

SERFF Tracking Number: BANN-126401912 State: Arkansas
Filing Company: Banner Life Insurance Company State Tracking Number: 44211
Company Tracking Number:
TOI: L04I Individual Life - Term Sub-TOI: L04I.003 Single Life - Single Premium
Product Name: Term Conversion Application
Project Name/Number: Term Conversion Application/LU1285 (10/09)

Filing at a Glance

Company: Banner Life Insurance Company

Product Name: Term Conversion Application SERFF Tr Num: BANN-126401912 State: Arkansas
TOI: L04I Individual Life - Term SERFF Status: Closed-Approved- State Tr Num: 44211
Closed

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: 12/04/2009
Date Submitted: 12/01/2009 Disposition Status: Approved-Closed
Implementation Date: Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

General Information

Project Name: Term Conversion Application
Project Number: LU1285 (10/09)
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:
Filing Status Changed: 12/04/2009

Status of Filing in Domicile: Authorized
Date Approved in Domicile: 11/30/2009
Domicile Status Comments:
Market Type: Individual
Group Market Size:
Group Market Type:
Explanation for Other Group Market Type:
State Status Changed: 12/03/2009
Created By: Ada Miller
Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Ada Miller

Filing Description:

We are submitting Term Conversion Application, form LU1285 (10/09) for approval. This form will replace a previously approved form, LU-279R (9/92,). If elected, this conversion application will be attached to the original application form, LIA (10-08) & LU1267 (10/08).

Once approved, LU1285 (10/09) will be implemented immediately.

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

SERFF Tracking Number: BANN-126401912 State: Arkansas
 Filing Company: Banner Life Insurance Company State Tracking Number: 44211
 Company Tracking Number:
 TOI: L041 Individual Life - Term Sub-TOI: L041.003 Single Life - Single Premium
 Product Name: Term Conversion Application
 Project Name/Number: Term Conversion Application/LU1285 (10/09)

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: \$125.00
 Retaliatory? Yes
 Fee Explanation: 1 form x \$125
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Banner Life Insurance Company	\$125.00	12/01/2009	32379379

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	12/04/2009	12/04/2009
Approved-Closed	Linda Bird	12/03/2009	12/03/2009

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Term Conversion Applicaton	Ada Miller	12/04/2009	12/04/2009

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Incorrect Form Attached	Note To Filer	Linda Bird	12/04/2009	12/04/2009
Incorrect Form Attached	Note To Reviewer	Ada Miller	12/04/2009	12/04/2009

SERFF Tracking Number: *BANN-126401912* *State:* *Arkansas*
Filing Company: *Banner Life Insurance Company* *State Tracking Number:* *44211*
Company Tracking Number:
TOI: *L041 Individual Life - Term* *Sub-TOI:* *L041.003 Single Life - Single Premium*
Product Name: *Term Conversion Application*
Project Name/Number: *Term Conversion Application/LU1285 (10/09)*

Disposition

Disposition Date: 12/04/2009

Implementation Date:

Status: Approved-Closed

Comment: Company has made changes to correct the Term Conversion Application form.

Rate data does NOT apply to filing.

SERFF Tracking Number: BANN-126401912 State: Arkansas
 Filing Company: Banner Life Insurance Company State Tracking Number: 44211
 Company Tracking Number:
 TOI: L041 Individual Life - Term Sub-TOI: L041.003 Single Life - Single Premium
 Product Name: Term Conversion Application
 Project Name/Number: Term Conversion Application/LU1285 (10/09)

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Life & Annuity - Acturial Memo		No
Supporting Document	RT-97		Yes
Form (<i>revised</i>)	Term Conversion Applicaton		Yes
Form	Term Conversion Applicaton	Replaced	Yes

SERFF Tracking Number: *BANN-126401912* *State:* *Arkansas*
Filing Company: *Banner Life Insurance Company* *State Tracking Number:* *44211*
Company Tracking Number:
TOI: *L04I Individual Life - Term* *Sub-TOI:* *L04I.003 Single Life - Single Premium*
Product Name: *Term Conversion Application*
Project Name/Number: *Term Conversion Application/LU1285 (10/09)*

Disposition

Disposition Date: 12/03/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: BANN-126401912 State: Arkansas
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Amendment Letter

Submitted Date: 12/04/2009

Comments:

Enclosed is the correct Term Conversion Application form. We have made the change to the Form Schedule tab.

Thank you!

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
LU1285 (10/09)	Application/ETerm nrollment Form	Conversion Applicaton	Initial				50.000	LU1285 (10-09).pdf

SERFF Tracking Number: BANN-126401912 *State:* Arkansas
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Product Name: Term Conversion Application
Project Name/Number: Term Conversion Application/LU1285 (10/09)

Note To Filer

Created By:

Linda Bird on 12/04/2009 09:28 AM

Last Edited By:

Linda Bird

Submitted On:

12/04/2009 09:28 AM

Subject:

Incorrect Form Attached

Comments:

Filing has been reopened in order for correction to be made in the Term Conversion Application.

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Product Name: Term Conversion Application
Project Name/Number: Term Conversion Application/LU1285 (10/09)

Note To Reviewer

Created By:

Ada Miller on 12/04/2009 06:52 AM

Last Edited By:

Ada Miller

Submitted On:

12/04/2009 06:53 AM

Subject:

Incorrect Form Attached

Comments:

Thank you for your approval of this filing. As I was printing out a copy of the filing for our records, I noticed that the wrong form was attached for the Term Conversion Application. The original Life Insurance Application was attached in error.

I would like to submit the correct Term Conversion Application for your records. Could you re-open the filing so that I might attach it?

Thanks!

ada miller

SERFF Tracking Number: BANN-126401912 State: Arkansas
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 TOI: L041 Individual Life - Term Sub-TOI: L041.003 Single Life - Single Premium
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Form Schedule

Lead Form Number: LU1285 (10/09)

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	LU1285 (10/09)	Application/ Term Conversion Enrollment Applicaton Form	Initial		50.000	LU1285 (10-09).pdf

Insured Information

Term Policy No.: _____ Name of Insured: _____
First MI Last

Date of Birth: _____ Social Security Number: _____

Home Address: _____
Street No & Name, Suite No City State Zip

Home Telephone _____ E-mail Address _____

Conversion Request

I hereby request a conversion of:

Full Term Policy

Partial Term Policy in the amount of \$ _____

Balance of Term Policy: To be Continued To be Discontinued

Term Rider (specify) _____

Any active benefits/riders currently on the term policy will be:

Continued on the new universal policy.

Discontinued Rider(s).

Conversion effective date: ____/____/____ (Cannot exceed Term Policy paid to date)
MM DD YYYY

Special Requests: _____

Planned Premium and Billing (Illustration must be attached)

Amount remitted with Application \$ _____

Payment Method: Direct Bill Electronic Funds Transfer (Include Form LP-187)

Payment Frequency: Single Annual Semi-annual Quarterly Monthly (EFT Only)

Planned Periodic Premium:

1st Year Only \$ _____ 2nd Year and Thereafter \$ _____

Premium for All Years \$ _____

SERFF Tracking Number: BANN-126401912 State: Arkansas
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Supporting Document Schedules

Item Status: **Status**
Date:

Satisfied - Item: Flesch Certification

Comments:

Flesch certification is attached.

Attachment:

LU1285 (10-09) Readability Certification.pdf

Item Status: **Status**
Date:

Satisfied - Item: Application

Comments:

Life Insurance Applicatoin LIA (10/08) and LU-1267 (10/08) were approved by your department on 10/17/08. If elected, the term conversion application will be attached to this.

Attachments:

LIA (10-08).pdf

LU-1267 (10-08).pdf

Item Status: **Status**
Date:

Satisfied - Item: RT-97

Comments:

The base term policy is attached and previously approved by your department on 10/22/97 for 10-15-20 year term and 11/20/97 for 30 year term.

Attachment:

RT-97.pdf

Readability Certification
LU1285 (10/09)

This is to certify that the form in this filing has been tested and meets the minimum required Flesch reading ease score.

Term Conversion Application Form LU1285 (10/09) has a Flesch score of 50.



*Nancy C. January, FSA, MAAA
Vice President, Product Development
Banner Life Insurance Company*

October 22, 2009
Date

Internet address: www.bannerlife.com

INSTRUCTIONS

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

DO

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

DO NOT

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

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)**

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.

SECTION A PROPOSED INSURED			
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	_____	_____	
SECTION B BENEFICIARY (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 _____	_____	
SECTION C OWNER			
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 _____		
SECTION D TRUST INFORMATION (If trust is Beneficiary and/or Owner).			
19. Exact Name of Trust _____	Trust Tax ID# _____		_____
Current Trustee(s) _____	Date of Trust _____		

PART 1 (continued)

SECTION E PAYOR

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

Name _____ Relationship to Insured/Owners _____

Address _____
Street City State Zip

Contact Phone # _____ Email address _____

SECTION F INSURANCE APPLIED FOR

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

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

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

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

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

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

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

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

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

Additional Benefits (if available)

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

SECTION G OTHER INSURANCE

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

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

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

Company	Policy Number	Face Amount	Business?		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)

SECTION H GENERAL QUESTIONS (Explain all Yes answers in Remarks section, Question 48.)		Yes	No
34.	Has any person promised or agreed to give or have they given to any party to the application, any inducement, fee or compensation as an incentive to purchase the policy?	<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"/>
SECTION I OTHER ACTIVITIES		Yes	No
42.	Do you hold a current pilot license, or have you in the past 5 years flown, or within the next 2 years do you intend to fly, other than as a passenger in any type of aircraft? (If Yes, complete Aviation Questionnaire.)	<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"/>
SECTION J PROPOSED INSURED FINANCIAL INFORMATION			
Complete this section when applying for face amount over \$1,000,000 or when the Proposed Insured is over age 65:			
45. a.	What is the purpose of this insurance? (e.g. income replacement, buy-sell, keyperson, estate conservation)	_____	
b.	How was the need for the face amount determined? _____	Yes	No
c.	In the last 5 years, has the Proposed Insured filed for bankruptcy or had any charge off of bad debts? If Yes, type of bankruptcy and discharge date or charge off date. _____	<input type="checkbox"/>	<input type="checkbox"/>
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

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.

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 last 5 years , unless previously stated on this application, have you:			
a. Been treated by a member of the medical profession or at a medical facility?	<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 _____

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"/> |

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

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"/> |

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

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? 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 last 5 years , unless previously stated on this application, have you:			
a. Been treated by a member of the medical profession or at a medical facility?	<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 past 2 years ?..... 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 _____

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)

7. To be completed if number 6.i. is answered Yes or if requested:		Yes	No	Remarks
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 _____



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.

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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	OPTION 1 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

SERFF Tracking Number: BANN-126401912 State: Arkansas
 Filing Company: Banner Life Insurance Company State Tracking Number: 44211
 Company Tracking Number:
 TOI: L041 Individual Life - Term Sub-TOI: L041.003 Single Life - Single Premium
 Product Name: Term Conversion Application
 Project Name/Number: Term Conversion Application/LU1285 (10/09)

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
12/01/2009	Form	Term Conversion Applicaton	12/04/2009	LIA (10-08).pdf (Superceded) LU-1267 (10-08).pdf (Superceded)

Internet address: www.bannerlife.com

INSTRUCTIONS

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

DO

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

DO NOT

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

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)**

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.

SECTION A PROPOSED INSURED			
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	_____	_____	
SECTION B BENEFICIARY (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 _____	_____	
SECTION C OWNER			
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 _____		
SECTION D TRUST INFORMATION (If trust is Beneficiary and/or Owner).			
19. Exact Name of Trust _____	Trust Tax ID# _____		_____
Current Trustee(s) _____	Date of Trust _____		

PART 1 (continued)

SECTION E PAYOR

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

Name _____ Relationship to Insured/Owners _____

Address _____
Street City State Zip

Contact Phone # _____ Email address _____

SECTION F INSURANCE APPLIED FOR

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

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

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

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

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

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

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

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

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

Additional Benefits (if available)

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

SECTION G OTHER INSURANCE

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

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

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

Company	Policy Number	Face Amount	Business?		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)

SECTION H GENERAL QUESTIONS (Explain all Yes answers in Remarks section, Question 48.)		Yes	No
34. Has any person promised or agreed to give or have they given to any party to the application, any inducement, fee or compensation as an incentive to purchase the policy?		<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"/>
SECTION I OTHER ACTIVITIES		Yes	No
42. Do you hold a current pilot license, or have you in the past 5 years flown, or within the next 2 years do you intend to fly, other than as a passenger in any type of aircraft? (If Yes, complete Aviation Questionnaire.)		<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"/>
SECTION J PROPOSED INSURED FINANCIAL INFORMATION			
Complete this section when applying for face amount over \$1,000,000 or when the Proposed Insured is over age 65:			
45. a. What is the purpose of this insurance? (e.g. income replacement, buy-sell, keyperson, estate conservation)			

b. How was the need for the face amount determined?	_____	Yes	No
c. In the last 5 years, has the Proposed Insured filed for bankruptcy or had any charge off of bad debts?		<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

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 last 5 years , unless previously stated on this application, have you:			
a. Been treated by a member of the medical profession or at a medical facility?	<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 _____

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"/> |

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

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"/> |

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

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.

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 last 5 years , unless previously stated on this application, have you:			
a. Been treated by a member of the medical profession or at a medical facility?	<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)

7. To be completed if number 6.i. is answered Yes or if requested:		Yes	No	Remarks
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 _____