Banner Life Insurance Company
3275 Bennett Creek Avenue
Frederick, Maryland 21704
(800) 638-8428

LIFE INSURANCE APPLICATION

Internet address: www.bannerlife.com

INSTRUCTIONS

As the Agent, you are responsible for completing the necessary forms required to process and underwrite this application. All forms must be completed in full and must be legible. Please follow these instructions carefully.

DO

- Print application in black ink.
- Verify identification of Proposed Insured.
- Obtain all of the necessary signatures.
- Give the Notice to Proposed Insured to your client.
- Have the Proposed Insured/Owner initial all changes. The Proposed Insured must initial all changes to questions involving insurability. Change an answer by putting a line through the incorrect answer and inserting the correct information.
- Complete Part 2, Medical History, if the Proposed Insured is to be considered without paramedical exam, if an exam on another company's form is being used or if an abbreviated exam will be done.
- Complete section K, Part 1 on all business cases and if required on non-business cases.
- Complete and obtain signature on Consent for HIV Testing Form for each Proposed Insured, if required in your state.
- If you accept payment with the application:
  - Complete the Temporary Insurance Application section of the Temporary Insurance Application and Agreement (TIAA), making sure that all questions are answered. If any are answered Yes, do not accept money.
  - Remit an amount equal to the first modal premium.
  - Explain the terms and conditions of the TIAA to the Owner and Proposed Insured and have them sign it.
  - Complete and sign the Licensed Insurance Agent's Statement on the TIAA.
  - Send the TIAA with the application, give the Owner a copy.
  - All checks collected must be made payable to Banner Life Insurance Company.
- If applicable, complete and obtain signature(s) on the Payment Options form.
- Complete and sign the Agent's Report on page 12. Please be sure to enter all agent information and your Banner agent number.

DO NOT

- Do not accept money on applications now applied for or pending with Banner Life Insurance Company totaling over $1,000,000.
- Do not accept any payment if any question on the Temporary Insurance Application and Agreement is answered Yes or left blank.
- Do not accept cash or cash equivalents (money order, cashiers check) or "starter" checks.
- Do not accept money if the Proposed Insured is over age nearest 70.
- Do not use pencil or correction fluid.

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NOTICE TO PROPOSED INSURED

(Please give to the Proposed Insured)

Thank you for applying to Banner Life Insurance Company. 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 to 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.

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, the policy may be void or your coverage may be lost if the application is incomplete or if it contains false statements or material misrepresentations. Any policy that may be issued will indicate when and under what circumstances it may be contested. Please be aware that if the application contains material misrepresentations 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. 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.

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 Notice. 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 receive copies if you wish, of 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, 3275 Bennett Creek Avenue, Frederick, Maryland 21704.

Federal Fair Credit Reporting Notice

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 may 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.

NOTICE TO PROPOSED INSURED

(Please give to the Proposed Insured)
(continued)

MIB (Medical Information Bureau) Pre-Notice Disclosure

Information regarding your insurability will be treated as confidential. Banner Life Insurance Company 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 each company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information 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, MA 02184-8734.

Banner Life Insurance Company, or its reinsurers, may also release information from its file to other 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.

Legal & General AMERICA

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PART 1
(Please Print)

SECTION A PROPOSED INSURED

1. Full Name (Include maiden name in parentheses)	2. Sex	3. Date of Birth			4. Social Security Number
	☐ M ☐ F	Month	Day	Year	

5. a. Home Address

Street _____ City, State _____ Zip _____ 5. b. How Long

6. Phone Numbers	7. State/Country of Birth	8. U.S. Citizen ☐ Yes ☐ No Visa Type _____
Home ( )		If No, Date of Entry into U.S. _____
Work ( )		Country of Citizenship _____

9. Marital Status	10. Driver's License Number and State of Issue or State ID Number
☐ M ☐ S ☐ W ☐ D	

11. Occupation (Include duties)	12. Annual Income	13. Total Net Worth

14. a. Employer's Name and Address and Nature of Business	14. b. How Long Employed

15. Have you ever used tobacco or nicotine products in any form? ☐ Yes - give details below ☐ No

Product	Date last used (month/year)	Amount / Frequency
Cigarettes		
Cigars		
Other		

SECTION B BENEFICIARY (Share percentage totals must equal 100%. If necessary, use Remarks section, Question 48. If Beneficiary is a trust, check box ☐ and complete Section D.)

16. Primary

Name _____ Relationship _____ % Share _____
SSN _____ Date of Birth _____
Name _____ Relationship _____ % Share _____
SSN _____ Date of Birth _____

17. Contingent

Name _____ Relationship _____ % Share _____
SSN _____ Date of Birth _____
Name _____ Relationship _____ % Share _____
SSN _____ Date of Birth _____

SECTION C OWNER

18. Owner is ☐ Proposed Insured ☐ Trust (also complete Section D) ☐ Other than Proposed Insured or Trust

Complete if the Proposed Insured is not the Owner. (If contingent Owner is required, use Remarks section, Question 48).

Name _____ SSN or Tax ID # _____ Date of Birth _____
Address _____ City, State _____ Zip _____
Contact Phone # _____ Relationship to Proposed Insured _____
If Owner is a business, web site address _____ Email address _____

SECTION D TRUST INFORMATION (If trust is Beneficiary and/or Owner).

19. Exact Name of Trust _____ Trust Tax ID# _____
Current Trustee(s) _____ Date of Trust _____

PART 1 (continued)

SECTION E PAYOR

20. Send premium notices to: ☐ Insured ☐ Owner ☐ Other - If Other, complete the information below

Name _____ Relationship to Insured/Owners _____

Address _____
Street City State Zip

Contact Phone # _____ Email address _____

SECTION F INSURANCE APPLIED FOR

21. Amount of Insurance $ _____ 22. Plan of Insurance _____

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

24. Payment method: ☐ Direct Bill ☐ Electronic Funds Transfer (EFT)

25. Frequency of premium payment: ☐ Single ☐ Annual ☐ Semi-annual ☐ Quarterly ☐ Monthly (EFT only)

26. Planned periodic premium for universal life product: (Provide details in Remarks section, Question 48.)

a. ☐ 1st Year Only $_____ 2nd Year and Thereafter $_____ b. ☐ Premium For All Years $ _____

27. Will the premiums for this policy be loaned or otherwise financed by an individual(s) or entity other than the Proposed Insured or immediate family members of the Proposed Insured? ☐ Yes ☐ No

If Yes, please identify all parties involved and provide copies of all financing agreements or promissory notes and all related side agreements and schedules. (Provide details in Remarks section, Question 48.)

28. a. Date to Save Age? ☐ Yes ☐ No b. Specific Policy Date? ☐ Yes ☐ No Date _____

Additional Benefits (if available)

29. ☐ Waiver of Premium ☐ Other (description and amount) _____

SECTION G OTHER INSURANCE

30. a. **Excluding** this application, amount of insurance **currently pending** with other companies. If NONE state NONE. $ _____

b. Of the above pending amount in 30.a., how much do you intend to accept? $ _____

c. Provide information for each policy in force (except group insurance). (If necessary, use Remarks section, Question 48.) If NONE state NONE.

Company	Policy Number	Face Amount	Business? Yes	Business? No	Issue Date	Replacing? Yes	Replacing? No	Beneficiary
			☐	☐		☐	☐	
			☐	☐		☐	☐	
			☐	☐		☐	☐	
			☐	☐		☐	☐	
			☐	☐		☐	☐	

	Yes	No
31. Have you ever had an application for life or health insurance declined, postponed, modified, rated or offered with a reduced face amount? (If Yes, provide details in Remarks section, Question 48.)	☐	☐
32. Will you, or are you likely to, replace, end, or change existing insurance or annuity with 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.)	☐	☐
33. Are there any plans to sell or permanently assign the policy to another person or entity, life settlement provider or an investor, or will it replace a policy that has already been sold to another life settlement company or investor? (If Yes, provide details in Remarks section, Question 48.)	☐	☐

PART 1 (continued)

SECTION H GENERAL QUESTIONS (Explain all Yes answers in Remarks section, Question 48.)

	Yes	No
34. Has any person promised or agreed to give or have they given to any party to the application, any inducement, fee or compensation as an incentive to purchase the policy?	☐	☐
35. Has any party to the application ever sold, transferred or assigned any life insurance policy to a third party, such as a viatical settlement entity, life settlement entity, insurance company, other secondary market provider, or premium financing entity?	☐	☐
36. Has any party to the application ever received inducement, fee or compensation as an incentive to purchase, sell, transfer or assign a policy?	☐	☐
37. In the past 5 years, have you requested or received a Worker's Compensation, Social Security, or disability income payment?	☐	☐
38. Have you ever been convicted of, or are you currently charged with, a felony or misdemeanor, or are you currently on parole or probation?	☐	☐
39. In the past 5 years, has your driver's license been suspended or revoked, or have you been convicted of 2 or more moving violations or accidents?	☐	☐
40. In the past 5 years, have you been convicted of, or plead guilty or no contest to, driving while impaired, intoxicated, or under the influence of alcohol or drugs? (If Yes, complete Alcohol/Drug Usage Questionnaire.)	☐	☐
41. Are you a member, or do you intend to become a member, of the armed forces, including the reserves?	☐	☐

SECTION I OTHER ACTIVITIES

	Yes	No
42. Do you hold a current pilot license, or have you in the past 5 years flown, or within the next 2 years do you intend to fly, other than as a passenger in any type of aircraft? (If Yes, complete Aviation Questionnaire.)	☐	☐
43. Have you in the past 2 years engaged in, or within the next 2 years do you intend to engage in, certain activities such as hang gliding, hot-air ballooning, ultra-light flying, heli-skiing, mountain, ice or rock climbing, cliff or base jumping, motor vehicle racing, motorcycle or any other motorized land or water vehicle racing, or scuba or sky diving? (If Yes, complete appropriate questionnaire.)	☐	☐
44. Do you intend to travel outside the U.S. or Canada, or change your country of residence in the next 12 months? (If Yes, list countries, cities, duration and purpose of travel in Remarks section, Question 48.)	☐	☐

SECTION J PROPOSED INSURED FINANCIAL INFORMATION

Complete this section when applying for face amount over $1,000,000 or when the Proposed Insured is over age 65:

45. a. What is the purpose of this insurance? (e.g. income replacement, buy-sell, keyperson, estate conservation)

_____

b. How was the need for the face amount determined? _____

	Yes	No
c. In the last 5 years, has the Proposed Insured filed for bankruptcy or had any charge off of bad debts?	☐	☐

If Yes, type of bankruptcy and discharge date or charge off date. _____

46. a. Gross annual earned income (salary, bonuses, etc. from W-2 forms) $ _____

b. Gross annual unearned income (dividends, interest, rental income, etc.) $ _____

	Yes	No
c. Is the Proposed Insured self-supporting?	☐	☐

If No, how much insurance is in-force on the life of the person providing the support? $ _____

What is that person's relationship to the Proposed Insured? _____

PART 1 (continued)

SECTION K BUSINESS FINANCIAL INFORMATION

Complete this section when applying for face amount over $1,000,000 and if Beneficiary or Owner is a business:

	Current YTD	Previous Year
47. a. Assets	$	$
b. Liabilities	$	$
c. Gross Sales	$	$
d. Net Income after Taxes	$	$
e. Fair Market Value of the business	$	$

f. How long has the business been established? _____

g. What percentage of the business does the Proposed Insured own? _____

	Yes	No
h. Are other partners/owners/executives being insured? (If Yes, use Remarks section, Question 48.)	☐	☐
i. In the last 5 years, has the business filed for bankruptcy or had any charge off of bad debts?	☐	☐

If Yes, type of bankruptcy and discharge date or charge off date. _____

j. Company web site address, if available _____

48. Remarks: Explanations and/or special requests. Use Part 1 Supplement to Application if necessary.

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

I/we have read the application and all statements and answers contained in Part 1 and Part 2 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 and complete to the best of my/our knowledge and belief and made to induce Banner Life Insurance Company (the Company) to issue an insurance policy. The statements and answers in the application are the basis for any policy issued by the Company, and no information about me will be considered to have been given to the Company unless it is stated in the application. 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: (a) accept risk; (b) make or modify contracts; (c) make, void, waive or change any conditions or provisions of the application, policy or receipt, as applicable; (d) waive any Company rights or requirements; (e) waive any information the Company requests; (f) discharge any contract of insurance; or (g) bind the Company by making promises respecting benefits upon any policy to be issued.

I agree that: **(1) I/we will notify the Insurer if any statement or answer given in any part of the application changes prior to policy delivery; and (2) except as provided in the Temporary Insurance Application and Agreement, if any, insurance will not begin unless all persons proposed for insurance are living and insurable as set forth in the application at the time a policy is delivered to and accepted by the Owner and the first modal premium is paid.**

Changes or corrections made by the Company and noted in Part 1, Question 48 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.

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I hereby authorize any physician, medical professional, hospital, clinic or medical care facility; pharmacy benefit manager, prescription database; any insurance or reinsurance company; any consumer reporting agency or insurance support organization; my employer; or the Medical Information Bureau (MIB), to provide the Company and its legal representatives or affiliated insurers, all information they have pertaining to: medical consultations; treatments; hospitalizations for physical and/or mental conditions, use of drugs or alcohol; drug prescriptions; or any other information for me. Other information could include items such as: other insurance information; personal finances; habits; hazardous avocations; motor vehicle records; court records; or foreign travel, etc.

I understand that the information obtained will be used by the Company to determine my eligibility for insurance. I authorize that any information gathered during the evaluation of my application may be disclosed to: reinsurers; the MIB; other persons or organizations performing business or legal services in connection with my application or claim; any physician designated by me; or any person or entity required to receive such information by law or as I may further consent.

I understand that this consent may be revoked at any time by sending a written request to the Company, Attn: Director of Underwriting, Banner Life Insurance Company, 3275 Bennett Creek Avenue, Frederick, Maryland 21704.

The consent will be valid for 24 months from the date of this application. I agree that a copy of this consent will be as valid as the original. I authorize the Company to obtain an investigative consumer report on me. I understand that I may request to be interviewed for the report and receive, upon written request, a copy of such report.

If an investigative consumer report is prepared, I elect to be interviewed: ☐ Yes ☐ No

DECLARATION

I/we have carefully read the Temporary Insurance Application and Agreement (TIAA) 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** (payee should not be left blank); checks are not to be made payable to the agent, agency or other third party. I/we have received the Notice to Proposed Insured, which includes the Medical Information Bureau Pre-Notice Disclosure and the Federal Fair Credit Reporting Notice.

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law. **Please see fraud warnings on page 6 prior to signing this application.**

_____ Signed at_____ on _____/_____/_____
Signature of Proposed Insured — City/State

_____ Signed at_____ on _____/_____/_____
Signature of Owner (if other than Proposed Insured) — City/State
If Owner is a firm or corporation, include officers' title with signature

_____
Print Owner/Officer Name and Title (if applicable)

_____ Signed at_____ on _____/_____/_____
Signature of Licensed Insurance Agent — City/State

FRAUD WARNINGS

Arkansas, District of Columbia
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information on an insurance application is guilty of a crime and may be subject to fines and imprisonment.

Florida
Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement or claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

New Jersey
Any person who includes any false or misleading information on an application for insurance is subject to criminal and civil penalties.

Legal & General AMERICA

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PART 2
Medical History

1. Name of Proposed Insured _____ Date of Birth _____

2. Height _____ft. _____in. 3. Weight _____ lbs.

If your weight has changed by over 10 lbs. in the last year, indicate amount and reason _____

_____

PHYSICIAN INFORMATION

4. **Primary Physician**

Name _____

Address _____

Telephone _____ Date last seen _____

Reason last seen and results of visit _____

5. **Physician Last Consulted**

Name _____ Specialty _____

Address _____

Telephone _____ Date last seen _____

Reason last seen and results of visit _____

	Yes	No
6. Has a parent or sibling ever been diagnosed or treated by a member of the medical profession for heart or kidney disease, stroke, diabetes, cancer, melanoma, suicide, Huntington's Disease, Sickle Cell Disease or Familial Adenomatous Polyposis (FAP)? If Yes, give details in the Family History chart below.	☐	☐

Family History: Include the age at onset/event for each medical condition.

	Medical Conditions	Age at Onset/Event	Age if Living	Cause of Death	Age at Death
Father					
Mother					
Brothers					
Sisters					

MEDICAL HISTORY - Provide details to Yes answers in the Remarks section. Include provider, date, symptoms, diagnosis and treatment.	Yes	No	**Remarks - Explain All Yes Answers** Enter question number before detailed response.
Questions 7-22, have you ever consulted a member of the medical profession regarding or have you been diagnosed or treated for:			
7. High blood pressure, high cholesterol, abnormal electrocardiogram, chest pain, irregular heart rhythm, palpitations, heart murmur, heart attack, angina, phlebitis, peripheral vascular disease, or any other disease or disorder of the heart or blood vessels?	☐	☐	
8. Hepatitis, ulcer, internal bleeding, colitis, acid reflux, GERD, or any other disease or disorder of the stomach, gall bladder, esophagus, liver, pancreas, spleen, intestines, colon, or rectum?	☐	☐	
9. A disorder of your blood or immune system including anemia, blood clots, bleeding, immune deficiency, leukemia, or lymphoma (excluding HIV)?	☐	☐	

PART 2 - Medical History (continued)

Name of Proposed Insured _____	Yes	No	Remarks - Explain All Yes Answers
10. Cancer, tumor, melanoma, or any other malignant disorder?	☐	☐	
11. Diabetes or high blood sugar or any other disease or disorder of the pituitary, thyroid, or endocrine glands?	☐	☐	
12. Albumin, protein, blood or sugar in the urine or any other disease or disorder of the kidney or bladder?	☐	☐	
13. Cyst, polyp, lump, or other growth, or any disease or disorder of the skin or lymph nodes?	☐	☐	
14. Any disease or disorder of the uterus, cervix, ovaries, or breasts?	☐	☐	
15. Any disease or disorder of the prostate or reproductive system?	☐	☐	
16. Any sexually transmitted disorders or diseases?	☐	☐	
17. Pregnancy, complications of pregnancy or infertility? If now pregnant, what is the expected date of delivery? _____	☐	☐	
18. Asthma, shortness of breath, chronic cough or hoarseness, bronchitis, emphysema, COPD (chronic obstructive pulmonary disease), sarcoidosis, pneumonia, TB (tuberculosis), sleep apnea, or any other disorder of the respiratory system?	☐	☐	
19. A disorder of the brain, spinal cord, or nervous system including chronic headaches, convulsions or loss of consciousness, seizures, tremors, paralysis, fainting, stroke, MS (multiple sclerosis), or TIA (transient ischemic attack)?	☐	☐	
20. Depression, anxiety, psychosis, suicidal thoughts or attempts of suicide, anorexia or bulimia, obsessive compulsive disorder, bipolar disorder, or other mental, nervous or emotional disorder?	☐	☐	
21. Arthritis or disorder of the bones, skin or muscles?	☐	☐	
22. Any disease or disorder of the eyes, ears, nose or throat?	☐	☐	
23. In the **last 5 years,** unless previously stated on this application, have you:			
a. Been treated by a member of the medical profession or at a medical facility?	☐	☐	
b. Had an electrocardiogram, x-ray, blood test, or other diagnostic test, excluding an HIV test?	☐	☐	
c. Had surgery or biopsy, or been an inpatient or outpatient in a hospital, clinic, or other medical or mental health facility?	☐	☐	
d. Been advised by a member of the medical profession to have surgery, medical treatment, biopsy, or diagnostic testing, excluding HIV testing, that has not yet been completed?	☐	☐	
e. Been referred to any other member of the medical profession or medical facility?	☐	☐	
f. Been unable to work, attend school or perform the normal activities of like age and gender, or been confined at home?	☐	☐	
24. a. Have you ever used amphetamines, barbiturates, cocaine, heroin, crack, marijuana, LSD, PCP, or other illegal, restricted or controlled substances, except as prescribed by a licensed physician?	☐	☐	
If Yes, please provide dates of use: From_____ To _____			
Name of drug used: _____			
Amount and frequency of use: _____			

PART 2 - Medical History (continued)

Name of Proposed Insured _____	Yes	No	Remarks - Explain All Yes Answers
24 b. Have you ever been addicted to prescription medication or been advised by a physician to discontinue using habit forming drugs?..... If Yes, provide dates of use, type and frequency.	☐	☐	
25. Have you ever: a. Consumed alcoholic beverages?..... If Yes, give type and number of drinks per day and/or per week. Date of last consumption: _____	☐	☐	
b. Been advised by a physician or other licensed medical practitioner to limit or cease the use of alcoholic beverages?	☐	☐	
c. Been counseled, sought help or treatment, or been advised by a physician or other licensed medical practitioner to undergo counseling or treatment for alcohol problems?.....	☐	☐	
d. Attended or joined any organization due to alcohol or related problems?	☐	☐	
26. Are you currently: a. Taking or have you been advised to take any prescribed medication (other than contraceptives)?.....	☐	☐	
b. Taking any herbal or non-prescription medication at least weekly?..... If Yes, give details. _____	☐	☐	
27. Have you taken any other medications in the **past 2 years**?..... If Yes, list in Remarks section at right.	☐	☐	
28. a. As part of an application for the purpose of obtaining insurance, have you tested positive for the HIV virus?.....	☐	☐	
b. Have you been diagnosed as having ARC (AIDS-Related Complex) or AIDS (Auto Immune Deficiency Syndrome)?.....	☐	☐	
29. In the past 5 years, have you been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for any disease or disorder not previously stated on this application? ..... If Yes, give details. _____	☐	☐	
30. Additional remarks (please indicate which question number remarks reference)			

I have read the answers as written before signing, the answers are true and complete to the best of my knowledge and belief, and there are no exceptions to any answers other than written on this document.

_____ Signed at _____ on ____/____/_____

Signature of Proposed Insured | City/State | Date

Legal & General AMERICA

Banner Life Insurance Company
3275 Bennett Creek Avenue
Frederick, Maryland 21704
(800) 638-8428

TEMPORARY INSURANCE APPLICATION AND AGREEMENT (TIAA)

Name of Proposed Insured _____ Date of Birth _____

Notice to Proposed Insured and Owner. Payment of the Amount Remitted may only be made at the same time that both the Application - Part 1 and this TIAA are completed. If the Insurer does not respond to you within 90 days, notify the Insurer at the above address. **Make the Amount Remitted payable to Banner Life Insurance Company. Do not make it payable to the licensed insurance agent or leave the payee blank. We do not accept cash or cash equivalents (money orders, cashiers checks) or "starter" checks.**

TEMPORARY INSURANCE APPLICATION (Answer all questions.)

Insurer The Insurer is Banner Life Insurance Company.

Temporary insurance cannot begin and you should make no payment if any question below is answered "Yes" or left blank.

	Yes	No
1. Is the Proposed Insured less than 15 days old or more than 70 years old (age nearest birthday) on the date of this TIAA?	☐	☐
2. Does the total amount of insurance on the Proposed Insured's life now applied for or pending with Banner Life Insurance Company exceed $1,000,000?	☐	☐
3. In the past 90 days, has the Proposed Insured been admitted, or medically advised by a member of the medical profession to be admitted, to a hospital or other licensed health care facility, had surgery performed or recommended, or been medically advised to have any diagnostic test (excluding an AIDS-related test) that was not completed?	☐	☐
4. In the past 5 years, has the Proposed Insured been diagnosed, treated for, or been advised to be treated for: heart disease; stroke; cancer; alcohol or drug dependence or abuse; or insulin dependent diabetes?	☐	☐

THIS AGREEMENT PROVIDES A LIMITED AMOUNT OF LIFE INSURANCE COVERAGE FOR A LIMITED AMOUNT OF TIME, SUBJECT TO THE TERMS AND CONDITIONS SET FORTH BELOW.

TEMPORARY INSURANCE AGREEMENT

Agreement. Subject to the terms of the policy applied for and this TIAA, the Insurer agrees to pay the Limited Amount to the beneficiaries listed in the Application - Part 1 upon receipt of due proof that the Proposed Insured died, except due to suicide, and provided all eligibility requirements and conditions for coverage under this Agreement have been met. The consideration for temporary insurance is the Temporary Insurance Application and payment of an amount equal to the first modal premium for the plan applied for or completion of the payment options form.

Limited Amount. The Limited Amount is the lesser of: (1) the amount of insurance applied for in the Application or (2) $1,000,000 minus the amount of insurance on the Proposed Insured's life with the Insurer under any other applications for insurance now pending or other temporary insurance agreements.

Start Date. Temporary insurance equal to the Limited Amount will begin on the Start Date subject to the terms of this TIAA. The Start Date is the Date of this TIAA.

Stop Date. Temporary insurance automatically ends on the **earliest** of the following: (1) the date the Owner withdraws the application for insurance or refuses to accept any policy issued or offered; (2) the date the Insurer mails or otherwise provides notice to the Owner or his/her agent that it was unable to approve the requested coverage at the premium amount quoted and a counter offer is made by the Insurer; (3) the date the Insurer mails or otherwise provides notice to the Owner or his/her representative that it has declined or cancelled the application; (4) the date the Insurer mails or otherwise provides a premium refund to the Owner or his/her representative; (5) the date the policy is delivered to the Owner and delivery requirements have been completed.

Policy Date. The policy date of any policy issued will be the Start Date unless the policy is backdated at the Owner's request. The prepayment for this temporary insurance will be applied to the first premium due if the policy is issued.

Other Limitations. The Insurer's liability will be limited to a return of the Amount Remitted if: (1) any part of the life insurance application or this TIAA contains a misrepresentation material to the Insurer; or (2) the Proposed Insured dies by suicide.

TEMPORARY INSURANCE APPLICATION AND AGREEMENT (TIAA)

(continued)

I represent that: (1) I have read and received a copy of this TIAA and agree to all of its terms and conditions; (2) I understand and agree that temporary insurance will not begin if any question in this TIAA is answered Yes or left blank and any collection of premium will not activate coverage under this agreement; (3) the answers given in this TIAA are true and correct, and I understand that, if they are false, temporary insurance may be denied or declined; (4) I understand that completing this TIAA does not guarantee that the Insurer will issue a policy on the Proposed Insured's life; (5) I understand that the licensed insurance agent is not authorized to change or waive the terms of this TIAA or to collect premium if the Proposed Insured is ineligible for coverage under this Agreement; and (6) I understand that any premium submitted with this TIAA will be refunded if the Insurer does not approve the requested coverage.

_____	_____	_____
Signature of Proposed Insured	Date of this TIAA	Signature of Owner (if other than Proposed Insured)

LICENSED INSURANCE AGENT'S STATEMENT

Amount Remitted $ _____ Person from Whom Received _____

On the Date of this TIAA, I received the Amount Remitted in exchange for this TIAA. The TIAA bears the same date as the Application - Part 1. I agree that I am not authorized to change or waive the terms of this TIAA and represent that I have not attempted to do so. I have read and explained the terms of this TIAA to the Proposed Insured and Owner. I have left a copy with the Owner.

_____	_____
Signature of Licensed Insurance Agent	Licensed Insurance Agent Number

Legal & General AMERICA

Banner Life Insurance Company
3275 Bennett Creek Avenue
Frederick, Maryland 21704
(800) 638-8428

TEMPORARY INSURANCE APPLICATION AND AGREEMENT (TIAA)

Name of Proposed Insured _____ Date of Birth _____

Notice to Proposed Insured and Owner. Payment of the Amount Remitted may only be made at the same time that both the Application - Part 1 and this TIAA are completed. If the Insurer does not respond to you within 90 days, notify the Insurer at the above address. **Make the Amount Remitted payable to Banner Life Insurance Company. Do not make it payable to the licensed insurance agent or leave the payee blank. We do not accept cash or cash equivalents (money orders, cashiers checks) or "starter" checks.**

TEMPORARY INSURANCE APPLICATION (Answer all questions.)

Insurer The Insurer is Banner Life Insurance Company.

Temporary insurance cannot begin and you should make no payment if any question below is answered "Yes" or left blank.

	Yes	No
1. Is the Proposed Insured less than 15 days old or more than 70 years old (age nearest birthday) on the date of this TIAA?	☐	☐
2. Does the total amount of insurance on the Proposed Insured's life now applied for or pending with Banner Life Insurance Company exceed $1,000,000?	☐	☐
3. In the past 90 days, has the Proposed Insured been admitted, or medically advised by a member of the medical profession to be admitted, to a hospital or other licensed health care facility, had surgery performed or recommended, or been medically advised to have any diagnostic test (excluding an AIDS-related test) that was not completed?	☐	☐
4. In the past 5 years, has the Proposed Insured been diagnosed, treated for, or been advised to be treated for: heart disease; stroke; cancer; alcohol or drug dependence or abuse; or insulin dependent diabetes?	☐	☐

THIS AGREEMENT PROVIDES A LIMITED AMOUNT OF LIFE INSURANCE COVERAGE FOR A LIMITED AMOUNT OF TIME, SUBJECT TO THE TERMS AND CONDITIONS SET FORTH BELOW.

TEMPORARY INSURANCE AGREEMENT

Agreement. Subject to the terms of the policy applied for and this TIAA, the Insurer agrees to pay the Limited Amount to the beneficiaries listed in the Application - Part 1 upon receipt of due proof that the Proposed Insured died, except due to suicide, and provided all eligibility requirements and conditions for coverage under this Agreement have been met. The consideration for temporary insurance is the Temporary Insurance Application and payment of an amount equal to the first modal premium for the plan applied for or completion of the payment options form.

Limited Amount. The Limited Amount is the lesser of: (1) the amount of insurance applied for in the Application or (2) $1,000,000 minus the amount of insurance on the Proposed Insured's life with the Insurer under any other applications for insurance now pending or other temporary insurance agreements.

Start Date. Temporary insurance equal to the Limited Amount will begin on the Start Date subject to the terms of this TIAA. The Start Date is the Date of this TIAA.

Stop Date. Temporary insurance automatically ends on the **earliest** of the following: (1) the date the Owner withdraws the application for insurance or refuses to accept any policy issued or offered; (2) the date the Insurer mails or otherwise provides notice to the Owner or his/her agent that it was unable to approve the requested coverage at the premium amount quoted and a counter offer is made by the Insurer; (3) the date the Insurer mails or otherwise provides notice to the Owner or his/her representative that it has declined or cancelled the application; (4) the date the Insurer mails or otherwise provides a premium refund to the Owner or his/her representative; (5) the date the policy is delivered to the Owner and delivery requirements have been completed.

Policy Date. The policy date of any policy issued will be the Start Date unless the policy is backdated at the Owner's request. The prepayment for this temporary insurance will be applied to the first premium due if the policy is issued.

Other Limitations. The Insurer's liability will be limited to a return of the Amount Remitted if: (1) any part of the life insurance application or this TIAA contains a misrepresentation material to the Insurer; or (2) the Proposed Insured dies by suicide.

TEMPORARY INSURANCE APPLICATION AND AGREEMENT (TIAA)

(continued)

I represent that: (1) I have read and received a copy of this TIAA and agree to all of its terms and conditions; (2) I understand and agree that temporary insurance will not begin if any question in this TIAA is answered Yes or left blank and any collection of premium will not activate coverage under this agreement; (3) the answers given in this TIAA are true and correct, and I understand that, if they are false, temporary insurance may be denied or declined; (4) I understand that completing this TIAA does not guarantee that the Insurer will issue a policy on the Proposed Insured's life; (5) I understand that the licensed insurance agent is not authorized to change or waive the terms of this TIAA or to collect premium if the Proposed Insured is ineligible for coverage under this Agreement; and (6) I understand that any premium submitted with this TIAA will be refunded if the Insurer does not approve the requested coverage.

_____	_____	_____
Signature of Proposed Insured	Date of this TIAA	Signature of Owner (if other than Proposed Insured)

LICENSED INSURANCE AGENT'S STATEMENT

Amount Remitted $ _____ Person from Whom Received _____

On the Date of this TIAA, I received the Amount Remitted in exchange for this TIAA. The TIAA bears the same date as the Application - Part 1. I agree that I am not authorized to change or waive the terms of this TIAA and represent that I have not attempted to do so. I have read and explained the terms of this TIAA to the Proposed Insured and Owner. I have left a copy with the Owner.

_____	_____
Signature of Licensed Insurance Agent	Licensed Insurance Agent Number

AGENT'S REPORT

1. Name of Proposed Insured _____ Date of Birth _____
2. Number of years you have known the primary Proposed Insured _____
3. Who first suggested the purchase of this insurance? ☐ Agent ☐ Owner/Applicant ☐ Proposed Insured ☐ Other _____

	Yes	No
4. Was the application signed after all questions were answered?	☐	☐
5. Did you personally see the Proposed Insured?	☐	☐
6. Did anyone sign or assist in the completion of Part 1 or Part 2 of the Application for or on behalf of the Proposed Insured?	☐	☐
7. Are you aware of any information that would adversely affect any Proposed Insured's eligibility, acceptability, or insurability? If Yes, please provide details in the Remarks section below, and do not provide limited temporary life insurance.	☐	☐
8. Did you provide the client with the Temporary Life Insurance Application and Agreement (TIAA) form?	☐	☐
9. Premium Class Quoted _____		
10. Are there any personal or business companion applications? If Yes, please provide name and date of birth in the Remarks section below.	☐	☐
11. a. To the best of your knowledge, does the policy applied for involve the replacement of existing insurance?	☐	☐
b. If Yes, has the Proposed Insured replaced other life insurance policies in the past 2 years?	☐	☐
12. Are there any plans to sell or assign this policy to another person or entity, life settlement provider or investor, or will it replace a policy that has already been sold to a life settlement company or investor?	☐	☐
13. Will the premium for this policy be loaned or otherwise financed by an individual(s) or entity other than the Proposed Insured or immediate family members of the Proposed Insured? If Yes, please identify all parties involved and provide copies of all financing agreements or promissory notes and all related side agreements and schedules.	☐	☐

Remarks _____

_____

_____

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 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 Temporary Insurance Application and Agreement 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.

_____ Phone No. ( ) _____
Signature of Licensed Insurance Agent Date

_____ Agent # _____ SSN _____
Print Name of Above Signature

_____ Share of commission _____
Print Name of Agency, if different from above

_____ Phone No. ( ) _____
Signature of Additional Licensed Insurance Agent Date

_____ Agent # _____ SSN _____
Print Name for Above Additional Signature

_____ Share of commission _____
Print Name of Additional Agency, if different from above

GENERAL AGENT INFORMATION

GA name _____ GA # _____ Case Manager _____

Banner Life Insurance Company
3275 Bennett Creek Avenue
Frederick, Maryland 21704
(800) 638-8428
www.LGAmerica.com

California - Option to Designate Additional Addressee

Insured_____ Policy Number _____
(leave blank if policy number not yet assigned)

Under California law, you as the owner of the policy listed above may designate one or more additional addressees to receive copies of premium notifications, including lapse and termination notices, for this policy. Please complete this form with the name(s) of any additional addressees and mail it to the company address indicated above.

I elect the person(s) named below in addition to myself to receive notice of a lapse or termination of my life insurance policy for non-payment of premium.

Name of Additional Addressee _____

Address of Additional Addressee Street _____

City _____ State _____ Zip Code_____

Telephone Number _____

Name of Additional Addressee _____

Address of Additional Addressee Street _____

City _____ State _____ Zip Code_____

Telephone Number _____

Name of Additional Addressee _____

Address of Additional Addressee Street _____

City _____ State _____ Zip Code_____

Telephone Number _____

_____ _____
Insured's Name Insured's Date of Birth

_____ _____
Policy Owner's Name Policy Owner's Date of Birth

_____ _____
Policy Owner's Signature Date

Banner Life Insurance Company
3275 Bennett Creek Avenue
Frederick, Maryland 21704
800-638-8428
www.LGAmerica.com

LEGAL & GENERAL AMERICA PRIVACY POLICY

Your privacy is important to us.

Your privacy is important to us. At Legal & General America (Banner Life Insurance Company, William Penn Life Insurance Company of New York, and Legal & General America Retirement Services, Banner's retirement division), 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 Legal & General America does with the personal information you provide to us and the measures we take to protect your privacy.

Who has access to LIFE INSURANCE policy customer information?

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

Who has access to ANNUITY customer information?

The information that is provided to us is used for company purposes only. Our employees have access to your information, and are authorized to review it, only for the purposes of carrying out their official duties and responsibilities. Our employees are required to keep customer information confidential.

Why does Legal & General America collect and maintain information?

As regulated insurance carriers, the Legal & General America companies are required by state laws and regulations to collect and maintain certain information about our 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 Legal & General America.

What type of information does Legal & General America collect and maintain?

We collect and maintain various types of information about our customers. The types of personal information we collect and share depend on the product or service you have with us. This information can include:

- Information that you submit to us, such as your name, address, telephone number, and Social Security Number.
- Information about your transactions, such as payment history and account balance.
- Information from non-affiliated third parties about your medical, employment and income history; banking relationships; 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 Legal & General America's website (www.LGAmerica.com).

Does Legal & General America disclose customer information to, or share customer information with, outsiders?

We do 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.

As allowed by law, we may from time to time share non-public personal financial information with a non-affiliated third party that performs services or functions on our behalf. These services or functions may include marketing of our own products and services; or financial products or services offered pursuant to a joint agreement between us and one or more financial institutions.

If our privacy policy changes in any material respect, we will notify you of such change as required by law.

How can you contact Legal & General America if you have privacy questions?

If you hve any questions about the privacy of your information, you can contact our Customer Service Department.

If you have a Banner life insurance policy, contact:
Banner Customer Service
Call: 800-638-8428 Toll Free
Fax: 301-294-6960
Hours: 8:00-5:00 ET, Monday - Friday
3275 Bennett Creek Avenue
Frederick, Maryland 21704

If you have a William Penn life insurance policy, contact:
William Penn Customer Service
Call: 800-346-4773 Toll Free
Fax: 516-229-3081
Hours: 8:30-4:45 ET, Monday - Friday
3275 Bennett Creek Avenue
Frederick, Maryland 21704

If you have a Banner retirement annuity, contact:
Retirement Customer Service
Call: 800-664-6129 Toll Free
Fax: 301-810-4889
Hours: 9:00-6:00 ET, Monday - Friday
3275 Bennett Creek Avenue
Frederick, Maryland 21704

We are in the business of maintaining long-term relationships, and we know there is no quicker way to lose trust than to misuse information.

Legal & General America Companies
This notice is provided by: Legal & General America, Banner Life Insurance Company, and William Penn Life Insurance Company of New York.

Legal & General AMERICA

Banner Life Insurance Company
3275 Bennett Creek Avenue
Frederick, Maryland 21704
(800) 638-8428

NOTICE AND CONSENT FOR BLOOD TESTING WHICH MAY INCLUDE AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING

To determine your insurability, the Insurer named above (the Insurer) has requested that you provide a sample of your blood for testing and analysis to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. The HIV antibody test that we perform is actually a series of tests done by a medically accepted procedure. The HIV antigen test directly identifies AIDS viral particles. These tests are extremely reliable. Other tests which may be performed include determinations of blood cholesterol and related lipids (fats) and screening for liver or kidney disorders, diabetes, and immune disorders.

Acquired Immunodeficiency Syndrome (AIDS) is a life-threatening disorder that damages the immune system which is caused by a virus, HIV. The virus is transmitted primarily by sexual contact with an infected person, from an infected mother to her newborn infant, or by exposure to infected blood or other body fluids (as in needle sharing during injection drug use), although there are other less common modes of transmission. AIDS may not develop until a person has been infected with HIV for several years, although the time it takes for someone infected with HIV to develop AIDS can vary in different people. A person may remain free of symptoms for years after becoming infected. Some people may experience flu-like symptoms within a month or two after being infected. During later stages of infection the immune system can weaken, and weight loss, night sweats, fatigue, enlarged lymph glands, and other symptoms can develop, and cancers, infectious diseases and many other illnesses may occur. Infected persons have a significant chance of developing AIDS. The most commonly used test for the HIV virus, the causative agent for AIDS, looks for antibodies, which are substances produced by the body in response to infection by the virus. There are also tests that can detect HIV protein and genetic material. These do not test for AIDS; AIDS can only be diagnosed by medical evaluation. If you test positive, you should consult with your personal physician, a public health clinic or an AIDS information organization to gain more information on the medical implications of a positive test result.

All tests results will be treated confidentially. They will be reported by the laboratory to the Insurer. When necessary for business reasons in connection with insurance you have or have applied for with the Insurer, the Insurer may disclose test results to others involved solely in the underwriting process such as reinsurers, employees, contractors, or affiliates, excluding agents and brokers. If the Insurer is a member of the Medical Information Bureau (MIB, Inc.), and if the test results for HIV antibodies/antigens are other than normal, the Insurer will report to the MIB, Inc. a generic code which signifies only a non-specific blood test abnormality. If your HIV test is normal, no report will be made about it to the MIB, Inc. Other test results may be reported to the MIB, Inc. in a more specific manner. The organizations described in this paragraph may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or as authorized by you.

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.

If your test results are negative, no routine notification will be sent to you. If your test results are reported by the laboratory to us as being other than normal, 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 results mean, you are asked to list your private physician so that we can have him or her tell you the test results and explain its meaning.

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

Address: _____

If you have not given a written consent authorizing a physician to receive positive test results, you will be urged, at the time you are informed of the positive test results, to contact a private physician, the County Department of Health, the State Department of Health, local medical societies or alternative test sites for appropriate counseling.

Positive HIV antibody/antigen test results do not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others.

Positive HIV antibody or antigen test results or other significant blood abnormalities 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.

I have read and I understand this Notice of Consent For Blood Testing Which May Include HIV Antibody/ Antigen Testing. I voluntarily consent to the withdrawal of blood from me by needle, the testing of that blood, and the disclosure of the test results as described above.

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.

Proposed Insured	Date of Birth

Signature of Proposed Insured or Parent/Guardian	Date	State of Residence

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.

California AIDS Counseling Facilities

AIDS Project - East Bay
1755 Broadway
2nd Floor
Oakland, CA 94612
(510) 457-4022

AIDS Project - Los Angeles
3550 Wilshire Boulevard
Suite 300
Los Angeles, CA 90010
(213) 201-1388

AIDS Service Foundation of Orange County
17982 Sky Park Circle
Suite J
Irvine, CA 92614
(949) 809-5700

ARIS Project
380 N. First Street
San Jose, CA 95112-4050
(408) 293-2747

San Diego AIDS Project
2440 Third Avenue
San Diego, CA 92101
(619) 235-6151

San Francisco AIDS Foundation
995 Market Street
Suite 200
San Francisco, CA 94103
(415) 487-3000

Cental Valley AIDS Team
P.O. Box 4640
Fresno, CA 93744
(209) 264-2437

Sacramento AIDS Foundation
P.O. Box 161418
Sacramento, CA 95816
(916) 448-2437

Legal & General AMERICA

Banner Life Insurance Company
3275 Bennett Creek Avenue
Frederick, Maryland 21704
(800) 638-8428

Accelerated Death Benefit Disclosure

Name of Proposed Insured _____ Policy Number _____

Receipt of accelerated death benefits may affect eligibility for Public Assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children and Supplemental Security Income (SSI). Receipt of accelerated death benefits may be taxable. Prior to applying for accelerated death benefits, policy owners should consult with a personal tax advisor and the appropriate social services agency. There is no additional premium or cost of insurance required for the Accelerated Death Benefit Rider; instead a lien is associated with the acceleration and an administrative charge, not to exceed $250, is required upon the exercise of the benefit. Review your Policy and the Accelerated Death Benefit Rider for complete limitations, terms, and conditions. The accelerated death benefit feature is subject to state variations; it may not be available in all states.

- We will pay an accelerated death benefit, at the Policy Owner's request, if the Policy Owner provides to us evidence that the Insured is living and has a medical condition that is reasonably expected to result in a life expectancy of twelve months or less.
- The maximum accelerated death benefit is the lesser of: (i) $500,000.00, or (ii) 75% of the policy's primary death benefit as of the date the company approves payment of the accelerated death benefit, less any outstanding loan balance. The accelerated death benefit will be paid in a lump sum.
- The requested accelerated death benefit amount, plus an administrative fee not to exceed $250, will create a lien against the policy. Interest on the amount of the Policy lien accrues daily and is added to the amount of the Policy lien. **The amount payable at the Insured's death is reduced by the amount of the Policy lien.**
- **Receipt of an accelerated death benefit will: 1) limit availability of partial and full cash surrender values and additional loans, 2) not affect future required premium payments or future cost of insurance rates and values, and 3) not affect the accumulation values, loan balance, or future loan interest charges.**
- **Continued premium payment is required to keep the Policy in force. Unpaid premiums will be added to the Policy lien. Prior to maturity, the Policy will not terminate unless the lien equals or exceeds the Policy's death benefit proceeds. Upon termination or maturity of the Policy, no further death benefits will be paid and available cash surrender values will be limited.**

The sample illustration assumes: (1) $500,000 death benefit; (2) $5,000 loan value. Owner requests maximum accelerated death benefit. The maximum accelerated death benefit equals .75 x $500,000, less outstanding policy loan ($5,000) = $370,000. Lien amount = $370,000 + $250 administrative fee = $370,250. This example is illustrative only and not intended to show actual values. Net Death Benefit = Death Benefit less Lien amount less any policy loan (if applicable). The Available Cash Surrender Value is the maximum available for full surrenders, partial surrenders, or loans.

	Immediately Before Acceleration	**Immediately After Acceleration Death Benefit Payment of $370,000**
Death Benefit (Gross)	$500,000	$500,000
Premium	$200 per month	$200 per month
Lien Amount	$0	$370,250
Policy Loan	$5,000	$5,000
Account Value	$32,000	$32,000
Cash Surrender Value	$30,000	$30,000
Available Cash Surrender Value	$25,000	$0
Net Death Benefit	$495,000	$124,750

Note: your policy may not provide for Cash Surrender Values and/or Loans. In such case, the maximum accelerated death benefit is the lesser of: i) 75% of the policy death benefit or ii) $500,000.

I acknowledge that I have received and read this Disclosure Statement and I understand that only the actual provisions of the Accelerated Death Benefit Rider will control payment of an accelerated death benefit.

_____ _____ _____ _____

Owner Signature Date Agent Signature Date

Legal & General AMERICA

Banner Life Insurance Company
3275 Bennett Creek Avenue
Frederick, Maryland 21704
(800) 638-8428

California Disclosure Notice to Persons Age 65 and Older

Note Instructions to Agent/Broker: Please insert the appropriate information below. This notice must be presented no less than 24 hours prior to initial meeting if meeting is to be held in Applicant/Prospective Owner/Insured's home. If other than initial meeting in Applicant/Prospective Owner/Insured's home and request for meeting in Applicant/Prospective Owner/Insured's home was initiated same day by Applicant/Prospective Owner/Insured, this notice must be delivered prior to meeting.

The following information is being presented to you in compliance with California Insurance Code Section 789.10:

This Notice confirms that I will be meeting with you at your home on _____, 20_____ at _____ a.m. / p.m. to talk about insurance, or to gather information for a follow up visit to sell insurance.

During this visit or follow up visit, you will be given a sales presentation on life insurance.

You have the right to have other persons present at the meeting, including family members, financial advisors or attorneys.

You have the right to end the meeting at any time.

You have the right to contact the Department of Insurance for information or to file a complaint. The Consumer Assistance telephone numbers are 800-927-HELP (4357).

The following individuals will be coming to your home with me (list all attendees and insurance license information, if applicable): _____
_____

Signature of Agent/Broker: _____ Date: _____

Print Name of Agent/Broker:_____

Name of Applicant/Prospective Owner/Insured: _____

Applicant/Prospective Owner/Insured Date of Birth: _____

Legal & General AMERICA

Banner Life Insurance Company
3275 Bennett Creek Avenue
Frederick, Maryland 21704
(800) 638-8428

California Applicant (65 Years or Older)
Verification of Disclosure Statements

I acknowledge and attest that I have been advised by the undersigned agent the following (initial all that apply):

1. _____ (Senior's Initials) **Advisement of Consequences in the Sale or Liquidation of Assets:** I have been advised by the undersigned Agent in writing that the sale or liquidation of any stock, bond, IRA, certificate of deposit, mutual fund, annuity, or other asset to fund the purchase of this life insurance product may have tax consequences, early withdrawal penalties or other costs or penalties as a result of the sale or liquidation. I have also been advised by the agent to consult independent legal or financial advice before selling or liquidating any assets, and prior to the purchase of any life insurance products being solicited, offered for sale, or sold.

2. _____ (Senior's Initials) **At home pre-solicitation notice:** If the sale of these life insurance products were conducted in my home, I received, no less than 24 hours prior to the agent's visit, or if I have an existing insurance relationship with the agent and requested the meeting the same day, just prior to the meeting, I received, written notice informing me of the pertinent details surrounding the products I was going to be presented, my rights to have others present at the presentation, my rights to contact the Department of Insurance for information or to file a complaint, and the names, title and insurance license information of all individuals coming to my home.

Signature of Proposed Insured _____ Date:_____

Print Name: _____ Date of Birth:_____

I attest that I have advised and provided the above-signed proposed insured (applicant) the above notices as written.

Signed _____ Date: _____

Print Agent Name: _____

Please make copies for relevant parties as appropriate.

Legal & General AMERICA
Banner Life Insurance Company
3275 Bennett Creek Avenue
Frederick, Maryland 21704
(800) 638-8428

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

THIS AUTHORIZATION COMPLIES WITH THE HIPAA PRIVACY RULE

Print Name of Proposed Insured / Patient

Date of Birth ____/____/____

Print Name of Person or Organization Providing Information

AUTHORIZATION

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, Pharmacy Benefit Manager, treatment facility, insurer, insurance support organization, service provider, Kaiser Permanente, financial institution, consumer credit reporting agency, certified public accountants and tax preparers, educational institution, Federal, State, or Local Governmental Agency, including the Social Security Administration, Veterans Administration, or Workers Compensation Board, an authorized medical officer of a United States Government facility, law enforcement agencies, state and local tax agencies, 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, or other personal, private, or privileged information concerning me for the past 10 years to **Banner Life Insurance Company**, its agents, employees, vendors or representatives. Any and all records and information regarding diagnosis, testing, treatment, and prognosis of my physical or mental condition are to be released. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases; genetic information and genetic testing results. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco.

My 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.**

I understand and acknowledge that any agreements I have made to restrict My Information, including protected health information, do not apply to this Authorization and I instruct any physician, health care professional, hospital, clinic, medical facility or other health care provider, or other entity to release and disclose My Information, including 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 refuse to sign or to revoke this authorization in writing, at any time, by sending a written request for revocation to the Company at 3275 Bennett Creek Avenue, Frederick, Maryland 21704, Attention: Privacy Official. I understand that a revocation is not effective if any of My Providers have relied on this authorization or to the extent that the Company has taken action in reliance on this Authorization or 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 if I refuse to sign, alter, or revoke this Authorization the Company may not be able to process my application and it may be a basis for denying my request for coverage, 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.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization.

Signature of Proposed Insured / Patient

Date (required)

Social Security Number of Proposed Insured

Agent or Witness Signature

Legal & General AMERICA

Banner Life Insurance Company
3275 Bennett Creek Avenue
Frederick, Maryland 21704
(800) 638-8428

NOTICE REGARDING REPLACEMENT

REPLACING YOUR LIFE INSURANCE POLICY OR ANNUITY?

Are you thinking about buying a new life insurance policy or an annuity and discontinuing or changing an existing one? If you are, your decision could be a good one - or a mistake. You will not know for sure unless you make a careful comparison of your existing benefits and the proposed benefits.

Make sure you understand the facts. You should ask the company or agent that sold you your existing policy to give you information about it.

Hear both sides before you decide. This way you can be sure you are making a decision that is in your best interest.

We are required by law to notify your existing company that you may be replacing their policy.

The following coverage may be replaced as a result of this transaction:

Insurer as it appears on the policy	Insured as it appears on the policy	Policy number or alternate identification

Applicant's Name (printed) _____ Agent's Name (printed) _____

Applicant's Signature _____ Agent's Signature _____

Date _____ Agent's License Number _____

Please make copies for relevant parties as appropriate.

Legal & General AMERICA

Banner Life Insurance Company
3275 Bennett Creek Avenue
Frederick, Maryland 21704
(800) 638-8428

ELECTRONIC FUNDS TRANSFER PAYMENT OPTIONS

Policy Owner Name_____ Policy Number _____
(leave blank if policy number not yet assigned)

Proposed Insured's Name_____ Date of Birth _____

Authorization

Banner Life will draft the checking account designated on this form for subsequent premiums only (unless initial premium payment is authorized by checking the box below) once the policy has been approved for issue, subject to the terms below.

☐ **Check here to authorize Banner Life to draft my checking account for the initial premium payment and subsequent premium payments subject to the terms of the life insurance contract.**

I understand and agree that this authorization is subject to the following conditions:

- This authorization shall remain in effect until revoked in writing by me or the Company.
- Signing this authorization does NOT mean that coverage is effective; coverage is effective only as stated in the application or Temporary Insurance Agreement, if issued.
- Completion of this form will satisfy the requirement for payment of an amount applied for as required by the Temporary Insurance Application and Agreement.
- Use of the selected payment method does not alter any provisions of any policy issued by Banner Life.
- Banner Life will process the selected payment only when one of the following events occur: 1) Banner Life has approved the policy for issue and there are no documents requiring the owner's and/or insured's signature; or 2) the policy has been accepted and Banner Life has received all of the necessary documents requiring the signature of the owner/insured.
- If necessary, refunds of initial premium will be refunded by Company check.
- If the payment method selected is not honored upon presentation, no coverage will be in effect and Banner Life will terminate any further attempt to use this payment method.

Temporary Insurance is limited to the lesser of: (1) the amount of insurance applied for in the Application or (2) $1,000,000 minus the amount of insurance on the Proposed Insured's life with the Insurer under any other applications for insurance now pending or other temporary insurance agreements.

Bank Account Information for Draft from Checking Accounts (Checking Accounts Only)

PLEASE ATTACH A VOID CHECK

Name of Financial Institution _____

ABA Routing Number _ _ _ _ _ _ _ _ _
(routing number typically located on bottom left of check)

Account Number _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _
(must include dashes and spaces as they appear in your account number)

Please indicate your payment frequency for your premium withdrawals.
(If no selection is made, withdrawals will be made monthly)

☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually

X _____ _____
Bank Account Owner Signature (Must be Payor, Owner or Proposed Insured as identified on application) Date

X _____ _____
Policy Owner Signature (If other than Bank Account Owner) Date

Legal & General AMERICA

Banner Life Insurance Company
3275 Bennett Creek Avenue
Frederick, Maryland 21704
(800) 638-8428

TRUST CERTIFICATION

Section 1 Purpose of this Form

This form is used for situations where a Trust is the owner or the beneficiary of the life insurance policy issued by our Company. The Trustee(s) should complete and execute this form.

Section 2 General Information

Proposed Insured name _____

Name of Trust _____

State where created _____ Date Trust created _____ Tax ID # _____

- If a living Trust, then the Tax ID may be the same as the grantor's SSN.

Section 3 Type of Trust (check all boxes that apply)

Trust is:

☐ Revocable Trust
☐ Irrevocable Trust
☐ Testamentary Trust under the last will and testament of _____
Date of death _____ Date will was executed _____

AND

Trust is:

☐ Family Trust
☐ Insurance Trust
☐ Trusteed Buy/Sell
☐ Employer Sponsored Trust
☐ Charity Trust
☐ Other type of Trust _____

Section 4 Grantor(s)

Identification information of the Grantor/Settlor(s) who established the Trust:

Name _____

Address _____ City, State, Zip _____

Name _____

Address _____ City, State, Zip _____

Section 5 Beneficiary(ies)

Names and relationships of the beneficiaries of the Trust:

Name _____ Relationship to Proposed Insured/Insured _____

Name _____ Relationship to Proposed Insured/Insured _____

Name _____ Relationship to Proposed Insured/Insured _____

Section 6 Trustee(s)

For multiple Trustees ONLY, please print the names of all Trustees and check one of the following boxes (if no box is checked, the Company will require all signatures on all policy requests).

☐ A majority may act for all
☐ Anyone may act alone
☐ All must act unanimously
☐ Certain trustees must act jointly (print names below)

Trustee #1 _____ Trustee #2 _____ Trustee #3 _____

Note: If the Insurance Producer is a Trustee, please provide the reason and relationship of that individual to the insured.

☐ Immediate family member or
☐ Other _____

Reason _____

I the undersigned Trustee(s) do hereby certify and affirm the following:

1. All information provided on this Certification is accurate and complete.
2. The named trust is currently in effect and has not been revoked, modified or amended in any manner that would cause the representations in this Certification to be incorrect.
3. I/We acknowledge and agree that the Company is relying exclusively on the representations in this Certification and not upon a review of the trust document, even if the trust document has been or is later provided. The Company is permitted to rely upon the representations in this Certification, unless or until notice of any change, amendment, or revocation is provided in writing and delivered to the Company.
4. I/We are duly authorized to act as trustee(s) under the terms of the trust provision and /or applicable law. I/We have the power to exercise all rights associated with ownership of a life insurance policy, including, but not limited to, purchase, surrender, selection of and transfers between variable funding options, withdrawal of funds, taking a loan or other encumberment and assigning the policy.
5. Beneficial interests under the Trust can and will only be established for persons who: (i) are related to the Proposed Insured(s) by blood or by law; (ii) have a substantial interest in the life of the Proposed Insured(s) engendered by love and affection; or (iii) hold a lawful and substantial economic interest in the continued life of the Proposed Insured(s).
6. If licensed to sell life insurance for the Company the undersigned trustee has reviewed and has abided by the Company's guidelines on producers acting as trustees.
7. Each of the undersigned, jointly and severally, individually, and as trustee, indemnifies the Company and agrees to hold the Company harmless against all obligations, demands, losses or liabilities (including attorney's fees) that the Company incurred, suffered, or paid or may incur, suffer or pay in the future because of the Company's reliance on this Certification and/or transactions or actions by the undersigned. By indemnifying the Company, each of the undersigned, jointly and severally, individually, and as trustee, indemnifies the Company's agents, officers, employees. This indemnification shall survive termination of this document or the life insurance policy.
8. I/We understand that neither the Company nor its agents are responsible for the estate planning and tax implications of this sale, that they may not give legal or tax advice and that the Company's acceptance of this Certification is not an endorsement of the named trust. I/we have the opportunity to consult with an independent attorney and /or tax advisor, to the extent necessary, before executing this Certification.
9. I/We agree to inform the Company in writing of any trust amendments, changes of trustee(s), or other facts and events that would affect or alter this Certification.
10. For life insurance policy/policies being applied for, the Proposed insured has been informed or is otherwise aware that a policy is being purchased on his/her life.
11. The Trustee(s) may be named as policy owner(s) and have the power to exercise all rights of ownership of a life insurance policy, including, but not limited to, the right to surrender the policy(ies), take a loan or withdrawal, or make changes in the allocation of any invested premium amounts.
12. The Trustee(s) may purchase life insurance in the state in which it is applied for and delivered in, apply for the policy, and invest trust funds in the policy(ies).

Signatures

Print name of Trustee #1 _____

Address _____

Signature _____ Date _____

Print name of Trustee #2 _____

Address _____

Signature _____ Date _____

Print name of Trustee #3 _____

Address _____

Signature _____ Date _____

Note: If more than three Trustees please provide the Trustee names, addresses, signatures, and dates on an additional sheet of paper and attach that paper to this form.