

SERFF Tracking Number: BANN-126383065 State: Arkansas  
Filing Company: Banner Life Insurance Company State Tracking Number: 44100  
Company Tracking Number:  
TOI: L04I Individual Life - Term Sub-TOI: L04I.003 Single Life - Single Premium  
Product Name: Renewable & Convertible Term Life Insurance  
Project Name/Number: 20 and 30 Year Increasing Premium Term - Value Term/RT-97 IPT2 & RT-97 IPT3

## Filing at a Glance

Company: Banner Life Insurance Company

Product Name: Renewable & Convertible Term SERFF Tr Num: BANN-126383065 State: Arkansas

Life Insurance

TOI: L04I Individual Life - Term

SERFF Status: Closed-Approved-  
Closed State Tr Num: 44100

Sub-TOI: L04I.003 Single Life - Single Premium Co Tr Num:

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Linda Bird

Author: Ada Miller

Disposition Date: 11/18/2009

Date Submitted: 11/13/2009

Disposition Status: Approved-  
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: 20 and 30 Year Increasing Premium Term - Value Term

Status of Filing in Domicile: Pending

Project Number: RT-97 IPT2 & RT-97 IPT3

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments: Maryland, our state  
of domicile, is part of the Interstate Compact.

The filing is currently being reviewed.

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 11/18/2009

Explanation for Other Group Market Type:

State Status Changed: 11/18/2009

Deemer Date:

Created By: Ada Miller

Submitted By: Ada Miller

Corresponding Filing Tracking Number:

Filing Description:

We are submitting an informational filing on Policy Schedule Page variations of our existing RT-97 forms. Each product has increasing premiums; however, the 20 year product has premiums that are subject to change after 20 years and the 30 year product has premiums subject to change after 30 years. We have revised Policy Schedule Page 3 and 3a to reflect the availability of this increasing premium term. This only affects the Policy Schedule Page and not the policy form itself. Enclosed are sample copies of the revised policy schedule pages for each term level. An Actuarial Memorandum for the Increasing Premium Term variations is also enclosed.

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To the best of our knowledge, information, and belief, this form complies with the rules and regulations of your department. Thank you for your further consideration and approval of this form.

## Company and Contact

### Filing Contact Information

Nancy January, Vice President, Product Development  
 1701 Research Boulevard  
 Rockville, MD 20850  
 njanuary@lgamerica.com  
 301-279-4868 [Phone]  
 301-294-6964 [FAX]

### Filing Company Information

Banner Life Insurance Company  
 1701 Research Boulevard  
 Rockville, MD 20850  
 (301) 279-4809 ext. [Phone]  
 CoCode: 94250  
 Group Code: 872  
 Group Name:  
 FEIN Number: 52-1236145  
 State of Domicile: Maryland  
 Company Type: Life Insurance  
 State ID Number:

## Filing Fees

Fee Required? Yes  
 Fee Amount: \$250.00  
 Retaliatory? Yes  
 Fee Explanation: 2 forms x \$125  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Banner Life Insurance Company	\$250.00	11/13/2009	32021165

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	11/18/2009	11/18/2009

*SERFF Tracking Number:*      *BANN-126383065*                      *State:*                      *Arkansas*  
*Filing Company:*              *Banner Life Insurance Company*                      *State Tracking Number:*      *44100*  
*Company Tracking Number:*  
*TOI:*                      *L04I Individual Life - Term*                      *Sub-TOI:*                      *L04I.003 Single Life - Single Premium*  
*Product Name:*              *Renewable & Convertible Term Life Insurance*  
*Project Name/Number:*      *20 and 30 Year Increasing Premium Term - Value Term/RT-97 IPT2 & RT-97 IPT3*

## **Disposition**

Disposition Date: 11/18/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		No
Supporting Document	Application		Yes
Supporting Document	Life & Annuity - Acturial Memo		No
Supporting Document	RT-97		Yes
Form	Policy Schedule		Yes
Form	Policy Schedule		Yes

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## Form Schedule

### Lead Form Number: RT-97

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	RT-97 IPT2	Policy/Cont	Policy Schedule ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial			RT-97 IPT2.pdf
	RT-97 IPT3	Policy/Cont	Policy Schedule ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial			RT-97 IPT3.pdf

POLICY SCHEDULE

<u>FORM NUMBER</u>	<u>TYPE OF COVERAGE</u>	<u>EXPIRATION DATE</u>	<u>FACE AMOUNT</u>	<u>*ANNUAL PREMIUM</u>	<u>RATING CLASSIFICATION</u>
RT-97 IPT2	RENEWABLE AND CONVERTIBLE TERM	8/01/2057	\$250,000	\$125.00	PREFERRED PLUS NON-TOBACCO

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MAXIMUM ANNUAL PREMIUM:

YEAR 1 : \$125.00  
YEARS 2 + : SEE SCHEDULE PAGE 3A

\*PREMIUMS MAY BE CHANGED AS PROVIDED IN THE CHANGE OF PREMIUM PROVISION, BUT THE ANNUAL PREMIUM WILL NOT EXCEED THE MAXIMUM ANNUAL PREMIUM SHOWN.

PREMIUM MODE: ANNUAL  
PREMIUM DUE DATE: 10/01

*PREMIUM MODES AVAILABLE:	ANNUAL	SEMI-ANNUAL	QUARTERLY	PAC
	\$125.00	\$63.75	\$32.50	\$10.94

END OF CONVERSION PERIOD: 09/30/2028

END OF EXCHANGE PERIOD: 09/30/2028

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INSURED:	JOHN DOE	TERM PERIOD:	ONE YEAR
ISSUE AGE & SEX:	35 MALE	ISSUE DATE:	10/01/2009
OWNER:	JOHN DOE	POLICY DATE:	10/01/2009
		POLICY NUMBER:	01000000

POLICY SCHEDULE (CONTINUED)

<u>YEAR</u>	<u>MAXIMUM ANNUAL RENEWAL PREMIUM</u>	<u>YEAR</u>	<u>MAXIMUM ANNUAL RENEWAL PREMIUM</u>
1	\$125.00	31	\$9,310.00
2	\$130.00	32	\$10,595.00
3	\$135.00	33	\$12,025.00
4	\$140.00	34	\$13,602.00
5	\$145.00	35	\$15,755.00
6	\$150.00	36	\$17,812.50
7	\$155.00	37	\$20,492.50
8	\$162.50	38	\$22,940.00
9	\$167.50	39	\$26,157.50
10	\$175.00	40	\$29,832.50
11	\$182.50	41	\$33,875.50
12	\$190.00	42	\$38,287.50
13	\$200.00	43	\$43,050.00
14	\$210.00	44	\$48,127.50
15	\$220.00	45	\$53,640.00
16	\$230.00	46	\$59,780.00
17	\$242.50	47	\$66,702.50
18	\$257.50	48	\$74,610.00
19	\$272.50	49	\$83,622.50
20	\$290.00	50	\$93,640.00
21	\$2,997.50	51	\$104,505.00
22	\$3,302.50	52	\$116,060.00
23	\$3,625.00	53	\$128,237.50
24	\$3,972.50	54	\$140,847.50
25	\$4,367.50	55	\$154,032.50
26	\$4,805.00	56	\$167,960.00
27	\$5,467.50	57	\$182,840.00
28	\$6,232.50	58	\$199,105.00
29	\$7,122.50	59	\$217,370.00
30	\$8,147.50	60	\$240,280.00

POLICY SCHEDULE

<u>FORM NUMBER</u>	<u>TYPE OF COVERAGE</u>	<u>EXPIRATION DATE</u>	<u>FACE AMOUNT</u>	<u>*ANNUAL PREMIUM</u>	<u>RATING CLASSIFICATION</u>
RT-97 IPT3	RENEWABLE AND CONVERTIBLE TERM	8/01/2057	\$250,000	\$140.00	PREFERRED PLUS NON-TOBACCO

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MAXIMUM ANNUAL PREMIUM:

YEAR 1 : \$140.00  
YEARS 2 + : SEE SCHEDULE PAGE 3A

\*PREMIUMS MAY BE CHANGED AS PROVIDED IN THE CHANGE OF PREMIUM PROVISION, BUT THE ANNUAL PREMIUM WILL NOT EXCEED THE MAXIMUM ANNUAL PREMIUM SHOWN.

PREMIUM MODE: ANNUAL  
PREMIUM DUE DATE: 10/01

*PREMIUM MODES AVAILABLE:	ANNUAL	SEMI-ANNUAL	QUARTERLY	PAC
	\$140.00	\$71.40	\$36.40	\$12.25

END OF CONVERSION PERIOD: 09/30/2038

END OF EXCHANGE PERIOD: 09/30/2038

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INSURED:	JOHN DOE	TERM PERIOD:	ONE YEAR
ISSUE AGE & SEX:	35 MALE	ISSUE DATE:	10/01/2009
OWNER:	JOHN DOE	POLICY DATE:	10/01/2009
		POLICY NUMBER:	01000000

POLICY SCHEDULE (CONTINUED)

<u>YEAR</u>	<u>MAXIMUM ANNUAL RENEWAL PREMIUM</u>	<u>YEAR</u>	<u>MAXIMUM ANNUAL RENEWAL PREMIUM</u>
1	\$140.00	31	\$9,310.00
2	\$150.00	32	\$10,595.00
3	\$157.50	33	\$12,025.00
4	\$167.50	34	\$13,602.00
5	\$177.50	35	\$15,755.00
6	\$187.50	36	\$17,812.50
7	\$197.50	37	\$20,492.50
8	\$210.00	38	\$22,940.00
9	\$222.50	39	\$26,157.50
10	\$237.50	40	\$29,832.50
11	\$252.50	41	\$33,875.50
12	\$270.00	42	\$38,287.50
13	\$287.50	43	\$43,050.00
14	\$307.50	44	\$48,127.50
15	\$330.00	45	\$53,640.00
16	\$355.00	46	\$59,780.00
17	\$375.00	47	\$66,702.50
18	\$397.50	48	\$74,610.00
19	\$417.50	49	\$83,622.50
20	\$437.50	50	\$93,640.00
21	\$455.00	51	\$104,505.00
22	\$475.00	52	\$116,060.00
23	\$495.00	53	\$128,237.50
24	\$520.00	54	\$140,847.50
25	\$552.50	55	\$154,032.50
26	\$587.50	56	\$167,960.00
27	\$630.00	57	\$182,840.00
28	\$675.00	58	\$199,105.00
29	\$725.00	59	\$217,370.00
30	\$777.50	60	\$240,280.00

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## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b> Flesch Certification		
<b>Bypass Reason:</b> not applicable for policy schedule pages		
<b>Comments:</b>		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Application		
<b>Comments:</b> Application form approved by your department on 10/17/08		
<b>Attachments:</b> LIA (10-08).pdf LU-1267 (10-08).pdf AR LIA Approval.pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> RT-97		
<b>Comments:</b> base policy form attached		
<b>Attachment:</b> RT-97.pdf		

Internet address: [www.bannerlife.com](http://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.

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, 1701 Research Boulevard, Rockville, MD 20850-3191.

**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)**

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**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](http://www.mib.com).

<b>SECTION A PROPOSED INSURED</b>			
1. Full Name (Include maiden name in parentheses) _____	2. Sex <input type="checkbox"/> M <input type="checkbox"/> F	3. Date of Birth Month _____ Day _____ Year _____	4. Social Security Number _____
5. a. Home Address Street _____ City, State _____ Zip _____			5. b. How Long _____
6. Phone Numbers Home (    ) _____ Work (    ) _____	7. State/Country of Birth _____	8. U.S. Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No Visa Type _____ If No, Date of Entry into U.S. _____ Country of Citizenship _____	
9. Marital Status <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> W <input type="checkbox"/> D	10. Driver's License Number and State of Issue or State ID Number _____		
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? <input type="checkbox"/> Yes - give details below <input type="checkbox"/> No			
Product	Date last used (month/year)	Amount / Frequency	
Cigarettes	_____	_____	
Cigars	_____	_____	
Other	_____	_____	
<b>SECTION B BENEFICIARY</b> (Share percentage totals must equal 100%. If necessary, use Remarks section, Question 48. If Beneficiary is a trust, check box <input type="checkbox"/> 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 _____	_____	
<b>SECTION C OWNER</b>			
18. Owner is <input type="checkbox"/> Proposed Insured <input type="checkbox"/> Trust (also complete Section D) <input type="checkbox"/> 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 _____		
<b>SECTION D TRUST INFORMATION</b> (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?		Issue Date	Replacing?		Beneficiary
			Yes	No		Yes	No	
			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	

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.)

Yes No

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)**

<b>SECTION H GENERAL QUESTIONS</b> (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?		<input type="checkbox"/>	<input type="checkbox"/>
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?		<input type="checkbox"/>	<input type="checkbox"/>
36. Has any party to the application ever received inducement, fee or compensation as an incentive to purchase, sell, transfer or assign a policy?		<input type="checkbox"/>	<input type="checkbox"/>
37. In the past 5 years, have you requested or received a Worker's Compensation, Social Security, or disability income payment?		<input type="checkbox"/>	<input type="checkbox"/>
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?		<input type="checkbox"/>	<input type="checkbox"/>
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?		<input type="checkbox"/>	<input type="checkbox"/>
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.)		<input type="checkbox"/>	<input type="checkbox"/>
41. Are you a member, or do you intend to become a member, of the armed forces, including the reserves?		<input type="checkbox"/>	<input type="checkbox"/>
<b>SECTION I OTHER ACTIVITIES</b>		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.)		<input type="checkbox"/>	<input type="checkbox"/>
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.)		<input type="checkbox"/>	<input type="checkbox"/>
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.)		<input type="checkbox"/>	<input type="checkbox"/>
<b>SECTION J PROPOSED INSURED FINANCIAL INFORMATION</b>			
<b>Complete this section when applying for face amount over \$1,000,000 or when the Proposed Insured is over age 65:</b>			
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?		<input type="checkbox"/>	<input type="checkbox"/>
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.)	\$ _____		
c. Is the Proposed Insured self-supporting?		<input type="checkbox"/>	<input type="checkbox"/>
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? \_\_\_\_\_

h. Are other partners/owners/executives being insured? (If Yes, use Remarks section, Question 48.)

Yes No

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.**



**FRAUD WARNINGS**

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**Arkansas, Kentucky, Louisiana, New Mexico, and Ohio**

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.

**Colorado**

It is unlawful to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding or attempting to defraud. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or insurance agent who knowingly provides false, incomplete or misleading information for the purpose of defrauding or attempting to defraud a policy holder or claimant with regard to a settlement shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**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.

**Georgia, Nebraska, South Carolina, Texas**

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statements may be guilty of insurance fraud.

**Washington, D.C., Maine, Virginia, Tennessee, and Washington**

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or denial of insurance benefits.

**Maryland**

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**New Jersey**

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

**Oklahoma**

Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**Pennsylvania**

Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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 \_\_\_\_\_

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. ....  Yes  No

**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.

**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? .....  Yes  No
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? .....  Yes  No
9. A disorder of your blood or immune system including anemia, blood clots, bleeding, immune deficiency, leukemia, or lymphoma (excluding HIV)? .....  Yes  No

**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?.....	<input type="checkbox"/>	<input type="checkbox"/>	
11. Diabetes or high blood sugar or any other disease or disorder of the pituitary, thyroid, or endocrine glands? .....	<input type="checkbox"/>	<input type="checkbox"/>	
12. Albumin, protein, blood or sugar in the urine or any other disease or disorder of the kidney or bladder? .....	<input type="checkbox"/>	<input type="checkbox"/>	
13. Cyst, polyp, lump, or other growth, or any disease or disorder of the skin or lymph nodes? .....	<input type="checkbox"/>	<input type="checkbox"/>	
14. Any disease or disorder of the uterus, cervix, ovaries, or breasts?.....	<input type="checkbox"/>	<input type="checkbox"/>	
15. Any disease or disorder of the prostate or reproductive system? .....	<input type="checkbox"/>	<input type="checkbox"/>	
16. Any sexually transmitted disorders or diseases?.....	<input type="checkbox"/>	<input type="checkbox"/>	
17. Pregnancy, complications of pregnancy or infertility? .....	<input type="checkbox"/>	<input type="checkbox"/>	
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? .....	<input type="checkbox"/>	<input type="checkbox"/>	
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)? .....	<input type="checkbox"/>	<input type="checkbox"/>	
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?.....	<input type="checkbox"/>	<input type="checkbox"/>	
21. Arthritis or disorder of the bones, skin or muscles?.....	<input type="checkbox"/>	<input type="checkbox"/>	
22. Any disease or disorder of the eyes, ears, nose or throat?.....	<input type="checkbox"/>	<input type="checkbox"/>	
23. In the <b>last 5 years</b> , unless previously stated on this application, have you:			
a. Been treated by a member of the medical profession or at a medical facility? .....	<input type="checkbox"/>	<input type="checkbox"/>	
b. Had an electrocardiogram, x-ray, blood test, or other diagnostic test, excluding an HIV test? .....	<input type="checkbox"/>	<input type="checkbox"/>	
c. Had surgery or biopsy, or been an inpatient or outpatient in a hospital, clinic, or other medical or mental health facility? .....	<input type="checkbox"/>	<input type="checkbox"/>	
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?.....	<input type="checkbox"/>	<input type="checkbox"/>	
e. Been referred to any other member of the medical profession or medical facility? .....	<input type="checkbox"/>	<input type="checkbox"/>	
f. Been unable to work, attend school or perform the normal activities of like age and gender, or been confined at home? .....	<input type="checkbox"/>	<input type="checkbox"/>	
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? .....	<input type="checkbox"/>	<input type="checkbox"/>	
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.	<input type="checkbox"/>	<input type="checkbox"/>	
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? .....	<input type="checkbox"/>	<input type="checkbox"/>	
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. _____	<input type="checkbox"/>	<input type="checkbox"/>	
27. Have you taken any other medications in the <b>past 2 years</b> ?..... If Yes, list in Remarks section at right.	<input type="checkbox"/>	<input type="checkbox"/>	
28. Have you tested positive for exposure to the HIV infection or been diagnosed as having ARC (AIDS-Related Complex) or AIDS (Auto Immune Deficiency Syndrome) caused by HIV infection or other sickness or condition derived from such infection?.....	<input type="checkbox"/>	<input type="checkbox"/>	
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. _____	<input type="checkbox"/>	<input type="checkbox"/>	
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.

\_\_\_\_\_  
 Signature of Proposed Insured

Signed at \_\_\_\_\_ on \_\_\_\_/\_\_\_\_/\_\_\_\_  
 City/State Date

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.**

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**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?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 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?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? .....  | <input type="checkbox"/> | <input type="checkbox"/> |

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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.

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**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

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?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 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?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? .....  | <input type="checkbox"/> | <input type="checkbox"/> |

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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 \_\_\_\_\_
- 4. Was the application signed after all questions were answered?.....  Yes  No
- 5. Did you personally see the Proposed Insured? .....  Yes  No
- 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? .....  Yes  No
- 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.  Yes  No
- 8. Did you provide the client with the Temporary Life Insurance Application and Agreement (TIAA) form?.....  Yes  No
- 9. Premium Class Quoted \_\_\_\_\_
- 10. Are there any personal or business companion applications?.....  Yes  No  
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? .....  Yes  No  
b. If Yes, has the Proposed Insured replaced other life insurance policies in the past 2 years? .....  Yes  No
- 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? .....  Yes  No
- 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? .....  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.

**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.

\_\_\_\_\_  
Signature of Licensed Insurance Agent Date

Phone No. ( ) \_\_\_\_\_

\_\_\_\_\_  
Print Name of Above Signature

Agent # \_\_\_\_\_ SSN \_\_\_\_\_

\_\_\_\_\_  
Print Name of Agency, if different from above

Share of commission \_\_\_\_\_

\_\_\_\_\_  
Signature of Additional Licensed Insurance Agent Date

Phone No. ( ) \_\_\_\_\_

\_\_\_\_\_  
Print Name for Above Additional Signature

Agent # \_\_\_\_\_ SSN \_\_\_\_\_

\_\_\_\_\_  
Print Name of Additional Agency, if different from above

Share of commission \_\_\_\_\_

**GENERAL AGENT INFORMATION**

GA name \_\_\_\_\_ GA # \_\_\_\_\_ Case Manager \_\_\_\_\_

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 \_\_\_\_\_

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 or Huntington's Disease, Sickle Cell Disease or Familial Adenomatous Polyposis (FAP)? If Yes, give details in the Family History chart below. Yes No

**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?.....	<input type="checkbox"/>	<input type="checkbox"/>	
11. Diabetes or high blood sugar or any other disease or disorder of the pituitary, thyroid, or endocrine glands? .....	<input type="checkbox"/>	<input type="checkbox"/>	
12. Albumin, protein, blood or sugar in the urine or any other disease or disorder of the kidney or bladder? .....	<input type="checkbox"/>	<input type="checkbox"/>	
13. Cyst, polyp, lump, or other growth, or any disease or disorder of the skin or lymph nodes? .....	<input type="checkbox"/>	<input type="checkbox"/>	
14. Any disease or disorder of the uterus, cervix, ovaries, or breasts?.....	<input type="checkbox"/>	<input type="checkbox"/>	
15. Any disease or disorder of the prostate or reproductive system? .....	<input type="checkbox"/>	<input type="checkbox"/>	
16. Any sexually transmitted disorders or diseases?.....	<input type="checkbox"/>	<input type="checkbox"/>	
17. Pregnancy, complications of pregnancy or infertility? .....	<input type="checkbox"/>	<input type="checkbox"/>	
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? .....	<input type="checkbox"/>	<input type="checkbox"/>	
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)?.....	<input type="checkbox"/>	<input type="checkbox"/>	
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?.....	<input type="checkbox"/>	<input type="checkbox"/>	
21. Arthritis or disorder of the bones, skin or muscles?.....	<input type="checkbox"/>	<input type="checkbox"/>	
22. Any disease or disorder of the eyes, ears, nose or throat?.....	<input type="checkbox"/>	<input type="checkbox"/>	
23. In the <b>last 5 years</b> , unless previously stated on this application, have you:			
a. Been treated by a member of the medical profession or at a medical facility? ....	<input type="checkbox"/>	<input type="checkbox"/>	
b. Had an electrocardiogram, x-ray, blood test, or other diagnostic test, excluding an HIV test? .....	<input type="checkbox"/>	<input type="checkbox"/>	
c. Had surgery or biopsy, or been an inpatient or outpatient in a hospital, clinic, or other medical or mental health facility? .....	<input type="checkbox"/>	<input type="checkbox"/>	
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?.....	<input type="checkbox"/>	<input type="checkbox"/>	
e. Been referred to any other member of the medical profession or medical facility? .....	<input type="checkbox"/>	<input type="checkbox"/>	
f. Been unable to work, attend school or perform the normal activities of like age and gender, or been confined at home? .....	<input type="checkbox"/>	<input type="checkbox"/>	
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? .....	<input type="checkbox"/>	<input type="checkbox"/>	
If Yes, please provide dates of use: From _____ To _____			
Name of drug used: _____			
Amount and frequency of use: _____			



Name of Proposed Insured \_\_\_\_\_ Date of Birth \_\_\_\_\_

**Instructions to the Examiner -**

This examination, once begun, is the property of the Company, and must not be destroyed or suppressed. Please weigh and measure this applicant. Explain all positive findings under Remarks.

The questions which appear below are intended only as a basis for the examination. The Company relies on its examiners to observe and report all information bearing on the acceptance of a proposed insured, even though not specifically requested on this form.

Please mail blood and urine specimens promptly.

1. Height (in shoes) \_\_\_\_\_ ft. \_\_\_\_\_ in.  
 Weight (clothed) \_\_\_\_\_ lbs.
- a. Did you weigh? Yes  No   
 b. Did you measure? Yes  No   
 If No, please explain \_\_\_\_\_  
 \_\_\_\_\_

3. Blood Pressure (record 3 readings)

Systolic	_____	_____	_____
Diastolic	_____	_____	_____

2. Measurements (males only)
- Chest (full inspiration) \_\_\_\_\_ in.  
 Chest (forced expiration) \_\_\_\_\_ in.  
 Abdomen (at umbilicus) \_\_\_\_\_ in.

4. Pulse At rest \_\_\_\_\_  
 Describe any irregularities (number per minute, etc.)  
 \_\_\_\_\_  
 \_\_\_\_\_

5. Are blood and urine specimens being collected and mailed to the lab? Yes  No

**IF EXAMINATION IS DONE BY A PHYSICIAN, ANSWER SECTIONS 6 AND 7. OTHERWISE GO DIRECTLY TO SECTION 8.**

6. After physical examination and inquiry, do you find any abnormality of the following:

	Yes	No	Remarks
a. Eyes, ears, nose, mouth, pharynx? .....	<input type="checkbox"/>	<input type="checkbox"/>	
b. Skin (including scars), thyroid, lymph nodes, veins, peripheral arteries? .....	<input type="checkbox"/>	<input type="checkbox"/>	
c. Brain, nervous system (including reflexes, gait, speech, coordination, paralysis)? .....	<input type="checkbox"/>	<input type="checkbox"/>	
d. Respiratory system? .....	<input type="checkbox"/>	<input type="checkbox"/>	
e. Stomach, abdominal organs? .....	<input type="checkbox"/>	<input type="checkbox"/>	
f. Is the liver enlarged or tender? .....	<input type="checkbox"/>	<input type="checkbox"/>	
g. Genitourinary system? .....	<input type="checkbox"/>	<input type="checkbox"/>	
h. Musculoskeletal system (including spine, joints, amputations and deformities)? .....	<input type="checkbox"/>	<input type="checkbox"/>	
i. Heart or blood vessels? (If there is a history of rheumatic fever, heart murmur, or if you find any abnormality in heart size, rhythm, or sounds, complete question 7.) .....	<input type="checkbox"/>	<input type="checkbox"/>	

Name of Proposed Insured \_\_\_\_\_

**PART 3 - Medical Examiner's Report (continued)**

	Yes	No	Remarks
7. To be completed if number 6.i. is answered Yes or if requested:			
a. Is there evidence of cardiac enlargement, or abnormal location of the apical impulse (PMI)?.....	<input type="checkbox"/>	<input type="checkbox"/>	
b. Are there any abnormalities of the first (S1) or second (S2) heart sounds?.....	<input type="checkbox"/>	<input type="checkbox"/>	
c. Are there gallops (S3 or S4)?.....	<input type="checkbox"/>	<input type="checkbox"/>	
d. Is/are there ejection sound(s) or systolic click(s)?.....	<input type="checkbox"/>	<input type="checkbox"/>	
e. Is/are there murmur(s) present? ..... If Yes, fully describe under Remarks including timing (systolic or diastolic), intensity (grade 1-6), location, transmission, or radiation.	<input type="checkbox"/>	<input type="checkbox"/>	
8. a. Are you aware of additional medical history: signs, symptoms, or laboratory findings not brought out in the foregoing questions which may have a bearing on this risk?.....			
	<input type="checkbox"/>	<input type="checkbox"/>	
b. Does the Proposed Insured appear in any way unhealthy or older than the stated age? .....			
	<input type="checkbox"/>	<input type="checkbox"/>	
9. a. Were you acquainted with the Proposed Insured prior to this examination?..... If Yes, fully describe the relationship in Remarks.			
	<input type="checkbox"/>	<input type="checkbox"/>	
b. Are you the Proposed Insured's personal physician?.....			
	<input type="checkbox"/>	<input type="checkbox"/>	
c. Was the examination conducted in a language other than English? ..... If Yes, indicate language used and provide name, address and relationship to Proposed Insured of person acting as interpreter.			
	<input type="checkbox"/>	<input type="checkbox"/>	
d. Did anyone sign or assist in the completion of the Part 2 Medical History for or on behalf of the Proposed Insured? .....			
	<input type="checkbox"/>	<input type="checkbox"/>	
10. How did you identify the Proposed Insured? <input type="checkbox"/> Driver's license <input type="checkbox"/> Other _____			
Record any additional medical information below. Use a separate piece of paper if necessary. Any additional comments regarding habits, character, residence, history or physical condition which may have a bearing on the risk will be appreciated. This information will be considered strictly confidential.			

I hereby certify that I have personally examined \_\_\_\_\_ and have correctly and fully reported my findings.  
Name of Proposed Insured

Examined at \_\_\_\_\_,  
Street address, City and State

this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_ at \_\_\_\_\_ AM/PM.

Print Examiner's name \_\_\_\_\_ Signature of Examiner \_\_\_\_\_  
 Paramed     MD     D.O.

Paramed Company \_\_\_\_\_ Telephone number \_\_\_\_\_

Address \_\_\_\_\_

SERFF Tracking Number: BANN-125826810 State: Arkansas  
 Filing Company: Banner Life Insurance Company State Tracking Number: 40559  
 Company Tracking Number:  
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
 Product Name: Life Insurance Application  
 Project Name/Number: Application/Medical History/LIA (8/08) & LU-1267 (8/08)

**Filing at a Glance**

LIA (10/08) & LU-1267(10/08)

Company: Banner Life Insurance Company  
 Product Name: Life Insurance Application  
 TOI: L08 Life - Other  
 Sub-TOI: L08.000 Life - Other  
 Filing Type: Form

SERFF Tr Num: BANN-125826810 State: Arkansas LH  
 SERFF Status: Closed State Tr Num: 40559  
 Co Tr Num: State Status: Approved-Closed  
 Co Status: Reviewer(s): Linda Bird  
 Author: Ada Miller Disposition Date: 10/17/2008  
 Date Submitted: 10/15/2008 Disposition Status: Approved  
 Implementation Date:

Implementation Date Requested: 01/01/2009

**General Information**

Project Name: Application/Medical History  
 Project Number: LIA-(8/08) & LU-1267 (8/08)  
 Requested Filing Mode: Review & Approval

Status of Filing in Domicile: Authorized  
 Date Approved in Domicile: 10/14/2008  
 Domicile Status Comments: Maryland, our state of domicile, is part of the Interstate Insurance Product Regulation Commission. The ICC has approved the use of the application and medical history forms. We have removed all references to the IIPRC for filings to states that are not part of the Compact.

Explanation for Combination/Other:  
 Submission Type: New Submission  
 Overall Rate Impact:  
 Filing Status Changed: 10/17/2008  
 State Status Changed: 10/17/2008  
 Created By: Ada Miller  
 Corresponding Filing Tracking Number:  
 Filing Description:

Market Type: Individual  
 Group Market Size:  
 Group Market Type:  
 Company Status Changed:  
 Deemer Date:  
 Submitted By: Ada Miller

Application form LIA (8/08) is being submitted for your review and approval. This is a new form, which upon approval, will become our new application form. It will replace Life Application Form BLA (5/99) previously approved by your department on February 4, 1999. Also being submitted for review and approval to be used with the new form is LU-1267 (8/08) Medical History form which will replace LU1034 now used with the current application form.

SERFF Tracking Number: BANN-125826810 State: Arkansas  
 Filing Company: Banner Life Insurance Company State Tracking Number: 40559  
 Company Tracking Number:  
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
 Product Name: Life Insurance Application  
 Project Name/Number: Application/Medical History/LIA (8/08) & LU-1267 (8/08)

Once approved, LIA (8/08) and LU-1267 (8/08) will be implemented on January 1, 2009.

To the best of our knowledge, information and belief, this application complies with the rules and regulations of your department.

## Company and Contact

### Filing Contact Information

Nancy January, Vice President, Product Development njJanuary@lgame.com  
 1701 Research Boulevard (301) 279-4868 [Phone]  
 Rockville, MD 20850 (301) 294-6964[FAX]

### Filing Company Information

Banner Life Insurance Company CoCode: 94250 State of Domicile: Maryland  
 1701 Research Boulevard Group Code: 872 Company Type: Life Insurance  
 Rockville, MD 20850 Group Name: State ID Number:  
 (301) 279-4809 ext. [Phone] FEIN Number: 52-1236145  
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## Filing Fees

Fee Required? Yes  
 Fee Amount: \$250.00  
 Retaliatory? Yes  
 Fee Explanation: 2 forms that make up new Application form x \$125.00  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Banner Life Insurance Company	\$250.00	10/15/2008	23191312



1701 Research Boulevard  
Rockville, MD 20850

**RIGHT TO EXAMINE POLICY FOR 20 DAYS.** Within 20 days after this policy is received, it may be returned to the agent through whom it was purchased or to our home office. We will pay the Face Amount to the Beneficiary if the Insured dies while this policy is in force. Such payment will be subject to the provisions of this policy.

**READ YOUR POLICY CAREFULLY - This policy is a legal contract between the policy owner and Banner Life Insurance Company.**

In this policy, Banner Life Insurance Company will be referred to as "we", "our" or "us".

We will pay the face amount to the beneficiary if the insured dies while this policy is in force. Such payment will be subject to the provisions of this policy.

All payments are subject to the terms of this policy. The following pages are part of this policy.

This policy is issued in consideration of the application and of the payment of the first premium as provided herein. A copy of the application is attached and is made a part of the policy.

Signed for Banner Life Insurance Company at its home office in Rockville, Maryland, on the policy date.

  
Secretary

  
President

**Renewable and Convertible Term Life Insurance**

**A change of premium provision is applicable subject to guaranteed maximum premiums**

**The face amount is payable at death prior to expiration date**

**Nonlevel premiums are payable as shown in the policy schedule to the expiration date or until the death of the insured**

**This policy is renewable to the expiration date**

**This policy is convertible to the end of the conversion period**

**This policy is nonparticipating and no dividends are payable**

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**Concluded with:**

**Riders, benefits, amendments, and endorsements, if any; and copy of applications**

**PLEASE READ YOUR POLICY CAREFULLY**

## DEFINITIONS

### Home and Administrative Office

Our Home Office and Administrative office is located at 1701 Research Boulevard, Rockville, Maryland 20850.

### Policy Date

The Policy Date is shown on the Policy Schedule. This date is used to determine premium due dates, policy anniversaries, years and months. Coverage will be effective on the Policy Date.

### Issue Date

The Issue Date is the date we complete the processing of the insured's approved application, and issue to the insured or the owner this life insurance policy. It is shown on the Policy Schedule.

### Written Notice/Recording Thereof

Written Notice means a notification or request received from the owner in a form satisfactory to us. Written notices are recorded at our administrative office. We will not be responsible for the validity of any written notice.

### Term Period

A Term Period is the period of time that premiums are level. The Term Periods are shown in the Policy Schedule.

### Renewal Date

A Renewal Date is the date on which the previous term period ended.

### Expiration Date

The Expiration Date is the end of the last term period. The Expiration Date is shown in the Policy Schedule.

### Age

Age is shown in the Policy Schedule and is the insured's Age as of the nearest birthday on the Policy Date.

### Beneficiary

The person to receive the proceeds payable at the insured's death.

## OWNERSHIP

The owner of this policy is shown in the policy schedule unless later changed. During the insured's lifetime, only the owner may exercise all the rights and agree with us as to changes in the policy. If the insured is not the owner and the owner dies, then the insured will become the owner.

All rights of the owner are subject to the rights of any assignee and of any Irrevocable Beneficiary designation we have on record.

## Assignment of Policy

This policy may be assigned. We will not be responsible for the validity of an assignment. We will not be liable for any payments made or actions taken before written notice of any assignment is received by us. Payments to any assignee will only be made in a lump sum.

## PREMIUMS

### Payment of Premiums

The first premium must be paid before any insurance becomes effective. The due date of the first premium is the policy date. Each subsequent premium is due on the premium due date(s) shown in the policy schedule. The owner may change the frequency of the premium payment to any frequency we offer on the date such change is requested. All premiums after the first are payable in advance at our administrative office. A premium receipt signed by one of our officers will be furnished upon request. In no event may premiums be paid beyond the expiration date.

### Grace Period

Except for the first premium, we will allow a 31 day grace period after the premium due date to pay each premium. During the grace period, the policy will remain in force. If a premium is not paid before the end of the grace period, the policy will terminate without value. If death occurs during the grace period, the premium required to provide insurance from the premium due date to the end of the policy month in which the insured's death occurs will be deducted from the proceeds.

### Reinstatement

A policy which terminates in accordance with the grace period provision may be reinstated if:

1. written request for reinstatement is made within five years after the expiration of the grace period and before the expiration date of the policy. The reinstated policy will be in force from the date we approve the application for Reinstatement and the required premiums are paid;
2. the owner submits a written application;
3. evidence of the insured's insurability is received and approved by us; and
4. all due and unpaid premiums, with interest payable at an annual rate of 6%, are paid.

## CHANGE OF PREMIUM

We may change the premium for this policy after the initial term period, exclusive of any riders, subject to the following;

1. the annual premium for this policy will not exceed the maximum annual premium shown in the policy schedule;

2. the premium may not be changed more than once during any 12 month period;
3. we will send the owner, at the address in our records, a written notice of any change in premium at least 30 days before the date on which the change will be effective;
4. any change of premium will be based on our expectations as to future experience for such elements as persistency, expenses, mortality, taxes, and investment earnings;
5. the modal premium will be calculated on the same basis as used on the issue date of this policy; and
6. any change in premium will be on a uniform basis applying to all policies with the same issue age, sex, rating classification, duration, and plan of insurance as this policy. A change of health will not cause a change of premium.
7. will take effect on the policy anniversary date following the date we make the change.

## **RENEWAL**

### **Renewability**

This policy may be renewable for additional term periods. Evidence of the insured's insurability need not be furnished. Renewal will occur only if premiums have been paid to the renewal date. This policy, however, will not continue beyond the expiration date.

### **Effective Date of Renewal**

The renewal premium must be paid within 31 days of the renewal date in order for the renewal to become effective. This policy will be renewed automatically if the insured dies during the 31-day period before the payment of a premium. If the insured dies during this period, the portion of the renewal premium required to provide insurance from the premium due date to the end of the policy month in which the insured's death occurs will be deducted in the calculation of proceeds payable.

### **Renewal Premiums**

The maximum annual renewal premium rates for this policy, including riders and benefits, are shown in the policy schedule.

### **Automatic Renewal**

This policy will be automatically renewed on the renewal date if:

1. it contains a total disability benefit; and
2. premiums are being waived to the renewal date under such disability benefit.

We will waive renewal premiums as long as the insured continues to be totally disabled under such total disability benefit.

## **CONVERSION**

This policy may be converted to a new policy on the insured's life. Evidence of the insured's insurability is not required. The conversion may be made:

1. on any premium due date, but not later than the end of the conversion period shown in the policy schedule;
2. if we receive the owner's written request and application for conversion;
3. the first premium for the new policy is paid; and
4. the owner returns this policy to us.

The new policy will be issued:

1. with the date of exchange as its policy date;
2. at the insured's age on the date of exchange;
3. with the same rating classification as that under this policy;
4. on any permanent life plan which we have available for conversion and, for the amount exchanged, we customarily issue on the date of exchange to applicants with the insured's rating classification;
5. with premiums based on our rates for the rating classification and plan of insurance on the date of exchange;
6. for an amount of insurance not less than our minimum for the plan selected, nor greater than the face amount of this policy on the conversion date. At least one plan of insurance will be available for conversion in an amount equal to the face amount of this policy on the conversion date;
7. the new policy will be issued so that the time limit specified in the Incontestability and Suicide provisions of the new policy will be measured from the Policy Date of this policy; and
8. the new policy will be subject to any assignment of this Policy received at our office.

The new policy will contain a total disability benefit and/or accidental death benefit if:

1. this policy contains such benefit;
2. on the date of exchange, we customarily issue such benefit to applicants with the insured's age, sex, and rating classification; and
3. on the date of exchange, we customarily issue such benefit in conjunction with the plan to which the insured converts.

If more than one type of total disability benefit is available on the date of exchange, the benefit attached to the new policy will be the benefit with the lowest premium.

### **Automatic Conversion**

This policy will be converted to a permanent life plan selected by us at the end of the conversion period if:

1. this policy contains a total disability benefit;
2. the insured is totally disabled under the terms of the disability benefit at the end of the conversion period; and
3. such disability continued during the 6 months prior to the end of the conversion period.

The new policy's premiums will be based on the insured's age on the date this policy is converted. The new policy will be issued for an amount equal to the face amount of this policy on the conversion date. Any premium falling due while the insured continues to be totally disabled will be waived.

### **EXCHANGE OF POLICY FOR SAME PLAN**

This policy may be exchanged for a new policy on the insured's life. Evidence of the insured's insurability satisfactory to us is required. The exchange may be made at any time during the exchange period. The exchange period expires as indicated in the policy schedule.

To make the exchange:

- (1) we must receive a new application for the exchange before the end of the exchange period while this policy is in force; and
- (2) all premiums due on this policy must be paid to the exchange date.

The new policy will be issued:

- (1) on the same plan of insurance as this policy; and
- (2) for a face amount not less than the minimum for this plan nor greater than the face amount of this policy on the exchange date.

Premiums for the new policy will be at the rates in effect for the insured's attained age on the exchange date. The new policy will be subject to our rules on frequency of premium payment and minimum premium in effect on the exchange date.

The issue date of the new policy will be the exchange date. The first premium for the new policy must be paid before coverage under the new policy begins. Coverage under this policy will end when coverage under the new policy begins.

The suicide provision in the new policy will be waived.

The new policy may contain any rider(s) included in this policy, subject to our rules and at the premium rates in effect on the exchange date.

## **GENERAL PROVISIONS**

### **Contract**

This policy, attached riders, amendments, benefits, and the application form the entire contract. Only the President, a Vice President, or the Secretary of Banner Life Insurance Company may change or waive any provision of this contract. Any changes or waivers must be in writing.

We may not change or amend this policy without the owner's consent except as expressly provided in the policy. However, we may change or amend the policy if such change or amendment is necessary for it to comply with any state or federal law, rule, or regulation.

### **Incontestability**

Statements in the application are considered representations, not warranties. Statements may be used to contest the validity of this policy or in defense of a claim only if they are contained in the application or in an endorsement or amendment, and a copy of that application, endorsement, or amendment is attached to the policy at issue or is made part of the policy when a change becomes effective.

We will not contest this policy after it has been in force during the Insured's lifetime for two years from the Issue Date, except for failure to pay premiums. If this policy is reinstated, it will be incontestable after it has been in force during the insured's lifetime for two years from the effective date of the Reinstatement. The Incontestability period will be based on the most recent applications.

### **Misstatement of Age and Sex**

If the insured's age or sex has been misstated, we will pay the amount of insurance that the premiums paid would have purchased at the correct age and sex.

### **Suicide**

The benefits payable are limited if the insured commits suicide, while sane or insane, within two years from the Issue Date. In such case, our liability will be limited to a refund of all premiums paid to us.

### **Non-participating**

This policy is non-participating and the owner will not share in Banner Life Insurance Company's profits or surplus. No dividends are payable on this policy.

## **AMOUNT OF PROCEEDS**

The life insurance proceeds payable at the insured's death will be (1) plus (2) plus (3) minus (4) where:

- (1) is the face amount of this policy, shown in the policy schedule;
- (2) is any insurance on the insured's life provided by riders;
- (3) is the portion of any premium paid for a period beyond the policy month in which the insured's death occurs; and
- (4) is any premium which is due and unpaid for a period from the premium due date to the end of the policy month in which the insured's death occurs.

We reserve the right to require the return of the policy at time of settlement.

## **BENEFICIARY PROVISIONS**

### **Beneficiary**

Unless otherwise provided by written notice to us, the beneficiaries are named in the application.

### **Change in Beneficiary**

During the insured's lifetime, the owner may change the beneficiary designation unless he or she has waived the right to do so. No beneficiary change will take effect until a written notice is received at our administrative office. Such changes will become effective on the date written notice is received by us. All changes will be subject to any payment made by us before notice was received.

### **Death of a Beneficiary**

Unless otherwise provided in the beneficiary designation:

- 1. the interest of any beneficiary who dies before the insured will pass to any surviving beneficiaries according to their respective interests; or
- 2. if no beneficiary survives the insured, the proceeds will be paid in one sum to the owner, if living; otherwise, to the owner's estate.

## **PAYMENT OF PROCEEDS**

Any amount payable under this contract will be paid in one sum unless otherwise provided. All or part of this sum may be applied to any payment option. However, options will not be available if:

- 1. the net proceeds are less than \$2,500;
- 2. the amount of each payment is less than \$50; or
- 3. in the case of payment option 1, 2 or 3, the payee is not a natural person receiving payment in his or her own right.

Proceeds left with us may be withdrawn by written notice where such right is given. The payment of any withdrawal may be postponed for as long as six months from the date we receive written notice.

We may require evidence of the survival of any Payee before any settlement payment payable to the payee is made.

## **ELECTION OF PAYMENT OPTIONS**

### **By Owner**

During the insured's lifetime, the owner may elect any payment option and may change such election if he or she has reserved the right to do so.

If the owner elects a payment option for the beneficiary, the beneficiary may not:

- 1. change or cancel the election;
- 2. assign or transfer the amount held by us; or
- 3. withdraw any future installments or unpaid interest installments unless these rights are granted in the election.

### **By Beneficiary**

If the owner does not elect a payment option, the beneficiary may do so after the insured's death.

Such election by the Beneficiary:

- 1. must be made before the payment of any Policy Proceeds has been made; and
- 2. shall be effective as of the date of the Insured's death.

### **Conditions for Election**

Any election or change must be made by written notice to us. No election or change will be effective until we record it.

## **PAYMENT OPTIONS**

The following sections describe the payment options available under this policy.

### **Option 1 - Life Income**

We will make equal monthly payments during the payee's lifetime. Payments will end with the last monthly payment before his or her death. The amount of each payment, per \$1,000 of Policy Proceeds, will not be less than that shown in the Option 1 table.

### **Option 2 - Life Income With Period Certain**

We will make equal monthly payments during the payee's lifetime, with a minimum period guaranteed (60, 120, 180 or 240 months). The amount of each payment, per \$1,000 of Policy Proceeds, will not be less than that shown in the Option 2 table. At the Payee's death, we will continue to pay the balance of the unpaid payments, if any, to the Payee's Beneficiary for the balance of the guaranteed period.

### **Option 3 - Joint Life Income**

We will make payments for as long as either of two designated persons live. The amount of each payment, per \$1,000 of Policy Proceeds, will not be less than that shown in the Option 3 table.

**Option 4 - Payments for a Fixed Period**

We will make payments for a fixed period. The amount of each payment, per \$1,000 of Policy Proceeds, will not be less than that shown in the Option 4 table. At the Payee's death, we will continue to pay the balance of the unpaid payments to the Payee's Beneficiary.

**Option 5 - At Interest**

The proceeds may be left with us to draw interest. Interest may be paid annually, semi-annually, quarterly, or monthly. The first payment will be made at the end of the interest frequency period chosen. The guaranteed interest rate is 3% a year, compounded yearly. Interest shall not be paid beyond the lifetime of one Payee except with our consent.

**Evidence of Survival**

We have the right to require satisfactory proof of any payee's age. The right to change options is not available after payments commence under this option.

**Automatic Payment Option**

If settlement of the proceeds of this policy is delayed over 30 days, option 5 will be applied automatically. Interest will be paid yearly and the person(s) entitled to the proceeds has the right to withdraw the proceeds or elect any payment option permitted by this policy. The legal rate indicated by the state will be used if it is higher than our declared rate.

**Basis of Values**

The payment option tables are based on 3% interest compounded yearly. For options involving lifetime income, rates in the tables are based on Table "a" mortality rates. We may offer more favorable rates than those determined on this basis.

**Additional Options**

Any proceeds payable under this policy may be paid under any other method of payment agreed to by us at the time of settlement.

ANNUITY TABLES  
Monthly Income per \$1,000 of proceeds

Age	OPTION1 LIFE ONLY		OPTION 2 LIFE WITH PERIOD CERTAIN							
	MALE	FEMALE	60 MONTHS		120 MONTHS		180 MONTHS		240 MONTHS	
			MALE	FEMALE	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE
50	4.30	3.94	4.29	3.93	4.26	3.92	4.20	3.89	4.11	3.85
51	4.38	4.00	4.37	3.99	4.33	3.98	4.27	3.95	4.17	3.90
52	4.47	4.07	4.45	4.06	4.41	4.04	4.34	4.01	4.23	3.96
53	4.56	4.14	4.54	4.13	4.49	4.11	4.41	4.07	4.29	4.02
54	4.65	4.21	4.63	4.21	4.58	4.18	4.49	4.14	4.35	4.07
55	4.75	4.29	4.73	4.29	4.67	4.26	4.57	4.21	4.42	4.14
56	4.86	4.38	4.83	4.37	4.77	4.34	4.65	4.28	4.48	4.20
57	4.97	4.47	4.94	4.46	4.87	4.42	4.74	4.36	4.55	4.26
58	5.09	4.56	5.06	4.55	4.97	4.51	4.82	4.44	4.61	4.33
59	5.22	4.67	5.18	4.65	5.09	4.61	4.92	4.52	4.68	4.40
60	5.35	4.77	5.32	4.76	5.20	4.71	5.01	4.61	4.74	4.47
61	5.50	4.89	5.46	4.87	5.33	4.81	5.11	4.70	4.81	4.54
62	5.65	5.01	5.61	4.99	5.46	4.92	5.20	4.80	4.87	4.61
63	5.82	5.14	5.77	5.12	5.59	5.04	5.31	4.90	4.93	4.69
64	6.00	5.28	5.94	5.25	5.73	5.16	6.41	5.00	4.99	4.76
65	6.19	5.43	6.12	5.40	5.88	5.29	5.51	5.10	5.05	4.83
66	6.40	5.59	6.31	5.55	6.04	5.43	5.61	5.21	5.11	4.90
67	6.61	5.76	6.51	5.71	6.19	5.57	5.71	5.32	5.16	4.97
68	6.85	5.94	6.72	5.89	6.36	5.72	5.81	5.43	5.20	5.03
69	7.10	6.14	6.95	6.08	6.52	5.88	5.91	5.54	5.25	5.09
70	7.36	6.36	7.19	6.28	6.70	6.05	6.01	5.66	5.29	5.15
71	7.65	6.59	7.44	6.50	6.87	6.22	6.10	5.77	5.32	5.20
72	7.95	6.84	7.71	6.73	7.05	6.40	6.19	5.88	5.35	5.25
73	8.28	7.11	7.99	6.98	7.23	6.59	6.27	5.99	5.38	5.30
74	8.63	7.41	8.29	7.25	7.40	6.79	6.34	6.09	5.41	5.34
75	9.00	7.72	8.60	7.54	7.58	6.98	6.42	6.19	5.43	5.37
76	9.41	8.07	8.92	7.84	7.75	7.19	6.48	6.28	5.45	5.40
77	9.84	8.44	9.26	8.17	7.93	7.39	6.54	6.37	5.46	5.42
78	10.30	8.85	9.61	8.51	8.09	7.59	6.59	6.45	5.47	5.44
79	10.79	9.29	9.98	8.87	8.25	7.79	6.64	6.52	5.48	5.46
80	11.32	9.77	10.35	9.26	8.40	7.98	6.68	6.58	5.49	5.47
81	11.88	10.29	10.73	9.66	8.54	8.17	6.72	6.63	5.50	5.48
82	12.48	10.85	11.12	10.08	8.67	8.34	6.75	6.68	5.50	5.49
83	13.12	11.46	11.51	10.51	8.80	8.51	6.77	6.72	5.51	5.50
84	13.79	12.11	11.91	10.96	8.91	8.66	6.80	6.75	5.51	5.50
85	14.50	12.82	12.30	11.41	9.01	8.80	6.81	6.78	5.51	5.51
86	15.24	13.58	12.69	11.86	9.11	8.92	6.83	6.80	5.51	5.51
87	16.03	14.39	13.08	12.32	9.19	9.03	6.84	6.82	5.51	5.51
88	16.86	15.26	13.46	12.76	9.26	9.13	6.85	6.83	5.51	5.51
89	17.75	16.17	13.83	13.19	9.33	9.22	6.86	6.84	5.51	5.51
90	18.70	17.13	14.20	13.60	9.39	9.29	6.86	6.85	5.51	5.51
91	19.71	18.12	14.57	14.00	9.44	9.35	6.86	6.86	5.51	5.51
92	20.79	19.16	14.92	14.38	9.48	9.41	6.87	6.86	5.51	5.51
93	21.96	20.24	15.26	14.73	9.51	9.45	6.87	6.87	5.51	5.51
94	23.22	21.37	15.59	15.07	9.54	9.49	6.87	6.87	5.51	5.51
95	24.59	22.55	15.91	15.40	9.56	9.53	6.87	6.87	5.51	5.51

ANNUITY TABLES  
Monthly Income per \$1,000 of proceeds

AGE OF FEMALE	OPTION 3 JOINT LIFE INCOME									
	AGE OF MALE									
	50	55	60	65	70	75	80	85	90	95
50	3.63	3.71	3.78	3.84	3.87	3.90	3.91	3.92	3.93	3.93
55	3.77	3.91	4.02	4.11	4.18	4.22	4.25	4.27	4.28	4.29
60	3.91	4.10	4.28	4.43	4.55	4.64	4.69	4.73	4.75	4.76
65	4.02	4.28	4.54	4.78	4.99	5.15	5.26	5.33	5.37	5.40
70	4.12	4.43	4.77	5.14	5.48	5.77	5.99	6.14	6.23	6.29
75	4.19	4.55	4.97	5.47	5.99	6.49	6.90	7.21	7.42	7.56
80	4.23	4.63	5.12	5.74	6.45	7.21	7.94	8.54	9.00	9.32
85	4.26	4.68	5.22	5.93	6.80	7.84	8.95	10.01	10.91	11.63
90	4.28	4.71	5.28	6.04	7.04	8.29	9.78	11.36	12.87	14.24
95	4.29	4.73	5.31	6.11	7.18	8.58	10.35	12.40	14.54	16.71

Income Payments for ages not shown furnished upon request.

ANNUITY TABLES

Monthly Income per \$1,000 of proceeds

OPTION 4 ANNUITY CERTAIN	
YEAR	INCOME
5	17.91
6	15.14
7	13.16
8	11.68
9	10.53
10	9.61
11	8.86
12	8.24
13	7.71
14	7.26
15	6.87
16	6.53
17	6.23
18	5.96
19	5.73
20	5.51
21	5.32
22	5.15
23	4.99
24	4.84
25	4.71
26	4.59
27	4.47
28	4.37
29	4.27
30	4.18



1701 Research Boulevard  
Rockville, MD 20850

### **Renewable and Convertible Term Life Insurance**

**A change of premium provision is applicable subject to guaranteed maximum premiums**

**The face amount is payable at death prior to expiration date**

**Nonlevel premiums are payable as shown in the policy schedule to the expiration date or until the death of the insured**

**This policy is renewable to the expiration date**

**This policy is convertible to the end of the conversion period**

**This policy is non-participating and no dividends are payable**