

(1) To indemnify you and hold you harmless from any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any check, draft or order, whether or not genuine, purporting to be executed or issued by or on behalf of the undersigned, and received by you in the regular course of business for the purpose of payment, including any costs or expenses reasonably incurred in connection therewith.

(2) To indemnify you for any loss in the event that any such check, draft or order shall be dishonored whether with or without cause, and whether intentionally or inadvertently, even though such dishonor results in a forfeiture of the insurance.

(3) To defend at our own cost and expense any action which might be brought by any depositor or any other persons because of your actions taken pursuant to the foregoing requests, or in any manner arising by reason of your participation in the foregoing plan of premium collection.

Gene Gilbertson
Senior Vice President and Chief Financial Officer

Authorized in a resolution adopted by the Board of Directors at Banner Life Insurance Company on December 3, 1986.

1701 Research Boulevard
Rockville, Maryland 20850
(301) 279-4800

Privacy Policy

Our corporate policy.

Your privacy is important to us. At Banner Life Insurance Company, we understand that the information you provide to us or we collect about you is private.

This privacy policy is provided to you so that you will understand what Banner Life does with the personal information you provide to us and the measures we take to protect your privacy.

Who has access to customer information?

The information that you provide to us is used for Banner Life purposes only. Banner Life employees and independent agents have access to your information, and are authorized to review it, only for the purposes of carrying out their official duties and responsibilities. Banner Life employees and independent agents are required to keep customer information confidential.

Why does Banner Life collect and maintain information?

As a regulated insurance carrier, Banner Life is required by state laws and regulations to collect and maintain certain information about its customers. The information we collect also enables us to provide you with services and products that meet your individual needs and to provide you with the high level of customer care that you have come to expect from Banner Life.

What type of information does Banner Life collect and maintain?

Banner Life collects and maintains various types of information about its customers. The types of information we collect and maintain about you may include:

- Information that you submit to us, such as your name, address, telephone number, and Social Security Number.
- Information about your transactions with Banner Life, such as payment history and account balance.
- Information from non-affiliated third parties about your medical, employment and income history; your assets and liabilities; and your driving record.
- Information from consumer reporting agencies about your credit history.
- Information about you that may be derived from your visits to Banner Life’s website.

Does Banner Life disclose customer information to, or share customer information with, outsiders?

Banner Life does not disclose any non-public personal financial or any non-public personal medical information about our customers or former customers to anyone, except as permitted or required by law.

It is Banner Life's current policy not to disclose customer information to, or share customer information with, other businesses for marketing purposes.

If this policy should change, Banner Life will notify you by mail, and you will be given an opportunity to request that your information not be disclosed to, or shared with, other businesses for marketing purposes.

How can I contact Banner Life if I have privacy questions?

If you have any questions about the privacy of your information, you can contact the Customer Service Department by:

Mail: Customer Service Department
Banner Life Insurance Department
1701 Research Boulevard
Rockville, MD 20850

or

E-mail: Banner_customerservice@lgamerica.com

or

Phone: 1-800-638-8428

LU 1236

Banner Life Insurance Company
1701 Research Boulevard
Rockville, Maryland 20850

ACKNOWLEDGMENT OF LIFE INSURANCE POLICY SALES ILLUSTRATION

Applicant Statement:

I acknowledge that no life insurance sales illustration has been given to me for the policy for which I have currently applied. Furthermore, I understand that I will receive an illustration, which conforms to any policy that may be issued, at the time of such policy delivery.

______________________________	______________________________
Signature of the Applicant/Owner	Date
Print Name of Applicant/Owner	Print Name of Proposed Insured, if different than Applicant/Owner

Agent Statement:

I certify that:

☐ A life insurance sales illustration, which conforms to the life insurance policy applied for, has **not** been used in the presentation and explanation of this policy.

☐ A sales illustration was displayed on a **computer screen** in the presentation and explanation of this policy based on the criteria below. A printed copy of this illustration will be delivered to the applicant no later than the time the application is submitted for underwriting.

Plan:______________________ Riders:___________ Initial Death Benefit:$_______________

Age:____________ Underwriting or Rating Class:___________________

Number of Years Illustrated:______ Premium Amount:$___________ (Annual/Semi-Ann/Qtrly/PAC)

(For Universal Life):

Guaranteed Interest Rate:__________% Non-Guaranteed Interest Rate:__________%

Assumed Number of Years of Premium Payments:__________

______________________________	______________________________
Signature of the Agent	Date
Print Name of Agent	Print Name of General Agent

Copy to Applicant/Owner   Copy to Home Office   Copy for Agent

LO-196 (2/98)

NOTICE AND CONSENT FOR AIDS-RELATED BLOOD TESTING

1701 Research Boulevard
Rockville, Maryland 20850
(301) 279-4800

Acquired Immunodeficiency Syndrome (AIDS) is a life-threatening disorder of the immune system, caused by a virus, HIV. The virus is transmitted by sexual contact with an infected person, from an infected mother to her newborn infant, or by exposure to infected blood (as in needles shared during intravenous drug use). Persons at high risk of contracting AIDS include males who have had sexual contact with another man, intravenous drug users, hemophiliacs and sexual contacts with any of these persons. Symptoms of HIV infection may include but not be limited to fever, sweats, lethargy, headache, aching of the muscles and joints, diarrhea, sore throat, lymph node enlargement, unintentional weight loss, and a skin rash.

To evaluate your insurability, the Insurer named above has requested that you provide a sample of your blood for testing and analysis to determine the presence of human immunodeficiency virus (HIV) antibodies and other tests which may include tests for cholesterol and related blood lipids, diabetes, liver or kidney disorders, or immune disorders. By signing and dating this form you agree that these tests may be done and that underwriting decisions will be based on the test results. Regarding the HIV test, a series of three tests will be performed by a licensed laboratory through a medically accepted procedure. An initial ELISA blood test will be done. If that is positive it will be repeated. If the second is positive a Western Blot test will be done.

Many public health organizations have recommended that before taking an AIDS-related blood test a person seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, prior to being tested. A list of counseling resources is attached.

The test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus. A positive test result does not mean that you have AIDS but that you are at a significantly increased risk of developing problems with your immune system and that you can transmit the virus to someone else. The test for HIV antibodies is very sensitive. Errors are rare, but they do occur. Your private physician, a public health clinic, or an AIDS information organization in your city might provide you with further information on the medical implications of a positive test.

Positive HIV antibody test results will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

All tests results will be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed as required by law or may be disclosed to employees of the insurer who have responsibility to make underwriting decisions on behalf of the insurer or to outside legal counsel who needs such information to effectively represent the insurer in regard to your application. The results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover results of tests for other diseases or conditions not related to AIDS, or for preparation of statistical reports that do not disclose the identity of any particular person.

If your test results are negative, no routine notification will be sent to you. If your test results are reported by the laboratory to the insurer as being positive, you are entitled to that information if you so desire. Because a trained person should deliver that information so that you can understand clearly what the test result means, you are asked to list your private physician so that the insurer can have him or her tell you the test result and explain its meaning.

Name of physician for reporting a possible positive test result:____

Address____

If you do not wish to know the results of the tests, initial here:________. In the event the test is positive and you are denied coverage because of that fact and you request the reason for the denial the insurer may require you to name a physician at that time in order to receive the information.

If you want to know the results of the test but do not at present have a private physician, initial here:________. The result will be sent to you at the address provided by registered mail with delivery restricted to you only. If you desire the results to be mailed to some person other than yourself who is not a physician, print that person's name and address here:____
____. The result will be sent to that person by registered mail with restricted delivery.

Consent

I have read and I understand this Notice and Consent for AIDS-Related Blood Testing. I voluntarily consent to the withdrawal of blood from me by needle from a vein or from a finger, the testing of that blood, and the disclosure of that test result as described above. I have read the information on this form about what a test result means and understand that I should contact a local AIDS service group or my private physician for further information and counseling if that test result is positive.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original. In the event the applicant is a minor, this authorization must be approved by a parent/guardian of the applicant in the space provided.

____
Signature of Proposed Insured   Social Security No.   Date

____
Witness   Date

APPROVED (if minor, 17 and under):   Parent - Guardian (circle one)

____
Signature of Parent or Guardian   Date

____
Address

HIV TEST COUNSELING RESOURCES LIST

Public health authorities urge that everyone become educated about how to protect themselves from HIV infection. If you have questions or concerns, your own physician or health care provider is your best source of information. Other counseling services may also be available to you.

As required by California law, the following list of counseling resources is being provided to you. It was compiled from publicly available information, which is subject to change without notice to the Insurer named on the reverse. Therefore, the Insurer makes no representations or warranties that this information is accurate as of the date you receive this list. Also, the Insurer makes no representations or warranties about the quality or nature of any services these resources may provide.

This is not a complete list of all resources that may be available to you. If you need further information, we suggest you contact your own physician or health care provider, your county health department, or your local chapter of the American Red Cross.

AIDS HOTLINE
U.S. Public Health Service
(800) 342-AIDS

SPANISH AIDS HOTLINE
(800) 222-AIDS

AIDS HOTLINE - SOUTHERN CALIFORNIA
(800) 922-AIDS

SAN FRANCISCO AIDS FOUNDATION
(415) 864-5855
San Francisco

CALIFORNIA DEPT. OF HEALTH SERVICES
Statewide Services - Office of AIDS
(916) 323-7415
Sacramento

AIDS HEALTH EDUCATION AND INFORMATION PROJECT
(213) 427-7421
Long Beach

SAN DIEGO AIDS PROJECT
(619) 543-0300
San Diego

NATIONAL AIDS RESEARCH AND EDUCATION
(415) 626-8784
San Francisco

INLAND EMPIRE AIDS COORDINATION AND EDUCATION PROJECT
(714) 825-7510
Riverside

AIDS PROJECT, HEMOPHILIA COUNCIL
(714) 834-2604
Santa Ana

CENTRAL VALLEY AIDS TEAM
(209) 264-AIDS
Fresno

SACRAMENTO AIDS FOUNDATION
(916) 448-2437
Sacramento

SAN JOAQUIN AIDS FOUNDATION
(209) 476-8533
Stockton

AIDS EDUCATION PROGRAM
(916) 225-6173
Redding

LOS ANGELES COUNTY AIDS EDUCATION PROGRAM
(213) 730-3613
Los Angeles

NOTICE AND CONSENT FOR AIDS-RELATED BLOOD TESTING

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Rockville, Maryland 20850
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____
Signature of Proposed Insured   Social Security No.   Date

____
Witness   Date

APPROVED (if minor, 17 and under):   Parent - Guardian (circle one)

____
Signature of Parent or Guardian   Date

____
Address

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San Francisco

INLAND EMPIRE AIDS COORDINATION AND EDUCATION PROJECT
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Riverside

AIDS PROJECT, HEMOPHILIA COUNCIL
(714) 834-2604
Santa Ana

CENTRAL VALLEY AIDS TEAM
(209) 264-AIDS
Fresno

SACRAMENTO AIDS FOUNDATION
(916) 448-2437
Sacramento

SAN JOAQUIN AIDS FOUNDATION
(209) 476-8533
Stockton

AIDS EDUCATION PROGRAM
(916) 225-6173
Redding

LOS ANGELES COUNTY AIDS EDUCATION PROGRAM
(213) 730-3613
Los Angeles

Banner Life Insurance Company
1701 Research Boulevard
Rockville, Maryland 20850

FINANCIAL AND MEDICAL RECORDS AUTHORIZATION

I hereby authorize ______________________________ (Name of Insurance Company), its agents, employees, and reinsurers, to possess and/or obtain medical and financial information about me, including but not limited to information about my mental or physical health, other insurance coverage, hazardous activities, character, general reputation, mode of living, finances, vocation, and other personal traits, for the purpose of evaluating my trial or potential application for life insurance coverage, or for making a preliminary, nonbinding evaluation or determination as to my insurability and the possible basis on which a formal application for life insurance coverage might be considered.

I further authorize any physicians, medical practitioners, medical care providers, psychologists, chiropractors, physical therapists, hospitals, nursing homes, mental health facilities, rehabilitation or ambulatory care centers, medical clinics, treatment facilities, or other medical or medically related facilities, insurers, reinsurers, financial sources, employers, consumer reporting agencies, or any other person, organization, institution, or entity that has any record or knowledge of or about me or my financial or medical information, to give or disclose that information to ______________________________ (Name of Insurance Company), its agents and employees. ______________________________ (Name of Insurance Company) may then use this information to decide, on a preliminary, nonbinding basis, whether or on what basis I may be insurable.

This authorization shall be valid for two (2) years after the date on which it is signed by me.

I understand that I am entitled to receive or obtain a copy of this authorization.

A copy of this Authorization is as valid as the original.

______________________________ Signature of Proposed Insured

______________________________ Date (required)

______________________________ Social Security Number of Proposed Insured

______________________________ Agent or Witness Signature

BannerLife®

Banner Life Insurance Company
1701 Research Boulevard
Rockville, Maryland 20850

AUTHORIZATION FOR RELEASE OF HEALTH-RELATED INFORMATION

This authorization complies with the HIPAA Privacy Rule.

Persons/organizations providing information:

____

____

Name of Proposed Insured / Patient (Please type or print) ________________ Date of Birth ___/___/___

I authorize any physician, health plan, medical practitioner, medical care provider, psychologist, chiropractor, physical therapist, hospital, nursing home, mental health facility, rehabilitation or ambulatory care center, medical clinic, laboratory, pharmacy, treatment facility, or other medical or medically related facility, specifically including those persons/organizations listed above, to give or disclose my entire medical record and any other protected health information concerning me for the past 10 years to **Banner Life Insurance Company**, its agents and employees. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

This protected health information is to be disclosed under this authorization so that **Banner Life Insurance Company** may: 1) underwrite my application for coverage, make eligibility, risk rating, and policy issuance determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with **Banner Life Insurance Company.**

By signing below, I terminate any agreements I have made to restrict my protected health information and I instruct any physician, health care professional, hospital, clinic, medical facility or other health care provider to release and disclose my entire medical record without restriction.

This authorization shall be valid for two (2) years after the date on which it is signed by me, and a copy of this authorization is as valid as the original.

I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to the Company at 1701 Research Boulevard, Rockville, Maryland 20850, Attention: Privacy Official. I understand that a revocation is not effective if any of My Providers has relied on this authorization or to the extent that the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by certain federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization, the Company may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments.

I understand and acknowledge that I will receive or have received a copy of this authorization.

Signature of Proposed Insured / Patient	Date (required)
Social Security Number of Proposed Insured	Agent or Witness Signature