

SERFF Tracking Number:	ALSB-126241800	State:	Arkansas
Filing Company:	Lincoln Benefit Life Company	State Tracking Number:	43097
Company Tracking Number:	FIC383 LBL SERIES		
TOI:	L08 Life - Other	Sub-TOI:	L08.000 Life - Other
Product Name:	FIC383 LBL Series		
Project Name/Number:	FIC383 Series/FIC383 Series		

## Filing at a Glance

Company: Lincoln Benefit Life Company

Product Name: FIC383 LBL Series

TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Filing Type: Form

SERFF Tr Num: ALSB-126241800 State: Arkansas

SERFF Status: Closed-Approved-Closed  
State Tr Num: 43097

Co Tr Num: FIC383 LBL SERIES

State Status: Approved-Closed

Reviewer(s): Linda Bird

Author: Elizabeth Vassallo

Disposition Date: 08/03/2009

Date Submitted: 08/03/2009

Disposition Status: Approved-Closed

Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

## General Information

Project Name: FIC383 Series

Project Number: FIC383 Series

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 08/03/2009

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Individual

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 08/03/2009

Created By: Elizabeth Vassallo

Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Elizabeth Vassallo

Filing Description:

We submit the above-referenced forms for your attention and approval. These are new forms, not previously submitted, and they do not replace any currently approved forms.

### Description of Forms

The following forms are intended for use with previously approved life insurance policies and may also be used with policies developed in the future.

FIC383 is a Part 2 Medical Questionnaire that will be used to determine the proposed insured's current state of health.

*SERFF Tracking Number:*      *ALSB-126241800*                      *State:*                      *Arkansas*  
*Filing Company:*              *Lincoln Benefit Life Company*                      *State Tracking Number:*      *43097*  
*Company Tracking Number:*      *FIC383 LBL SERIES*  
*TOI:*                      *L08 Life - Other*                      *Sub-TOI:*                      *L08.000 Life - Other*  
*Product Name:*              *FIC383 LBL Series*  
*Project Name/Number:*      *FIC383 Series/FIC383 Series*

FIC384BIQ is a Business Insurance Questionnaire that will be used to determine a company's current financial position when they apply for life insurance.

FIC384CAQ is a Civilian Aviation Questionnaire and will be completed by proposed insureds who currently fly non-military aircraft.

FIC384CQ is a Climbing Questionnaire and will be completed by proposed insureds who actively participate in climbing activities.

FIC384CFQ is a Confidential Financial Questionnaire and will be used to determine the proposed insured's financial condition when applying for life insurance.

FIC384DAQ is a Drug and Alcohol Questionnaire and will be completed by proposed insureds whose medical history or answers to application questions raise concerns about their use of alcohol or drugs.

FIC384FTRQ is a Foreign Travel and (Delete "Travel and" for FL, GA & LA) Residence Questionnaire and will be completed by proposed insureds who have lived or traveled outside of the United States within the past two years.

FIC384MAQ is a Military Aviation Questionnaire and will be completed by proposed insureds who are currently flying aircraft for the military.

FIC384MSQ is a Motor Sports Questionnaire and will be completed by proposed insureds who actively participate in motor sports.

FIC384SPQ is a Skydiving and Parachuting Questionnaire and will be completed by proposed insureds who actively participate in skydiving and/or parachuting activities.

FIC384UDQ is an Underwater Diving Questionnaire and will be completed by proposed insureds who currently engage in underwater diving.

The filing fee is attached to the "Filing Fee" component of this filing submission and required readability certification is attached to the "Supporting Documentation" component.

If you have any questions, please feel free to contact me at the address, phone, or e-mail on my letterhead. Thank you for your consideration of this matter.

Elizabeth J. Vassallo

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Senior Product & Financial Analyst  
 Contract Development and Filing

## Company and Contact

### Filing Contact Information

Elizabeth Vassallo, evass@allstate.com  
 3100 Sanders Rd, Suite M2A 847-402-2355 [Phone]  
 Northbrook, IL 60062 847-326-5224 [FAX]

### Filing Company Information

Lincoln Benefit Life Company CoCode: 65595 State of Domicile: Nebraska  
 2940 South 84th Street Group Code: 8 Company Type:  
 Lincoln, NE 68506-4142 Group Name: State ID Number:  
 (800) 525-2799 ext. [Phone] FEIN Number: 47-0221457

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## Filing Fees

Fee Required? Yes  
 Fee Amount: \$275.00  
 Retaliatory? No  
 Fee Explanation: \$25/form x 11 forms=\$275  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Lincoln Benefit Life Company	\$275.00	08/03/2009	29587165

SERFF Tracking Number: ALSB-126241800

State: Arkansas

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TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Product Name: FIC383 LBL Series

Project Name/Number: FIC383 Series/FIC383 Series

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	08/03/2009	08/03/2009

SERFF Tracking Number: ALSB-126241800 State: Arkansas  
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Product Name: FIC383 LBL Series  
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## Disposition

Disposition Date: 08/03/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: ALSB-126241800 State: Arkansas  
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Certification of Compliance		Yes
Supporting Document	Statement of Variability		Yes
Form	Application for Life Insurance Part 2 - Medical Questionnaire		Yes
Form	Business Insurance Questionnaire		Yes
Form	Civilian Aviation Questionnaire		Yes
Form	Climbing Questionnaire		Yes
Form	Confidential Financial Questionnaire		Yes
Form	Drug and Alcohol Questionnaire		Yes
Form	Foreign Travel and Residence Questionnaire		Yes
Form	Military Aviation Questionnaire		Yes
Form	Motor Sports Questionnaire		Yes
Form	Skydiving and Parachuting Questionnaire		Yes
Form	Underwater Diving Questionnaire		Yes

SERFF Tracking Number: ALSB-126241800 State: Arkansas  
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## Form Schedule

### Lead Form Number: FIC383 Series

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	FIC383	Other	Application for Life Insurance Part 2 - Medical Questionnaire	Initial		61.000	FIC383 Medical Questionnaire .pdf
	FIC384BIQ	Other	Business Insurance Questionnaire	Initial		47.000	FIC384BIQ Questionnaire .pdf
	FIC384CAQ	Other	Civilian Aviation Questionnaire	Initial		63.000	FIC384CAQ Questionnaire .pdf
	FIC384CQ	Other	Climbing Questionnaire	Initial		54.000	FIC384CQ Questionnaire .pdf
	FIC384CFQ	Other	Confidential Financial Questionnaire	Initial		45.000	FIC384CFQ Questionnaire .pdf
	FIC384DAQ	Other	Drug and Alcohol Questionnaire	Initial		54.000	FIC384DAQ Questionnaire .pdf
	FIC384FTRQ	Other	Foreign Travel and Residence Questionnaire	Initial		63.000	FIC384FTR Questionnaire .pdf
	FIC384MAQ	Other	Military Aviation Questionnaire	Initial		59.000	FIC384MAQ Questionnaire .pdf
	FIC384MSQ	Other	Motor Sports Questionnaire	Initial		63.000	FIC384MSQ Questionnaire .pdf
	FIC384SPQ	Other	Skydiving and Parachuting Questionnaire	Initial		61.000	FIC384SPQ Questionnaire .pdf

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FIC384UD	Other	Underwater Diving	Initial	61.000	FIC384UDQ
Q		Questionnaire			Questionnaire
					.pdf

# APPLICATION FOR LIFE INSURANCE - PART 2 MEDICAL QUESTIONNAIRE

Lincoln Benefit Life Company, P.O. Box 80469, Lincoln, NE 68501-0469 FAX: 1-866-525-5433

Allstate Life Insurance Company, P.O. Box 80469, Lincoln, NE 68501-0469 FAX: 1-877-255-1329

Proposed Insured's Name (First, Middle, Last)	Policy Number (If assigned)	Date of Birth (MM/DD/YYYY)

1. Have you ever used tobacco or nicotine products? (If "yes," give details below)  Yes  No
- Current** user of tobacco/nicotine products:  Cigarettes, \_\_\_\_\_ packs per day Years smoked \_\_\_\_\_
- Other \_\_\_\_\_ Amount/day \_\_\_\_\_ Years used \_\_\_\_\_
- Former** user of tobacco/nicotine products: Type(s) \_\_\_\_\_ When quit? \_\_\_\_\_ Years used \_\_\_\_\_
- (MM/YYYY)
- Cigarettes, \_\_\_\_\_ packs per day
- Other \_\_\_\_\_ Amount/day \_\_\_\_\_

2. Primary Physician Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Address \_\_\_\_\_

Date (MM/DD/YYYY) and Reason Last Consulted \_\_\_\_\_

Diagnoses, test results, treatment, and referrals \_\_\_\_\_

3. Do you have a family history of heart disorder, stroke or cancer beginning before age 65 in any natural parent or sibling? (If "yes," complete table below.)  Yes  No

Relationship to Proposed Insured	Disorder	Age at Onset	Age at Death	Cause of Death	Age if Living

**GIVE DETAILS OF ALL "YES" ANSWERS ON NEXT PAGE.**

4. Have you ever been diagnosed with, or sought treatment or advice for:
- a. High blood pressure, heart attack, chest pain, murmur, abnormal heart valve, heart failure, abnormal heart rhythm, or other heart disorder?  Yes  No
  - b. Stroke, mini-stroke (TIA), aneurysm, or other disorder of blood vessels?  Yes  No
  - c. Cancer, tumor, polyp, or disorder of lymph nodes?  Yes  No
  - d. Dependency on or addiction to alcohol or any drug?  Yes  No
5. Have you ever been diagnosed by a medical professional as having Acquired Immune Deficiency Syndrome (AIDS)?  Yes  No
6. In the past 10 years, have you been diagnosed with, or sought treatment or advice for:
- a. Epilepsy, seizures, fainting, paralysis, disorder of the brain or nervous system, mental or nervous disorder?  Yes  No
  - b. Diabetes, elevated blood sugar, disorder of thyroid or other endocrine glands?  Yes  No
  - c. Asthma, emphysema, shortness of breath, sleep apnea, sarcoidosis, tuberculosis, or other disorder of the lungs?  Yes  No
  - d. Ulcers, colitis, enteritis, blood in the stool, hepatitis, cirrhosis, or other disorder of digestive tract, liver, or pancreas?  Yes  No
  - e. Anemia, clotting disorder, or other disorder of blood, blood cells, or bone marrow?  Yes  No
  - f. Disorder of kidneys, bladder, prostate, or reproductive organs; or blood in urine?  Yes  No
  - g. Arthritis, lupus, or any disorder of muscles, bones, spine, or joints?  Yes  No
7. Other than previously disclosed, in the past 5 years, have you:
- a. Had a checkup, consultation, hospitalization, illness, surgery, or medical or diagnostic test?  Yes  No
  - b. Been advised to have a medical consultation, diagnostic test, or surgery that has not been done?  Yes  No
8. Are you taking any prescription or over-the-counter medications, herbs, supplements, or alternative medications not previously disclosed?  Yes  No



## MEDICAL EXAMINER'S REPORT

1. Height _____ft. _____in.	2. Weight _____lbs.	3. Waist at Umbilicus _____in.	4. Hips at Widest _____in.	5. Did you weigh? <input type="checkbox"/> Yes <input type="checkbox"/> No
7. Has weight changed 10 lbs. or more in past year? (If "yes," give details)				6. Did you measure? <input type="checkbox"/> Yes <input type="checkbox"/> No
8. Blood Pressure (Systolic/Diastolic) _____ / _____			9. Pulse Rate _____ Irregularities/min. _____	
10. Sent to Lab: <input type="checkbox"/> Urine Specimen <input type="checkbox"/> Blood Profile <input type="checkbox"/> Other: _____				
11. Is Proposed Insured currently menstruating? <input type="checkbox"/> Yes <input type="checkbox"/> No (Even if "yes," specimen should be collected.)				

**COMPLETE FOR PHYSICIAN EXAMS ONLY**

**EXPLANATIONS AND DETAILS OF ALL "YES" ANSWERS**

12. Is/are there any:
- a. Heart enlargement?  Yes  No
  - b. Dyspnea or rales?  Yes  No
  - c. Carotid bruits?  Yes  No
  - d. Cyanosis or edema?  Yes  No
  - e. Other signs of CHF, CAD, or PVD?  Yes  No
13. Are there any heart murmurs?  Yes  No
- Murmur is:  Constant  Inconstant
- Timing:  Systolic  Presystolic  Diastolic
- Grade:  Soft (1-2)  Mod. (3-4)  Loud (5-6)
- Location: \_\_\_\_\_
- Transmission: \_\_\_\_\_
14. Are there any abnormalities of:
- a. Eyes, ears, nose, mouth, pharynx?  Yes  No
  - b. Skin (including scars), lymph nodes, blood vessels?  Yes  No
  - c. Nervous system (including reflexes, gait, paralysis)?  Yes  No
  - d. Respiratory system?  Yes  No
  - e. Abdomen (including scars)?  Yes  No
  - f. Genitourinary system (including prostate)?  Yes  No
  - g. Endocrine system (including thyroid)?  Yes  No
  - h. Musculoskeletal system (including spine, joints, amputations, deformities)?  Yes  No
15. Is appearance unhealthy or older than stated age?  Yes  No
16. Do you have any information or observations that have not already been noted or are inconsistent with stated history?  Yes  No
17. Do you have any relationship or business association with Proposed Insured?  Yes  No

How did you identify the Proposed Insured? \_\_\_\_\_

Examiner's Signature \_\_\_\_\_ Date (MM/DD/YYYY) \_\_\_\_\_

Examiner's Address \_\_\_\_\_ Examiner's Phone Number: \_\_\_\_\_

**IF PROPOSED INSURED IS AGE 70 OR OLDER, COMPLETE SENIOR ASSESSMENT.**

# BUSINESS INSURANCE QUESTIONNAIRE

Lincoln Benefit Life Company, P.O. Box 80469, Lincoln, NE 68501-0469 FAX: 1-866-525-5433

Allstate Life Insurance Company, P.O. Box 80469, Lincoln, NE 68501-0469 FAX: 1-877-255-1329

Proposed Insured's Name (First, Middle, Last)	Policy Number (If assigned)	Date of Birth (MM/DD/YYYY)

1. Name of Company: \_\_\_\_\_ 2. Year Established: \_\_\_\_\_

3. Accounting or Banking Reference (Name, Phone): \_\_\_\_\_

4. How is your company organized?  C Corp.  S Corp.  Partnership  Sole Proprietorship  Other \_\_\_\_\_

5. Please provide the following figures from the company's financial statements:

Balance Sheet Summary		Income Statement Summary for the Past 2 Years	
Current Assets	\$	Total Revenue	Net Income
Long Term Assets	\$	Year: \$	\$
Current Liabilities	\$	Year: \$	\$
Long Term Liabilities	\$	Current Year - Best Estimate	\$
Net Worth	\$		

*If available, please also provide copies of company's balance sheets and income statements for past 2 years.*

6. Company's Current Fair Market Value and Calculation Method (times income, times inventory, etc.):  
\$ \_\_\_\_\_

7. Proposed Insured's % Ownership \_\_\_\_\_ %

8. Other Major Owners' Names and % Ownership: \_\_\_\_\_

9. Business Purpose of Insurance (check at least one box and provide details):

**A.  Key Person**

i. What special skills, knowledge, or relationships do you have that make this insurance necessary? \_\_\_\_\_

ii. How was the amount of insurance calculated? \_\_\_\_\_

**B.  Stock Redemption/Buy-Sell**

i. A written agreement is:  in effect (please provide copy)  in process – expected completion date (MM/DD/YYYY): \_\_\_\_\_  not planned

ii. How is the business valued for purposes of the agreement? \_\_\_\_\_

**C.  Business Loan**

i. Loan Amount \$ \_\_\_\_\_ ii. Purpose \_\_\_\_\_

iii. Name and Address of Lender \_\_\_\_\_ iv. Loan Date (MM/DD/YYYY) \_\_\_\_\_

v. Is this life insurance required by the lender?  Yes  No vi. Repayment Terms \_\_\_\_\_

**D.  Other Business Purpose** \_\_\_\_\_

10. Is insurance in-force or pending on others in this business for the same purpose? (Give details below.)  Yes  No

Name	Title	In-Force	Amount Applied For

11. Is a reorganization, acquisition, or merger of this business pending? (If "yes," explain below.)  Yes  No

12. Has this business filed for bankruptcy in the past 7 years? (If "yes," explain below.)  Yes  No

## SIGNATURES

I declare that the answers and statements given above are full and correct to the best of my knowledge and belief. I agree that this Questionnaire is part of my application and will become part of the policy applied for, if issued.

SIGN HERE

\_\_\_\_\_  
Signed at (City, State)

\_\_\_\_\_  
Date (MM/DD/YYYY)

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

\_\_\_\_\_  
Signature of Owner if other than Proposed Insured

# CIVILIAN AVIATION QUESTIONNAIRE

Lincoln Benefit Life Company, P.O. Box 80469, Lincoln, NE 68501-0469 FAX: 1-866-525-5433

Allstate Life Insurance Company, P.O. Box 80469, Lincoln, NE 68501-0469 FAX: 1-877-255-1329

Proposed Insured's Name (First, Middle, Last)	Policy Number (if assigned)	Date of Birth (MM/DD/YYYY)

1. Provide the number of hours you have flown or estimate you will fly in the following categories and time periods:

Type of Flying		Lifetime Total	Last 12 Months	Next 12 Months Estimated
<b>PRIVATE</b>	Student			
	Ultralight			
	Light Sport			
	Personal Business (Not for pay)			
	Other General Aviation (Describe):			
<b>COMMERCIAL</b>	Corporate Pilot, Employer-Owned Aircraft			
	Scheduled Airlines			
	Charter			
	Air Taxi			
	Instruction - Unlicensed Students			
	Other Instruction (Describe):			
	Other Flying for Pay, Including Crew (Describe):			
Other Non-Pilot, Non-Crew Flying (e.g. smoke jumping, reconnaissance, flight nurses and paramedics) (Describe):				
<b>TOTAL - ALL TYPES</b>				

2a. For any charter or air taxi flying, whom/what do you typically transport? \_\_\_\_\_

b. Where do you transport them? \_\_\_\_\_

c. What percentage of these hours is regularly scheduled? \_\_\_\_\_% Employer Web site: \_\_\_\_\_

3. Certificates and ratings:  Student  Sport Pilot  Recreational  Private  Commercial  ATP  IFR

Other: \_\_\_\_\_ If you have an IFR, is it current by FAA requirements?  Yes  No

4a. List aircraft flown in past 3 years and circle those you typically fly now: \_\_\_\_\_

\_\_\_\_\_

b. List aircraft other than above that you intend to fly in the next 24 months: \_\_\_\_\_

\_\_\_\_\_

c. Are any of the above aircraft experimental?  Yes  No

If "yes," which? \_\_\_\_\_

5a. FAA Medical Certificate Class:  I  II  III

b. Date of last medical exam (MM/YYYY): \_\_\_\_\_

c. Do you have restrictions (other than glasses), Waiver, Special Issuance, or SODA?  Yes  No

If "yes," explain: \_\_\_\_\_



# CLIMBING QUESTIONNAIRE

Lincoln Benefit Life Company, P.O. Box 80469, Lincoln, NE 68501-0469 FAX: 1-866-525-5433

Allstate Life Insurance Company, P.O. Box 80469, Lincoln, NE 68501-0469 FAX: 1-877-255-1329

Proposed Insured's Name (First, Middle, Last)	Policy Number (If assigned)	Date of Birth (MM/DD/YYYY)

- Check all of the activities you engage in:
  - Hikes, treks, trails or scrambles, non-technical climbs, no special equipment required
  - Climbing Towers       Rappelling       Rock Climbing       Mountain Climbing       Ice Climbing
  - Other (describe): \_\_\_\_\_
- How long have you engaged in the activities indicated above? \_\_\_\_\_
- Have you engaged in any of these activities in the past two years?  Yes    No  
If "yes", details: \_\_\_\_\_
- Do you intend to engage in any of these activities in the next two years?  Yes    No  
If "yes", details: \_\_\_\_\_
- Do you have any formal training or hold licenses or certifications?  Yes    No  
If "yes", details: \_\_\_\_\_
- Do you belong to any clubs or sanctioning organizations?  Yes    No  
If "yes", details: \_\_\_\_\_
- Do you participate for money or compensation?  Yes    No
- Do you engage or plan to engage in climbs alone, at night, in winter or off-season?  Yes    No  
If "yes", details: \_\_\_\_\_
- In what counties, states or provinces do you climb? \_\_\_\_\_
- What mountains or other formations/structures do you climb? \_\_\_\_\_
- Average duration of climb? \_\_\_\_\_      12. Maximum duration of climb? \_\_\_\_\_
- Have you ever climbed to over 14,000 feet elevation, or do you plan to do so?  Yes    No  
If "yes", details: \_\_\_\_\_
- Maximum altitude climbed to date: \_\_\_\_\_      15. Maximum altitude planned in next two years: \_\_\_\_\_
- Do any of your climbs require guides or altitude acclimatization, or are they considered expedition climbs?  Yes    No  
If "yes", details: \_\_\_\_\_
- Please indicate the equipment you use:
  - Altimeter       Ascenders (jumars)       Belay Anchors       Cams, Camalots, SLCDs       Chocks & Nuts, Hexes       Climbing Harness
  - Crampons       Etriers or Web Ladders       Headlights or Flashlights       Helmet       Ice Axe/Adze       Ice Screws
  - Mountaineering Boots       Oxygen Tanks       Perlon Ropes & Carabiners       Portaledge       Radio       Snow Picket
  - Stoppers       Other \_\_\_\_\_

## SIGNATURES

I declare that the answers and statements given above are full and correct to the best of my knowledge and belief. I agree that this Questionnaire is part of my application and will become part of the policy applied for, if issued.

SIGN HERE

\_\_\_\_\_  
Signed at (City, State)

\_\_\_\_\_  
Date (MM/DD/YYYY)

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

\_\_\_\_\_  
Signature of Owner if other than Proposed Insured

# CONFIDENTIAL FINANCIAL QUESTIONNAIRE

Lincoln Benefit Life Company, P.O. Box 80469, Lincoln, NE 68501-0469 FAX: 1-866-525-5433

Allstate Life Insurance Company, P.O. Box 80469, Lincoln, NE 68501-0469 FAX: 1-877-255-1329

Proposed Insured's Name (First, Middle, Last)		Policy Number (If assigned)	Date of Birth (MM/DD/YYYY)
Assets		Liabilities and Net Worth	
Cash, Savings, CDs	\$	Notes Payable to Banks	\$
IRA, Other Retirement Accounts	\$	Notes Payable to Others	\$
Accounts and Notes Receivable	\$	Accounts Payable Including Credit Cards	\$
Cash Value of Life Insurance	\$	Loans on Life Insurance	\$
Stocks and Bonds	\$	Taxes and Interest Due	\$
Home	\$	Mortgages - Home	\$
Other Real Estate (List addresses)	\$	Mortgages or Liens - Other Real Estate (List addresses)	\$
Business Interest	\$	Other (Describe):	\$
Personal Property (auto, furniture, etc.)	\$		\$
Other (Describe):	\$		\$
		<b>Total Liabilities</b>	\$
<b>Total Assets</b>	\$	<b>Net Worth</b>	\$
Earned Income (Income, before taxes, from employment or active involvement in a business, including salaries, wages, fees, commissions, or bonuses)			
		Last Year	Prior Year
Salary, Commissions, or Draw	\$	\$	\$
Bonuses	\$	\$	\$
Share of Profits Left in Business	\$	\$	\$
Other Earned Income (Describe):	\$	\$	\$
		<b>Total Earned Income</b>	\$
Unearned Income (Income, before taxes, that does not depend on employment or active involvement in a business)			
		Last Year	Prior Year
Dividends and Interest	\$	\$	\$
Real Estate Income	\$	\$	\$
Income from Passive Business Interest	\$	\$	\$
Social Security, Retirement, or Disability Income	\$	\$	\$
Alimony/Child Support	\$	\$	\$
Other Unearned Income (Describe):	\$	\$	\$
		<b>Total Unearned Income</b>	\$

1. Are there currently any lawsuits or judgments pending against you?  Yes  No  
 If "yes," explain: \_\_\_\_\_

2. Have you filed for bankruptcy in the past 7 years?  Yes  No  
 If "yes," type, date filed, and date discharged: \_\_\_\_\_

3. Contact information (name, phone, and email if known) of accountant, banker, or other financial advisor:  
 \_\_\_\_\_

## SIGNATURES

I declare that the answers and statements given above are full and correct to the best of my knowledge and belief. I agree that this Questionnaire is part of my application and will become part of the policy applied for, if issued.

SIGN HERE

\_\_\_\_\_  
Signed at (City, State)

\_\_\_\_\_  
Date (MM/DD/YYYY)

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

\_\_\_\_\_  
Signature of Owner if other than Proposed Insured

# DRUG AND ALCOHOL QUESTIONNAIRE

Lincoln Benefit Life Company, P.O. Box 80469, Lincoln, NE 68501-0469 FAX: 1-866-525-5433

Allstate Life Insurance Company, P.O. Box 80469, Lincoln, NE 68501-0469 FAX: 1-877-255-1329

Proposed Insured's Name (First, Middle, Last)	Policy Number (If assigned)	Date of Birth (MM/DD/YYYY)

1. List all prescription drugs you have used in the last 12 months:

Name of Medication:	Date Last Used (MM/DD/YYYY):	Reason Prescribed:

2. Do you presently drink alcoholic beverages?  Yes – proceed to “a”  No – proceed to “b”

a. If “yes,” show quantities:

	Beer	Wine	Liquor
Drinks per Day			
Drinks per Week			
Drinks per Month			

b. If “no,” date last used and reason for stopping: \_\_\_\_\_

3. Did you ever drink more than at present?  Yes  No If yes, dates (MM/DD/YYYY): \_\_\_\_\_ and quantities:

	Beer	Wine	Liquor
Drinks per Day			
Drinks per Week			
Drinks per Month			

4. Other than as prescribed by a medical professional, have you ever used, or are you currently using, any of the following:

- a. Speed, any amphetamine, or methamphetamine?  Yes  No
- b. Cocaine, including crack cocaine?  Yes  No
- c. Heroin, morphine, codeine, oxycodone, hydrocodone, methadone, or other opiates?  Yes  No
- d. LSD (acid), MDMA (ecstasy), mescaline, salvia, or other hallucinogens?  Yes  No
- e. Marijuana, hashish, hash oil, or THC in any form?  Yes  No
- f. Pentobarbital (Nembutal), secobarbital (Seconal), phenobarbital, or other barbiturates?  Yes  No
- g. Diazepam (Valium), alprazolam (Xanax), or other benzodiazepines?  Yes  No
- h. Other illegal or mind-altering substances, including but not limited to anabolic steroids, PCP, GHB, solvents or inhalants, or psilocybin (magic) mushrooms?  Yes  No

Provide details of any “yes” answers to 4a – 4h:

Name of Substance	Dates of Use (From/To)	Amount	Frequency (per day/week/month)

5a. Have you ever consulted a medical professional, received treatment or participated in counseling because of alcohol or drug use? (If "yes," provide details below and complete "b.")  Yes  No

Date(s) (MM/DD/YYYY)	Reason Seen and How Treated	Name and Address of Physician/Facility

b. Have you ever had a relapse following treatment?  Yes  No  
 If "yes," how many? \_\_\_\_\_ Dates (MM/DD/YYYY) of each: \_\_\_\_\_

6. Are you currently, or have you ever been a member of Alcoholics Anonymous, Narcotics Anonymous, or other addiction support group?  Yes  No  
 If "yes," name of group? \_\_\_\_\_ Frequency of Meeting Attendance: \_\_\_\_\_

7. Have you ever been charged or convicted for driving while intoxicated or under the influence of alcohol or any drug? (If "yes," provide details below.)  Yes  No

Dates (MM/DD/YYYY) and Details of "Yes" Answer to Question 7:	

8. Have you ever been required to attend a court-ordered alcohol and/or drug education or awareness program? (If "yes," provide details below.)  Yes  No

Dates (MM/DD/YYYY) and Details of "Yes" Answer to Question 8:	

**Please provide any additional explanation or information you feel is important regarding your use of alcohol or drugs:**

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**SIGNATURES**

I declare that the answers and statements given above are full and correct to the best of my knowledge and belief. I agree that this Questionnaire is part of my application and will become part of the policy applied for, if issued.

**SIGN HERE**

\_\_\_\_\_  
Signed at (City, State)

\_\_\_\_\_  
Date (MM/DD/YYYY)

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

\_\_\_\_\_  
Signature of Owner if other than Proposed Insured

# FOREIGN TRAVEL AND RESIDENCE QUESTIONNAIRE

Lincoln Benefit Life Company, P.O. Box 80469, Lincoln, NE 68501-0469 FAX: 1-866-525-5433

Allstate Life Insurance Company, P.O. Box 80469, Lincoln, NE 68501-0469 FAX: 1-877-255-1329

Proposed Insured's Name (First, Middle, Last)	Policy Number (If assigned)	Date of Birth (MM/DD/YYYY)

## A. CITIZENSHIP

Are you a citizen of the US? (If "Yes," complete Section C. If "No," complete Sections B and C)  Yes  No

## B. NON-US CITIZEN ONLY

- Of what country are you now a citizen? \_\_\_\_\_
- What type of visa do you have? \_\_\_\_\_
  - Permanent visa – give alien registration number: \_\_\_\_\_  
(Attach copy of permanent resident card, not employment authorization card.)
  - Temporary visa type (per I94 form): \_\_\_\_\_ Expiration date: \_\_\_\_\_  
(Attach copy of I94 form.) (MM/DD/YYYY)
- Have you applied for US citizenship?  Yes  No
- Do you currently maintain a foreign residence?  Yes  No  
If "yes," address: \_\_\_\_\_
- Where does your immediate family (spouse and children) reside? \_\_\_\_\_
- Do you plan to return to your native country?  Yes  No  
If "yes," expected frequency and duration: \_\_\_\_\_
- How long have you lived in the US? \_\_\_\_\_
- List your major assets/property and country where located (including but not limited to real estate, business and bank or investment accounts):  
\_\_\_\_\_

## C. FOREIGN TRAVEL OR RESIDENCE

1. Have you lived or traveled outside the US in the past 2 years?  Yes  No

City	Country	Purpose	From (MM/DD/YYYY)	To (MM/DD/YYYY)

2. Do you plan to live or travel outside the US in the next 2 years?  Yes  No

City	Country	Purpose	From (MM/DD/YYYY)	To (MM/DD/YYYY)

3. Where is your primary residence (City, Country)? \_\_\_\_\_

## D. ADDITIONAL COMMENTS

\_\_\_\_\_  
\_\_\_\_\_

## E. SIGNATURES

I declare that the answers and statements given above are full and correct to the best of my knowledge and belief. I agree that this Questionnaire is part of my application and will become part of the policy applied for, if issued.

SIGN HERE

\_\_\_\_\_  
Signed at (City, State)

\_\_\_\_\_  
Date (MM/DD/YYYY)

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

\_\_\_\_\_  
Signature of Owner if other than Proposed Insured

# MILITARY AVIATION QUESTIONNAIRE

Lincoln Benefit Life Company, P.O. Box 80469, Lincoln, NE 68501-0469 FAX: 1-866-525-5433

Allstate Life Insurance Company, P.O. Box 80469, Lincoln, NE 68501-0469 FAX: 1-877-255-1329

Proposed Insured's Name (First, Middle, Last)	Policy Number (If assigned)	Date of Birth (MM/DD/YYYY)

1. Give the number of hours you have flown or estimate you will fly in the following categories and time periods:

	Hours as a Pilot or Co-Pilot		Hours as Crew Member Only	
	Active Military	Reserves or National Guard	Active Military	Reserves or National Guard
<b>Total</b>				
<b>Last 12 Months</b>				
<b>Estimated Next 12 Months</b>				

2. Branch of Service \_\_\_\_\_

3. Expected Termination of Service Date \_\_\_\_\_

4. (a) List all aircraft flown in past 3 years: \_\_\_\_\_

(b) List the aircraft you typically fly now: \_\_\_\_\_

5. Indicate any of the following that describe your flying in the past 3 years. If none, so indicate:

None

- |  |   |  |  |                                       |   |
|--|---|--|--|---------------------------------------|---|
| <input type="checkbox"/> Aerobatics Team | <input type="checkbox"/> Counterdrug Reconnaissance | <input type="checkbox"/> Disaster Relief   | <input type="checkbox"/> Experimental      | <input type="checkbox"/> Flight Nurse | <input type="checkbox"/> Flight Surgeon |
| <input type="checkbox"/> Instructor      | <input type="checkbox"/> Proficiency Only           | <input type="checkbox"/> Search and Rescue | <input type="checkbox"/> Space Exploration | <input type="checkbox"/> Student      | <input type="checkbox"/> Weather        |

6. Do you anticipate any changes in the aircraft you fly or types of flying in the next 2 years?

Yes  No

If "yes", describe: \_\_\_\_\_

7. Do you anticipate service outside the U.S. in the next 12 months?

Yes  No

If "yes", explain: \_\_\_\_\_

8. Are you a service academy cadet or in advanced ROTC subject to aviation involvement?

Yes  No

If "yes", explain: \_\_\_\_\_

## Additional Information or Explanation

## SIGNATURES

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\_\_\_\_\_  
Signed at (City, State)

\_\_\_\_\_  
Date (MM/DD/YYYY)

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

\_\_\_\_\_  
Signature of Owner if other than Proposed Insured

# MOTOR SPORTS QUESTIONNAIRE

Lincoln Benefit Life Company, P.O. Box 80469, Lincoln, NE 68501-0469 FAX: 1-866-525-5433

Allstate Life Insurance Company, P.O. Box 80469, Lincoln, NE 68501-0469 FAX: 1-877-255-1329

Proposed Insured's Name (First, Middle, Last)	Policy Number (If assigned)	Date of Birth (MM/DD/YYYY)

- Are you affiliated with any racing organization?  Yes  No  
If "yes," provide name(s): \_\_\_\_\_
- Have you attended a competition drivers' school?  Yes  No
- Do you hold a competition driver's license from any organization?  Yes  No  
If "yes," specify which one(s): \_\_\_\_\_
- Indicate the type(s) of racing in which you participate (check all that apply):  
 ATV       Auto Crash/Demolition Derby       Championship/Indy Car/Formula 1       Drag       Dune/Sand Buggy       Go Kart  
 Midget       Motorcycle       Sprint       Powerboat       Sports Car       Record Attempts  
 Solo Events (Rally, Slalom)       Stock Car/NASCAR       Vintage       Other \_\_\_\_\_
- Type(s) of event(s): \_\_\_\_\_
- Vehicle make(s) and model(s): \_\_\_\_\_
- Class/Category/Division: \_\_\_\_\_
- Engine Displacement/Horsepower: \_\_\_\_\_ 9. Gas/fuel: \_\_\_\_\_
- Do you adhere to **all** required safety procedures and required equipment?  Yes  No  
If "no," give details: \_\_\_\_\_
- Type(s) of course(s) (check all that apply):  
 Paved Track     Drag Strip     Oval Track     Ice     Dirt Track     Road Course     Desert/Off Road  
 Water     Other \_\_\_\_\_
- Years of experience: \_\_\_\_\_ 13. Length of each track/course: \_\_\_\_\_
- Length of race (laps, miles, or time): \_\_\_\_\_ 15. Maximum Speed (MPH): \_\_\_\_\_
- Average Speed (MPH): \_\_\_\_\_ 17. If **drag race**, elapsed time (E.T.): \_\_\_\_\_
- Number of races (a) last 12 months: \_\_\_\_\_ (b) anticipated in next 12 months: \_\_\_\_\_
- Do you anticipate engaging in any other type or class of racing?  Yes  No  
If "yes," give type(s) and details for each: \_\_\_\_\_
- In the last 10 years, have you been involved in any accidents causing injury to yourself or others?  Yes  No  
If "yes," give dates and details: \_\_\_\_\_

## SIGNATURES

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SIGN HERE

\_\_\_\_\_  
Signed at (City, State)

\_\_\_\_\_  
Date (MM/DD/YYYY)

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

\_\_\_\_\_  
Signature of Owner if other than Proposed Insured

# SKYDIVING AND PARACHUTING QUESTIONNAIRE

Lincoln Benefit Life Company, P.O. Box 80469, Lincoln, NE 68501-0469 FAX: 1-866-525-5433

Allstate Life Insurance Company, P.O. Box 80469, Lincoln, NE 68501-0469 FAX: 1-877-255-1329

Proposed Insured's Name (First, Middle, Last)	Policy Number (If assigned)	Date of Birth (MM/DD/YYYY)

- When did you begin skydiving or other parachuting? \_\_\_\_\_
- What was the date of your last jump? \_\_\_\_\_
- Please give number of jumps in each time period:  
 Lifetime \_\_\_\_\_ Past 12 months \_\_\_\_\_ Estimated Next 12 Months \_\_\_\_\_
- What is the highest altitude from which you have jumped, and when? \_\_\_\_\_
- Are you a member of a national parachuting organization?  Yes  No  
 If "yes," organization name and when you joined: \_\_\_\_\_
- Do you ever jump into areas not designated specifically for parachute landings or do not have drop zone staff?  Yes  No
- Within the past 2 years, have you participated in:
  - parachuting competitions, or do you plan to do so in the future?  Yes  No
  - wing suit flying, sky surfing, or night jumps, or do you plan to do so in the future?  Yes  No
- Are you a parachuting instructor?  Yes  No
- Do you parachute as a member of the armed services or as a requirement of any other occupation?  Yes  No
- Have you ever participated in BASE jumping?  Yes  No

**Additional Information or Explanation**

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## SIGNATURES

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**SIGN HERE**

\_\_\_\_\_  
Signed at (City, State)

\_\_\_\_\_  
Date (MM/DD/YYYY)

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

\_\_\_\_\_  
Signature of Owner if other than Proposed Insured

# UNDERWATER DIVING QUESTIONNAIRE

Lincoln Benefit Life Company, P.O. Box 80469, Lincoln, NE 68501-0469 FAX: 1-866-525-5433

Allstate Life Insurance Company, P.O. Box 80469, Lincoln, NE 68501-0469 FAX: 1-877-255-1329

Proposed Insured's Name (First, Middle, Last)	Policy Number (If assigned)	Date of Birth (MM/DD/YYYY)

1. When and where did you learn to dive? \_\_\_\_\_

2. Diving organization(s) by which you are certified:  NAUI  PADI  YMCA Other (describe) \_\_\_\_\_

3. What is your level of certification?  Basic  Open Water  Adventure Diver  Advanced Open Water Diver  
 Rescue Diver  Master Scuba Diver Other \_\_\_\_\_ Date of Certification (MM/DD/YYYY) \_\_\_\_\_

4. Indicate the type(s) of diving in which you have participated (check all that apply):

	Date Last Participated (MM/DD/YYYY)	Certified?
<input type="checkbox"/> Rescue Diver		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Emergency First Diver		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Search and Recovery		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Night Diver		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Deep Diver		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Wreck Diver		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Cavern Diver		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Ice Diver		<input type="checkbox"/> Yes <input type="checkbox"/> No

5. Types of water in which you dive:  Oceans  Lakes  Rivers  Mines or quarries  Caves  Other \_\_\_\_\_

6. Indicate number of dives in each category:

	<60'	60-100'	101-150'	>150'
Past 12 months				
Expected in next 12 months				

7. Depth of deepest dive you have participated in and when: \_\_\_\_\_

8. Have you ever had the bends, air embolism, or loss of consciousness from diving?  Yes  No

9. Do you ever dive alone?  Yes  No

10. Do you ever dive for pay?  Yes  No

## Explanation and Details of any "Yes" Answers to Questions 8-10

\_\_\_\_\_  
 \_\_\_\_\_

## SIGNATURES

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\_\_\_\_\_  
Signed at (City, State)

\_\_\_\_\_  
Date (MM/DD/YYYY)

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

\_\_\_\_\_  
Signature of Owner if other than Proposed Insured

SERFF Tracking Number: ALSB-126241800 State: Arkansas  
Filing Company: Lincoln Benefit Life Company State Tracking Number: 43097  
Company Tracking Number: FIC383 LBL SERIES  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: FIC383 LBL Series  
Project Name/Number: FIC383 Series/FIC383 Series

## Supporting Document Schedules

**Item Status:** **Status**  
**Date:**

**Satisfied - Item:** Flesch Certification  
**Comments:**  
**Attachment:**  
LBL Readability Certification.pdf

**Item Status:** **Status**  
**Date:**

**Bypassed - Item:** Application  
**Bypass Reason:** Please see form schedule for filed Medical Exam form and Questionnaires  
**Comments:**

**Item Status:** **Status**  
**Date:**

**Satisfied - Item:** Certification of Compliance  
**Comments:**  
**Attachment:**  
AR LBL Cert of Comp.pdf

**Item Status:** **Status**  
**Date:**

**Satisfied - Item:** Statement of Variability  
**Comments:**  
**Attachment:**  
LBL Medical Exam and Questionnaires SOV.pdf

## LINCOLN BENEFIT LIFE COMPANY READABILITY CERTIFICATION

I hereby certify the accuracy of the Flesch reading ease test score for the following policy forms. These forms are at least ten (10) point type, two (2) point leaded.

TITLE	FORM NUMBER	FLESCH SCORE
Application for Life Insurance Part 2 – Medical Questionnaire	FIC383	61
Business Insurance Questionnaire	FIC384BIQ	47
Civilian Aviation Questionnaire	FIC384CAQ	63
Confidential Financial Questionnaire	FIC384CFQ	45
Climbing Questionnaire	FIC384CQ	54
Drug and Alcohol Questionnaire	FIC384DAQ	54
Foreign Travel and Residence Questionnaire	FIC384FTRQ	63
Military Aviation Questionnaire	FIC384MAQ	59
Motor Sports Questionnaire	FIC384MSQ	63
Skydiving and Parachuting Questionnaire	FIC384SPQ	61
Underwater Diving Questionnaire	FIC384UDQ	61

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Robert Transon, Assistant Vice President

July 23, 2009

**STATE OF ARKANSAS**  
**CERTIFICATION OF COMPLIANCE**

I hereby certify that to the best of my knowledge and belief this submission complies with Ark. Code Ann. 23-79-138, Regulation 49, and Regulation 33.

August 3, 2009

**Date**

\_\_\_\_\_  
**Signature of Officer**

Robert E. Transon

**Name**

Assistant Vice President

**Title and/or Business Affiliation**

**Statement of Variability - Life  
Lincoln Benefit Life Company**

**Forms: FIC383, FIC384BIQ, FIC384CAQ, FIC384CFQ, FIC384CQ, FIC384DAQ,  
FIC384FTRQ, FIC384MAQ, FIC384MSQ, FIC384SPQ, FIC384UDQ**

Items in the above-referenced form(s) are bracketed to indicate variable information. Some items vary to reflect policy-specific information.

<b>Page</b>	<b>Bracketed Items</b>	<b>Description of Variability</b>
1	Company Address & Fax Number	Company location, zip codes and fax numbers may vary over time.