

SERFF Tracking Number: ALSB-126838291 State: Arkansas
Filing Company: Lincoln Benefit Life Company State Tracking Number: 47004
Company Tracking Number: FIC400 SERIES
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: FIC400 Series
Project Name/Number: FIC400 Series/FIC400 Series

Filing at a Glance

Company: Lincoln Benefit Life Company

Product Name: FIC400 Series

TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Filing Type: Form

SERFF Tr Num: ALSB-126838291 State: Arkansas

SERFF Status: Closed-Approved-
Closed State Tr Num: 47004

Co Tr Num: FIC400 SERIES

State Status: Approved-Closed

Author: Devyn Porstner

Reviewer(s): Linda Bird

Date Submitted: 10/07/2010

Disposition Date: 10/11/2010

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: FIC400 Series

Project Number: FIC400 Series

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 10/11/2010

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: 10/11/2010

Created By: Devyn Porstner

Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Devyn Porstner

Filing Description:

PLEASE REVIEW IN CONJUNCTION WITH SERFF TRACKING NUMBER ALSB-126838290.

We submit via SERFF 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

Application forms FIC400, FIC400T and FIC400PQ are new business applications that will be used to apply for coverage of all life insurance policies previously approved by your Department. These forms may also be used to write

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life policies developed in the future.

Forms FIC400 and FIC400T contain customer specific information, disclosures and owner/agent signature sections.

Form FIC400PQ consists of an underwriting questionnaire and will be used with Form FIC400T.

Form FIC400ATTSIG provides additional signature lines for multiple owners, insured's and/or children.

Form FIC400TIA is a receipt and temporary insurance agreement.

Form FIC400PF is a premium finance supplement to life application. This form will be completed by proposed insureds whose premiums are to be funded directly or indirectly by a loan or advance from any person or entity other than the individual's employer.

Explanation of Multiple Companies Listed on Forms

Lincoln Benefit Life Company and Allstate Life Insurance Company (Allstate Life) will use the above referenced forms. We have provided separate filings for each company. The reason these forms have been filed for use by two companies is for the benefit of our agents who sell both companies' products. We would like to have forms that can be used with each company's products.

Please be aware that no other company other than the ones listed at the time of filing, will be used on these forms. Should the need to add another company become necessary, the forms will be re-filed with your Department for approval.

These forms have been generated by our home office computer system. These forms may also be generated using other hardware, which can result in changes in formatting (e.g., typeface, margins, page breaks), but the contents will remain unaffected.

Please note that some of the variable information on the pdfs of these forms was bracketed using Adobe Acrobat. Although the bracketing appears on the attached pdfs when viewed electronically, the bracketing may not appear on printed hard copies unless your printer is given special instructions to do so.

Thank you for your consideration of this matter.

Sincerely,

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Devyn Marie Stoltz
 State Filing Project Coordinator
 Contract Development and Filing

Company and Contact

Filing Contact Information

Devyn Stoltz, dpors@allstate.com
 3100 Sanders Rd, Suite M2A 847-402-2962 [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

Filing Fees

Fee Required? Yes
 Fee Amount: \$300.00
 Retaliatory? No
 Fee Explanation: 50.00 per form X 6 forms
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Lincoln Benefit Life Company	\$300.00	10/07/2010	40409944

SERFF Tracking Number: ALSB-126838291

State: Arkansas

Filing Company: Lincoln Benefit Life Company

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Company Tracking Number: FIC400 SERIES

TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Product Name: FIC400 Series

Project Name/Number: FIC400 Series/FIC400 Series

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	10/11/2010	10/11/2010

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Supporting Document	Statement of Variability	Devyn Porstner	10/11/2010	10/11/2010

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document (<i>revised</i>)	Statement of Variability		Yes
Supporting Document	Statement of Variability		Yes
Form	Application for Life Insurance		Yes
Form	Application for Life Insurance (Tele-App)		Yes
Form	Application for Life Insurance Part 2		Yes
Form	Receipt and Temporary Insurance Agreement		Yes
Form	Premium Finance Supplement to Life Application		Yes
Form	Additional Signatures - Application for Life Insurance		Yes

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Amendment Letter

Submitted Date: 10/11/2010

Comments:

We submitted statements of variability with the incorrect company name. This has been corrected and we apologize for any inconvenience.

Changed Items:

Supporting Document Schedule Item Changes:

User Added -Name: Statement of Variability

Comment:

FIC400 and FIC400T SOV _1010_.pdf

FIC400ATTSIG SOV _1010_.pdf

FIC400PQ, FIC400TIA, FIC400PF SOV _1010_.pdf

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Form Schedule

Lead Form Number: FIC400 Series

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	FIC400	Application/ Enrollment Form	Application for Life Insurance	Initial		52.000	FIC400 New Life App Part 1 and Part 2 (0111) B.pdf
	FIC400T	Application/ Enrollment Form	Application for Life Insurance (Tele-App)	Initial		62.200	FIC400T New Life App Tele-App_Part 1 (0111) B.pdf
	FIC400PQ	Application/ Enrollment Form	Application for Life Insurance Part 2	Initial		66.000	FIC400PQ New Life App Part 2 (0111) B.pdf
	FIC400TIA	Application/ Enrollment Form	Receipt and Temporary Insurance Agreement	Initial		65.900	FIC400TIA New Life App TIA (0111) B.pdf
	FIC400PF	Application/ Enrollment Form	Premium Finance Supplement to Life Application	Initial		61.000	FIC400PF New Life App Premium Finance (0111) B.pdf
	FIC400ATT SIG	Application/ Enrollment Form	Additional Signatures - Application for Life Insurance	Initial		53.000	FIC400ATTSIG New Life App Signature Overflow (0111) B.pdf

APPLICATION FOR LIFE INSURANCE

Lincoln Benefit Life Company ("The Company"), Lincoln, NE 68501

Allstate Life Insurance Company ("The Company"), Northbrook, IL 60062

APPLICATION FOR LIFE INSURANCE - PART 1

SECTION A. PRIMARY PROPOSED INSURED

1. Name (First, Middle, Last)		2. Driver's License Number/State	3. Sex <input type="checkbox"/> M <input type="checkbox"/> F
4. Home Address (include street, city, state, zip)			
5. Birth Date (MM/DD/YYYY) <input type="text"/> <input type="text"/>		6. Birth State/Country	7. Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced
8. Primary Phone	Secondary Phone (if any)	9. E-mail Address	

BENEFICIARIES

10. Primary Beneficiary Name (First, Middle, Last)			
11. Address <input type="checkbox"/> Same as Primary Proposed Insured		<input type="checkbox"/> Other (include street, city, state, zip)	
12. SSN/TIN	13. Birth Date/Trust Date (MM/DD/YYYY)	14. Relationship	15. % Share (if not equal)
16. Additional Beneficiary Name (First, Middle, Last)(Check Primary or Contingent)			<input type="checkbox"/> Primary <input type="checkbox"/> Contingent
17. Address <input type="checkbox"/> Same as Primary Proposed Insured		<input type="checkbox"/> Other (include street, city, state, zip)	
18. SSN/TIN	19. Birth Date/Trust Date (MM/DD/YYYY)	20. Relationship	21. % Share (if not equal)

SECTION B. ADDITIONAL/JOINT PROPOSED INSURED - If more than one AIR, submit additional copies of Section B

1. Name (First, Middle, Last)		2. Driver's License Number/State	3. Sex <input type="checkbox"/> M <input type="checkbox"/> F
4. Home Address (include street, city, state, zip)			
5. Birth Date (MM/DD/YYYY) <input type="text"/> <input type="text"/>		6. Birth State/Country	7. Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced
8. Primary Phone	Secondary Phone (if any)	9. Relationship to Insured	10. E-mail Address

BENEFICIARIES

11. Primary Beneficiary Name (First, Middle, Last)			
12. Address <input type="checkbox"/> Same as Additional/Joint Proposed Insured		<input type="checkbox"/> Other (include street, city, state, zip)	
13. SSN/TIN	14. Birth Date/Trust Date (MM/DD/YYYY)	15. Relationship	16. % Share (if not equal)
17. Additional Beneficiary Name (First, Middle, Last)(Check Primary or Contingent)			<input type="checkbox"/> Primary <input type="checkbox"/> Contingent
18. Address <input type="checkbox"/> Same as Additional/Joint Proposed Insured		<input type="checkbox"/> Other (include street, city, state, zip)	
19. SSN/TIN	20. Birth Date/Trust Date (MM/DD/YYYY)	21. Relationship	22. % Share (if not equal)

SECTION C. CHILDREN PROPOSED FOR CHILDREN'S LEVEL TERM RIDER - Must be age 17 or less and Primary Proposed Insured's child, legally adopted child, or stepchild living with Primary Proposed Insured. Not available if Owner is a business.

1. Name (First, Middle, Last)	2. Sex	3. Birth Date (MM/DD/YYYY)	4. SSN/TIN
	<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F		

SECTION D. OWNER - If other than Primary Proposed Insured

1. Name (First, Middle, Last) (If the Owner is a trust, provide full title of the trust and names of current trustees.)	2. Primary Phone
3. Home Address (include street, city, state, zip)	
4. Birth Date/Trust Date (MM/DD/YYYY)	5. Relationship to Primary Proposed Insured
<input type="text"/>	6. E-mail Address

SECTION E. PREMIUM PAYOR - If other than Owner

1. Name (First, Middle, Last)
2. Home Address (include street, city, state, zip)
3. Relationship to Primary Proposed Insured
4. E-mail Address

SECTION F. PREMIUM FUNDING - Required if Primary Proposed Insured is over age 60

- Will premiums be paid directly or indirectly with borrowed funds or by any party not named in this application? (If "yes," complete the Premium Finance Supplement to Life Application.) Yes No
- Will or has any Proposed Insured, Owner, or other party be(en) given or offered anything of value to apply for this policy or to transfer or assign benefits under it to any party not named in this application? Yes No
- Is this policy being applied for with the understanding, written or unwritten, that it or any right or interest in it will be sold or transferred for value to any party not named in this application? Yes No
- Is any existing life insurance policy on any Proposed Insured now owned by, or in the process of being sold or offered for sale to, a viatical or settlement company, investor(s), or any party who does not have insurable interest in the Insured's life? Yes No

Details of "yes" answers:

SECTION G. CITIZENSHIP

- Are all Proposed Insureds, Beneficiaries, Owners, and Payors United States citizens or holders of a permanent resident card? (If "no," give details below) Yes No

Name and Role (e.g. "Insured")	Country	Visa No. and Type (Attach copy if available)

SECTION H. THE POLICY

1. Plan of Insurance (for term plans include level period) _____ 2. Base Face Amount _____ 3. Death Benefit Option (UL/VUL Only - when applicable)
 1 2 3

4. Additional Benefits, Riders, Options:
 WP COP \$ _____ CLTR _____ Units (\$5,000 per unit) PTR \$ _____
 Accidental DB (ADB) - Primary Insured \$ _____ Automatic Premium Loan (for Whole Life Only) Date to save age (if within allowed timeframe)
 Other: _____

For Legacy products only: Guarantee period under Coverage Protection Rider (if not lifetime): _____ years or to age _____ Limited Pay for _____ years or to age _____
 Additional Insured Rider(s):
 Name _____ \$ _____ Level Period* _____ ADB on AIR \$ _____
 Name _____ \$ _____ Level Period* _____ ADB on AIR \$ _____
 *Required for AIR on term base policy only

5. UL/VUL Premiums (must match illustration) _____ Planned Modal Premium _____ Additional Lump Sum Premium (Includes expected 1035 funds if any) _____ 6. Substandard Rating Quoted (if any) _____
 \$ _____ \$ _____

7. Premium Mode/Method (must match illustration) Single Monthly EFT Quarterly Semiannual Annual Other _____

SECTION I. REPLACEMENT AND OTHER INSURANCE - Provide required forms for replacement, including change form(s) for internal replacements.

1. Are there any life insurance or annuity contracts, including group life, on any Proposed Insured
- a. in force or applied for in any company, other than this application? Yes No
 - b. which have been or will be terminated because of the proposed policy? Yes No
 - c. which have been or will be borrowed against or withdrawn from, used to pay any portion of premiums for, or changed in any way because of the proposed policy? Yes No
 - d. which will be replaced in a 1035 exchange by the policy applied for? (Must be life insurance, not annuity.) Yes No

List all policies in force or applied for and give details below:

Person Covered	Company	Life Amount Including Riders	Issue Date (MM/YYYY)	Policy Number	Plan Type	Check if Replacing
						<input type="checkbox"/>
						<input type="checkbox"/>
						<input type="checkbox"/>

SECTION J. PRELIMINARY UNDERWRITING QUESTIONS - Do not submit payment with this application if any of the questions below are answered "yes," or if any Primary, Additional, or Joint Insured is less than 15 days or more than 70 years of age

1. In the past 5 years, have any Proposed Insureds:
- a. used, received treatment or counseling for using, or been arrested for possession, sale or delivery of, any illegal drug? Yes No
 - b. been diagnosed or treated for heart disease, stroke, or cancer (other than non-melanoma skin cancer)? Yes No
 - c. been diagnosed or treated by a medical professional for Acquired Immune Deficiency Syndrome (AIDS)? Yes No
 - d. been charged with, or been on probation or parole for, any felony? Yes No
2. In the past 90 days, have any Proposed Insureds been hospitalized overnight (other than for normal childbirth), had inpatient surgery, or been advised by a medical professional to be hospitalized or have inpatient surgery? Yes No

Details of "yes" answers:

SECTION K. AGENT REMARKS/SPECIAL INSTRUCTIONS

APPLICATION FOR LIFE INSURANCE - PART 2

SECTION A. GENERAL QUESTIONS - Must be completed even if an exam is required

1. PRIMARY PROPOSED INSURED		
a. Employer Name and Phone Number	b. Occupation and Duties	c. Annual Income
2. ADDITIONAL/JOINT INSURED		
a. Employer Name and Phone Number	b. Occupation and Duties	c. Annual Income

3. Have any Proposed Insureds had more than one moving violation in the past 3 years or been convicted of driving under the influence or reckless driving in the past 10 years? Yes No

4. In the past 3 years, have any Proposed Insureds:

a. flown as a pilot or crew member of any aircraft? Yes No

b. engaged in sky or scuba diving, vehicle racing, mountain or rock climbing? Yes No

5. Have any Proposed Insureds ever had an application for life insurance declined, postponed, rated, or modified? Yes No

6. Have any Proposed Insureds resided in the U.S. continuously for less than 3 years? Yes No

7. Do any Proposed Insureds plan to spend more than 2 weeks outside the U.S. in the next year? Yes No

8. For Primary or Additional Proposed Insured under age 18: Including the policy applied for, will the total life insurance on the Primary/Additional Insured exceed: (If yes to either question, give amounts and explain.)

a. The amount on any sibling in the same household? Yes No

b. Half the amount on any custodial parent? Yes No

Details of "yes" answers:

SECTION B. HEALTH AND MEDICAL HISTORY

PRIMARY PROPOSED INSURED							
1. Height and Weight: Ft. In. Lbs.	2a. Do you currently use tobacco or nicotine? <input type="checkbox"/> Yes <input type="checkbox"/> No						
2b. If "yes" to 2a, what type: <input type="checkbox"/> Cigarettes _____ per _____ <input type="checkbox"/> Cigars _____ per _____ <input type="checkbox"/> Pipe <input type="checkbox"/> Smokeless <input type="checkbox"/> Nicotine gum/patch <input type="checkbox"/> Other _____	2c. If "no" to 2a, have you ever used tobacco or nicotine? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", what did you use: <input type="checkbox"/> Cigarettes <input type="checkbox"/> Other _____ When did you quit (MM/YYYY)? _____						
ADDITIONAL/JOINT INSURED							
3. Height and Weight: Ft. In. Lbs.	4a. Do you currently use tobacco or nicotine? <input type="checkbox"/> Yes <input type="checkbox"/> No						
4b. If "yes" to 4a, what type: <input type="checkbox"/> Cigarettes _____ per _____ <input type="checkbox"/> Cigars _____ per _____ <input type="checkbox"/> Pipe <input type="checkbox"/> Smokeless <input type="checkbox"/> Nicotine gum/patch <input type="checkbox"/> Other _____	4c. If "no" to 4a, have you ever used tobacco or nicotine? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", what did you use: <input type="checkbox"/> Cigarettes <input type="checkbox"/> Other _____ When did you quit (MM/YYYY)? _____						
5. Does any Primary or Additional/Joint Proposed Insured have a family history of heart disorder, stroke or cancer beginning before age 60 in any natural parent or sibling? (If "yes," complete table below.) <input type="checkbox"/> Yes <input type="checkbox"/> No							
Proposed Insured	Which Relative	Disorder	Age at Onset	Age at Death	Cause of Death	Age if Living	

PERMIT TO OBTAIN AND DISCLOSE CERTAIN DATA

- A. The Company, its reinsurers, consumer reporting agencies, and other parties acting on The Company's behalf may get data about my health, medical history, prescription medication history and related information, mode of living (except as may be related directly or indirectly to sexual orientation), avocations, finances, credit history, driving record, and any criminal record. I understand that the information obtained by use of this authorization will be used to determine eligibility for insurance and/or benefits, or for The Company to determine its obligations under the policy issued in connection with this application.
- B. Any doctor, practitioner, medical or medically related facility, laboratory, Pharmacy Benefit Managers, the Veterans Administration, the Medical Information Bureau, Inc. (MIB, Inc.), viatical settlement company, employer, consumer reporting agency, creditor, government agency, insurance or reinsurance company or any other person or entity which has such data about me may give such data to The Company and its reinsurers when this Permit or a copy of it is shown. All sources but the MIB, Inc., may give such data to agents or agencies acting on behalf of The Company. The information as provided herein pursuant to the authorization will not be redisclosed unless authorized by me or otherwise required by law. Covered entities, as defined by the Health Insurance Portability and Accountability Act of 1996, may not condition treatment, payment, enrollment, or eligibility for benefits on whether this Permit is signed.
- C. Any request by The Company for medical records is on my behalf; the information must be provided within any requirements imposed by applicable statutes governing patient access to medical records.
- D. Data about mental illness, alcoholism, sexually transmitted diseases, and the use of drugs is to be included.
- E. The Company or its reinsurers may make a brief report about me to the MIB, Inc.
- F. This Permit is good for 24 months after it is signed. **I understand that, if applicable, my electronic signature on this form operates as my original signature.**
- G. The Company may obtain an investigative consumer report ("inspection report") on me. I want to be interviewed if such a report is obtained.
- H. I have read this Permit and know I may request a copy of it. I may revoke this Permit by writing to The Company. I also have received the Disclosures and Notices.

DECLARATIONS

- A. I (each undersigned) declare that all answers written on this application are full and correct to the best of my knowledge and belief. Except in [Maine, Missouri, New Jersey, Oregon, and South Carolina], The Company is not presumed to know any information not in this application.
- B. The Company may add to or correct the application on an addendum page. Any changes are agreed to if I (we) accept the policy, but written agreement will be obtained from me for any change in insurance amount, plan, benefits, payment class or age at issue. (In [West Virginia, Maryland, New Hampshire, and Pennsylvania], written consent will be obtained for any changes.)
- C. Insurance will start only as provided in the Receipt and Temporary Insurance Agreement issued in connection with this application. If no receipt is issued or if insurance under it has stopped and not started again, no insurance will start by reason of the application until the policy is delivered and the first premium paid in full. No insurance will start if at that time the health of all Proposed Insureds is not as described in the application.
- D. I have read and understand this application, including the Disclosures and Notices, which I acknowledge receiving.
- E. Only an officer of The Company may change this application or waive a right or requirement. No agent may do this.

ALL QUESTIONS WERE ASKED OF ME AND, IF APPLICABLE, THE ADDITIONAL/JOINT INSURED AND PARENTS OF ANY CHILDREN LISTED ON THIS APPLICATION. I (WE) HAVE READ ALL INFORMATION BEFORE SIGNING.

LIFE ILLUSTRATION ACKNOWLEDGEMENT: Unless checked, applicant acknowledges that no illustration conforming to the policy applied for has been provided and understands that an illustration conforming to the policy as issued will be provided no later than the time the policy is delivered. If checked, submit applicable signed illustration with application.

I declare that the answers and statements written above are full and correct to the best of my knowledge and belief. I understand and agree that the statements above, along with the application, will be the basis for any insurance issued.

Substitute Form W-9 - Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. person (including U.S. resident alien).

The Internal Revenue Service does not require your consent to any provisions of this document other than the certification required to avoid backup withholding.

SIGN HERE

Signature of Owner, if other than Insured (and title, if applicable, such as "Trustee" or "President") SSN/TIN

Signature of Joint Owner (and title, if applicable, such as "Trustee" or "President") SSN/TIN

Signature of Primary Proposed Insured SSN/TIN

Signature of Additional/Joint Proposed Insured SSN/TIN

Signature of Parent/Legal Guardian (if any Insured is under Age 15)

Signed at (City, State) Date (MM/DD/YYYY) Signature of Agent

DISCLOSURES AND NOTICES - Please leave with Applicant

IMPORTANT INFORMATION REGARDING MEDICAL EXAMS

As part of the underwriting process we may ask for medical tests or exams to be completed at our expense. Common tests may include a paramedical exam, which will consist of questions about your medical history and measurements of your body including, but not limited to height, weight, blood pressure, and pulse. Blood and urine specimens are also generally collected. Undressing is not required for any of these tests. In some instances, an EKG (Electrocardiogram) may be required. An EKG is a recording of the electrical impulses in the heart. You will be asked to lay down with your shirt unbuttoned so the EKG leads can be placed on your chest.

If you have any questions about the specific tests that will be required of you, please feel free to contact your agent.

NOTICE REGARDING THE MIB

Information regarding your insurability will be treated as confidential. The 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 company, MIB, upon request, will supply such 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 the 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, Massachusetts 02184-8734].

The 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].

INSURANCE INFORMATION PRACTICES

We will rely primarily on the information you give us. We may also get information from other sources, such as doctors, or other medical professionals who have treated you. In some cases, we may ask a consumer reporting agency to gather information and send us an investigative consumer report as explained in the Notice Under the Federal Fair Credit Reporting Act below. You may ask to be interviewed as part of the preparation of any such report.

In certain limited circumstances, we are allowed by law to disclose necessary items of personal information to third parties without your specific authorization. You have the right to be told about and to see and copy items of personal information about you that appear in our files, including information contained in the 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 Underwriting Department, Allstate Life Insurance Company/Lincoln Benefit Life Company, [P.O. Box 660191, Dallas, TX 75266-0191].

NOTICE UNDER THE FAIR CREDIT REPORTING ACT

In compliance with the Federal Fair Credit Reporting Act, you are hereby notified that an investigative report may be made. This would be by personal interviews with neighbors, friends, associates, or other persons. This will concern the character, general reputation, personal characteristics, and mode of living (except as may be related to sexual orientation) of any person proposed for insurance. You may obtain additional information concerning the nature and scope of this investigation and a written summary of your rights under the Federal Fair Credit Reporting Act by contacting our Home Office. Our address is Allstate Life Insurance Company/Lincoln Benefit Life Company, [P.O. Box 660191, Dallas, TX 75266-0191]. Upon your written request, you will be informed whether or not an investigation was made by us. If so, you will receive the name and address of the consumer reporting agency involved. You may receive and inspect a copy of the Investigative Consumer Report by contacting the consumer reporting agency.

NON-SUFFICIENT FUNDS (NSF) FEE

This notice is to inform you of a fee The Company may charge in the event that a life insurance policy premium payment and/or loan payment is not honored by your financial institution due to NSF. In the event there is a NSF transaction, we may charge a NSF fee up to \$25.00 (fee varies by state). If your policy is on bank draft, we may draft your account for the NSF fee. If your policy is on direct bill, we may send you a paper bill for the NSF fee.

The NSF fee is separate from your policy premium payments. All policy premium payments must be made within the required time period to keep your policy in force.

IMPORTANT INFORMATION

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

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APPLICATION FOR LIFE INSURANCE

Lincoln Benefit Life Company ("The Company") [Lincoln, NE 68501]

Allstate Life Insurance Company ("The Company") [Northbrook, IL 60062]

APPLICATION FOR LIFE INSURANCE - PART 1

SECTION A. PRIMARY PROPOSED INSURED

1. Name (First, Middle, Last)		2. Driver's License Number/State	3. Sex <input type="checkbox"/> M <input type="checkbox"/> F
4. Home Address (include street, city, state, zip)			
5. Birth Date (MM/DD/YYYY) [][] [][] [][] [][] [][] [][] [][]		6. Birth State/Country	7. Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced
8. Primary Phone		Secondary Phone (if any)	9. E-mail Address

BENEFICIARIES

10. Primary Beneficiary Name (First, Middle, Last)			
11. Address <input type="checkbox"/> Same as Primary Proposed Insured <input type="checkbox"/> Other (include street, city, state, zip)			
12. SSN/TIN	13. Birth Date/Trust Date (MM/DD/YYYY)	14. Relationship	15. % Share (if not equal)
16. Additional Beneficiary Name (First, Middle, Last)(Check Primary or Contingent)			<input type="checkbox"/> Primary <input type="checkbox"/> Contingent
17. Address <input type="checkbox"/> Same as Primary Proposed Insured <input type="checkbox"/> Other (include street, city, state, zip)			
18. SSN/TIN	19. Birth Date/Trust Date (MM/DD/YYYY)	20. Relationship	21. % Share (if not equal)

SECTION B. ADDITIONAL/JOINT PROPOSED INSURED - If more than one AIR, submit additional copies of Section B

1. Name (First, Middle, Last)		2. Driver's License Number/State	3. Sex <input type="checkbox"/> M <input type="checkbox"/> F
4. Home Address (include street, city, state, zip)			
5. Birth Date (MM/DD/YYYY) [][] [][] [][] [][] [][] [][] [][]		6. Birth State/Country	7. Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced
8. Primary Phone		Secondary Phone (if any)	9. Relationship to Insured
10. E-mail Address			

BENEFICIARIES

11. Primary Beneficiary Name (First, Middle, Last)			
12. Address <input type="checkbox"/> Same as Additional/Joint Proposed Insured <input type="checkbox"/> Other (include street, city, state, zip)			
13. SSN/TIN	14. Birth Date/Trust Date (MM/DD/YYYY)	15. Relationship	16. % Share (if not equal)
17. Additional Beneficiary Name (First, Middle, Last)(Check Primary or Contingent)			<input type="checkbox"/> Primary <input type="checkbox"/> Contingent
18. Address <input type="checkbox"/> Same as Additional/Joint Proposed Insured <input type="checkbox"/> Other (include street, city, state, zip)			
19. SSN/TIN	20. Birth Date/Trust Date (MM/DD/YYYY)	21. Relationship	22. % Share (if not equal)

SECTION C. CHILDREN PROPOSED FOR CHILDREN'S LEVEL TERM RIDER - Must be age 17 or less and Primary Proposed Insured's child, legally adopted child, or stepchild living with Primary Proposed Insured. Not available if Owner is a business.

1. Name (First, Middle, Last)	2. Sex	3. Birth Date (MM/DD/YYYY)	4. SSN/TIN
	<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F		

SECTION D. OWNER - If other than Primary Proposed Insured

1. Name (First, Middle, Last) (If the Owner is a trust, provide full title of the trust and names of current trustees.)	2. Primary Phone
3. Home Address (include street, city, state, zip)	
4. Birth Date/Trust Date (MM/DD/YYYY)	5. Relationship to Primary Proposed Insured
<input type="text"/>	6. E-mail Address

SECTION E. PREMIUM PAYOR - If other than Owner

1. Name (First, Middle, Last)
2. Home Address (include street, city, state, zip)
3. Relationship to Primary Proposed Insured
4. E-mail Address

SECTION F. PREMIUM FUNDING - Required if Primary Proposed Insured is over age 60

- Will premiums be paid directly or indirectly with borrowed funds or by any party not named in this application? Yes No
(If "yes," complete the Premium Finance Supplement to Life Application.)
- Will or has any Proposed Insured, Owner, or other party be(en) given or offered anything of value to apply for this policy or to transfer or assign benefits under it to any party not named in this application? Yes No
- Is this policy being applied for with the understanding, written or unwritten, that it or any right or interest in it will be sold or transferred for value to any party not named in this application? Yes No
- Is any existing life insurance policy on any Proposed Insured now owned by, or in the process of being sold or offered for sale to, a viatical or settlement company, investor(s), or any party who does not have insurable interest in the Insured's life? Yes No

Details of "yes" answers:

SECTION G. CITIZENSHIP

- Are all Proposed Insureds, Beneficiaries, Owners, and Payors United States citizens or holders of a permanent resident card? Yes No
(If "no," give details below)

Name and Role (e.g. "Insured")	Country	Visa No. and Type (Attach copy if available)

SECTION H. THE POLICY

1. Plan of Insurance (for term plans include level period)	2. Base Face Amount	3. Death Benefit Option (UL/VUL Only - when applicable) <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input checked="" type="checkbox"/> 3
--	---------------------	--

4. Additional Benefits, Riders, Options:

<input type="checkbox"/> WP	<input type="checkbox"/> COP \$ _____	<input type="checkbox"/> CLTR _____ Units (\$5,000 per unit)	<input type="checkbox"/> PTR \$ _____
<input type="checkbox"/> Accidental DB (ADB) - Primary Insured \$ _____	<input type="checkbox"/> Automatic Premium Loan (for Whole Life Only)		<input type="checkbox"/> Date to save age (if within allowed timeframe)
<input type="checkbox"/> Other: _____			

For Legacy products only: Guarantee period under Coverage Protection Rider (if not lifetime): _____ years or to age _____ Limited Pay for _____ years or to age _____

Additional Insured Rider(s):

Name _____	\$ _____	Level Period* _____	<input type="checkbox"/> ADB on AIR \$ _____
Name _____	\$ _____	Level Period* _____	<input type="checkbox"/> ADB on AIR \$ _____

*Required for AIR on term base policy only

5. UL/VUL Premiums (must match illustration)	Planned Modal Premium \$ _____	Additional Lump Sum Premium (Includes expected 1035 funds if any) \$ _____	6. Substandard Rating Quoted (if any)
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7. Premium Mode/Method (must match illustration) Single Monthly EFT Quarterly Semiannual Annual Other _____

SECTION I. REPLACEMENT AND OTHER INSURANCE - Provide required forms for replacement, including change form(s) for internal replacements.

1. Are there any life insurance or annuity contracts, including group life, on any Proposed Insured
 - a. in force or applied for in any company, other than this application? Yes No
 - b. which have been or will be terminated because of the proposed policy? Yes No
 - c. which have been or will be borrowed against or withdrawn from, used to pay any portion of premiums for, or changed in any way because of the proposed policy? Yes No
 - d. which will be replaced in a 1035 exchange by the policy applied for? (Must be life insurance, not annuity.) Yes No

List all policies in force or applied for and give details below:

Person Covered	Company
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Life Amount Including Riders	Issue Date (MM/YYYY)	Policy Number	Plan Type	Check if Replacing <input type="checkbox"/>
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Person Covered	Company
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Life Amount Including Riders	Issue Date (MM/YYYY)	Policy Number	Plan Type	Check if Replacing <input type="checkbox"/>
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SECTION J. PRELIMINARY UNDERWRITING QUESTIONS - Do not submit payment with this application if any of the questions below are answered "yes," or if any Primary, Additional, or Joint Insured is less than 15 days or more than 70 years of age

1. In the past 5 years, have any Proposed Insureds:
 - a. used, received treatment or counseling for using, or been arrested for possession, sale or delivery of, any illegal drug? Yes No
 - b. been diagnosed or treated for heart disease, stroke, or cancer (other than non-melanoma skin cancer)? Yes No
 - c. been diagnosed or treated by a medical professional for Acquired Immune Deficiency Syndrome (AIDS)? Yes No
 - d. been charged with, or been on probation or parole for, any felony? Yes No
2. In the past 90 days, have any Proposed Insureds been hospitalized overnight (other than for normal childbirth), had inpatient surgery, or been advised by a medical professional to be hospitalized or have inpatient surgery? Yes No

Details of "yes" answers:

SECTION K. AGENT REMARKS/SPECIAL INSTRUCTIONS

PERMIT TO OBTAIN AND DISCLOSE CERTAIN DATA

- A. The Company, its reinsurers, consumer reporting agencies, and other parties acting on The Company's behalf may get data about my health, medical history, prescription medication history and related information, mode of living (except as may be related directly or indirectly to sexual orientation), avocations, finances, credit history, driving record, and any criminal record. I understand that the information obtained by use of this authorization will be used to determine eligibility for insurance and/or benefits, or for The Company to determine its obligations under the policy issued in connection with this application.
- B. Any doctor, practitioner, medical or medically related facility, laboratory, Pharmacy Benefit Managers, the Veterans Administration, the Medical Information Bureau, Inc. (MIB, Inc.), viatical settlement company, employer, consumer reporting agency, creditor, government agency, insurance or reinsurance company or any other person or entity which has such data about me may give such data to The Company and its reinsurers when this Permit or a copy of it is shown. All sources but the MIB, Inc., may give such data to agents or agencies acting on behalf of The Company. The information as provided herein pursuant to the authorization will not be redisclosed unless authorized by me or otherwise required by law. Covered entities, as defined by the Health Insurance Portability and Accountability Act of 1996, may not condition treatment, payment, enrollment, or eligibility for benefits on whether this Permit is signed.
- C. Any request by The Company for medical records is on my behalf; the information must be provided within any requirements imposed by applicable statutes governing patient access to medical records.
- D. Data about mental illness, alcoholism, sexually transmitted diseases, and the use of drugs is to be included.
- E. The Company or its reinsurers may make a brief report about me to the MIB, Inc.
- F. This Permit is good for 24 months after it is signed. **I understand that, if applicable, my electronic signature on this form operates as my original signature.**
- G. The Company may obtain an investigative consumer report ("inspection report") on me. I want to be interviewed if such a report is obtained.
- H. I have read this Permit and know I may request a copy of it. I may revoke this Permit by writing to The Company. I also have received the Disclosures and Notices.

DECLARATIONS

- A. I (each undersigned) declare that all answers written on this application are full and correct to the best of my knowledge and belief. Except in Maine, Missouri, New Jersey, Oregon, and South Carolina The Company is not presumed to know any information not in this application.
- B. The Company may add to or correct the application on an addendum page. Any changes are agreed to if I (we) accept the policy, but written agreement will be obtained from me for any change in insurance amount, plan, benefits, payment class or age at issue. (In West Virginia, Maryland, New Hampshire, and Pennsylvania written consent will be obtained for any changes.)
- C. Insurance will start only as provided in the Receipt and Temporary Insurance Agreement issued in connection with this application. If no receipt is issued or if insurance under it has stopped and not started again, no insurance will start by reason of the application until the policy is delivered and the first premium paid in full. No insurance will start if at that time the health of all Proposed Insureds is not as described in the application.
- D. I have read and understand this application, including the Disclosures and Notices, which I acknowledge receiving.
- E. Only an officer of The Company may change this application or waive a right or requirement. No agent may do this.

ALL QUESTIONS WERE ASKED OF ME AND, IF APPLICABLE, THE ADDITIONAL/JOINT INSURED AND PARENTS OF ANY CHILDREN LISTED ON THIS APPLICATION. I (WE) HAVE READ ALL INFORMATION BEFORE SIGNING.

LIFE ILLUSTRATION ACKNOWLEDGEMENT: Unless checked, applicant acknowledges that no illustration conforming to the policy applied for has been provided and understands that an illustration conforming to the policy as issued will be provided no later than the time the policy is delivered. If checked, submit applicable signed illustration with application.

I declare that the answers and statements written above are full and correct to the best of my knowledge and belief. I understand and agree that the statements above, along with the application, will be the basis for any insurance issued.

Substitute Form W-9 - Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. person (including U.S. resident alien).

The Internal Revenue Service does not require your consent to any provisions of this document other than the certification required to avoid backup withholding.

SIGN HERE

Signature of Owner, if other than Insured (and title, if applicable, such as "Trustee" or "President") SSN/TIN

Signature of Joint Owner (and title, if applicable, such as "Trustee" or "President") SSN/TIN

Signature of Primary Proposed Insured SSN/TIN

Signature of Additional/Joint Proposed Insured SSN/TIN

Signature of Parent/Legal Guardian (if any Insured is under Age 15)

Signed at (City, State) Date (MM/DD/YYYY) Signature of Agent

DISCLOSURES AND NOTICES - Please leave with Applicant

IMPORTANT INFORMATION REGARDING MEDICAL EXAMS

As part of the underwriting process we may ask for medical tests or exams to be completed at our expense. Common tests may include a paramedical exam, which will consist of questions about your medical history and measurements of your body including, but not limited to height, weight, blood pressure, and pulse. Blood and urine specimens are also generally collected. Undressing is not required for any of these tests. In some instances, an EKG (Electrocardiogram) may be required. An EKG is a recording of the electrical impulses in the heart. You will be asked to lay down with your shirt unbuttoned so the EKG leads can be placed on your chest.

If you have any questions about the specific tests that will be required of you, please feel free to contact your agent.

NOTICE REGARDING THE MIB

Information regarding your insurability will be treated as confidential. The 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 company, MIB, upon request, will supply such 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 the 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, Massachusetts 02184-8734.

The 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.

INSURANCE INFORMATION PRACTICES

We will rely primarily on the information you give us. We may also get information from other sources, such as doctors, or other medical professionals who have treated you. In some cases, we may ask a consumer reporting agency to gather information and send us an investigative consumer report as explained in the Notice Under the Federal Fair Credit Reporting Act below. You may ask to be interviewed as part of the preparation of any such report.

In certain limited circumstances, we are allowed by law to disclose necessary items of personal information to third parties without your specific authorization. You have the right to be told about and to see and copy items of personal information about you that appear in our files, including information contained in the 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 Underwriting Department, Allstate Life Insurance Company/Lincoln Benefit Life Company, P.O. Box 660191, Dallas, TX 75266-0191.

NOTICE UNDER THE FAIR CREDIT REPORTING ACT

In compliance with the Federal Fair Credit Reporting Act, you are hereby notified that an investigative report may be made. This would be by personal interviews with neighbors, friends, associates, or other persons. This will concern the character, general reputation, personal characteristics, and mode of living (except as may be related to sexual orientation) of any person proposed for insurance. You may obtain additional information concerning the nature and scope of this investigation and a written summary of your rights under the Federal Fair Credit Reporting Act by contacting our Home Office. Our address is Allstate Life Insurance Company/Lincoln Benefit Life Company, P.O. Box 660191, Dallas, TX 75266-0191. Upon your written request, you will be informed whether or not an investigation was made by us. If so, you will receive the name and address of the consumer reporting agency involved. You may receive and inspect a copy of the Investigative Consumer Report by contacting the consumer reporting agency.

NON-SUFFICIENT FUNDS (NSF) FEE

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APPLICATION FOR LIFE INSURANCE

Lincoln Benefit Life Company ("The Company"), [Lincoln, NE 68501]

Allstate Life Insurance Company ("The Company"), [Northbrook, IL 60062]

APPLICATION FOR LIFE INSURANCE - PART 2

SECTION A. GENERAL QUESTIONS - Must be completed even if an exam is required

1. PRIMARY PROPOSED INSURED

a. Name (First, Middle, Last)	b. SSN/TIN <input type="text"/> <input type="text"/>	c. Employer Phone Number
d. Employer Name	e. Occupation and Duties	f. Annual Income

2. ADDITIONAL/JOINT INSURED

a. Name (First, Middle, Last)	b. SSN/TIN <input type="text"/> <input type="text"/>	c. Employer Phone Number
d. Employer Name	e. Occupation and Duties	f. Annual Income

3. Have any Proposed Insureds had more than one moving violation in the past 3 years or been convicted of driving under the influence or reckless driving in the past 10 years? Yes No
4. In the past 3 years, have any Proposed Insureds:
- a. flown as a pilot or crew member of any aircraft? Yes No
 - b. engaged in sky or scuba diving, vehicle racing, mountain or rock climbing? Yes No
5. Have any Proposed Insureds ever had an application for life insurance declined, postponed, rated, or modified? Yes No
6. Have any Proposed Insureds resided in the U.S. continuously for less than 3 years? Yes No
7. Do any Proposed Insureds plan to spend more than 2 weeks outside the U.S. in the next year? Yes No
8. For Primary or Additional Proposed Insured under age 18: Including the policy applied for, will the total life insurance on the Primary/Additional Insured exceed: (If yes to either question, give amounts and explain.)
- a. The amount on any sibling in the same household? Yes No
 - b. Half the amount on any custodial parent? Yes No

Details of "yes" answers:

SECTION B. HEALTH AND MEDICAL HISTORY

PRIMARY PROPOSED INSURED

1. Height and Weight: Ft. In. Lbs.	2a. Do you currently use tobacco or nicotine? <input type="checkbox"/> Yes <input type="checkbox"/> No
2b. If "yes" to 2a, what type: <input type="checkbox"/> Cigarettes _____ per _____ <input type="checkbox"/> Cigars _____ per _____ <input type="checkbox"/> Pipe <input type="checkbox"/> Smokeless <input type="checkbox"/> Nicotine gum/patch <input type="checkbox"/> Other _____	2c. If "no" to 2a, have you ever used tobacco or nicotine? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", what did you use: <input type="checkbox"/> Cigarettes <input type="checkbox"/> Other _____ When did you quit (MM/YYYY)? _____

ADDITIONAL/JOINT INSURED

3. Height and Weight: Ft. In. Lbs.	4a. Do you currently use tobacco or nicotine? <input type="checkbox"/> Yes <input type="checkbox"/> No
4b. If "yes" to 4a, what type: <input type="checkbox"/> Cigarettes _____ per _____ <input type="checkbox"/> Cigars _____ per _____ <input type="checkbox"/> Pipe <input type="checkbox"/> Smokeless <input type="checkbox"/> Nicotine gum/patch <input type="checkbox"/> Other _____	4c. If "no" to 4a, have you ever used tobacco or nicotine? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", what did you use: <input type="checkbox"/> Cigarettes <input type="checkbox"/> Other _____ When did you quit (MM/YYYY)? _____

SECTION B. HEALTH AND MEDICAL HISTORY - Continued

5. Does any Primary or Additional/Joint Proposed Insured have a family history of heart disorder, stroke or cancer beginning before age 60 in any natural parent or sibling? (If "yes," complete table below.) Yes No

Proposed Insured	Which Relative	Disorder	Age at Onset	Age at Death	Cause of Death	Age if Living

Answer Questions 6 - 11 for all Proposed Insured(s) including children proposed for CLTR, and give details below.

6. Have any Proposed Insureds ever been diagnosed with, or sought treatment or advice for:
- a. high blood pressure, heart attack, stroke, or other disorder of heart or blood vessels? Yes No
 - b. cancer or tumor? Yes No
 - c. dependency on or addiction to alcohol or any drug? Yes No
 - d. diabetes? Yes No
7. In the past 10 years, have any Proposed Insureds been diagnosed with, or sought treatment or advice for:
- a. epilepsy or seizures, disorder of the brain or nervous system, depression, or other mental or nervous disorder? Yes No
 - b. asthma, emphysema, sleep apnea, or any lung disorder? Yes No
 - c. any disorder of the digestive tract, liver or pancreas? Yes No
 - d. anemia or other disorder of blood or blood cells? Yes No
 - e. disorder of kidneys or reproductive organs? Yes No
 - f. arthritis or disorder of bones, skin or muscle? Yes No
8. Other than previously disclosed, in the past 5 years, have any Proposed Insureds:
- 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
9. Are any Proposed Insureds taking any prescription medications not previously disclosed? Yes No

PRIMARY PROPOSED INSURED

10a. Name and Address of Primary Physician or Medical Facility (if none, state "None")	10b. Phone Number
--	-------------------

10c. Have you visited this physician/facility in the last 5 years for any reason not already explained? (If "yes", explain below) Yes No

ADDITIONAL/JOINT INSURED

11a. Name and Address of Primary Physician or Medical Facility (if none, state "None")	11b. Phone Number
--	-------------------

11c. Have you visited this physician/facility in the last 5 years for any reason not already explained? (If "yes", explain below) Yes No

Question Number	Proposed Insured Name	Details (name of condition, dates, how treated, current status)	Name and Address of Doctor or Medical Facility

SIGNATURES

I declare that the answers written above are full and correct to the best of my knowledge and belief. I understand and agree that the statements above, along with the application, will be the basis for any insurance issued.

Date (MM/DD/YYYY) _____ Signature of Primary Proposed Insured (Parent/Guardian if under 15)

Signature of Owner (If other than Primary Proposed Insured)

Signature of Additional/Joint Insured (Parent/Guardian if under 15)

Signature of Agent

SIGN HERE

Lincoln Benefit Life Company ("The Company") [Lincoln, NE 68501]

Allstate Life Insurance Company ("The Company") [Northbrook, IL 60062]

RECEIPT AND TEMPORARY INSURANCE AGREEMENT - Referred to as "Agreement"

- This Agreement must be completed if payment is submitted with the application.
- All checks must be made payable to The Company indicated above (Allstate Life Insurance Company or Lincoln Benefit Life Company). Do not make checks payable to the agent or leave the payee blank.
- This Agreement shall not be completed and is not valid if:
 - The amount of insurance applied for on any one life exceeds \$1,000,000.
 - Any question(s) in Section J of the application are answered "yes" or not answered.
 - Any Primary, Additional, or Joint Insured is less than 15 days or more than 70 years of age.

\$ _____ has been received from _____ (Payor) as a payment for the life insurance on

_____ (Insured/Additional/Joint Insured) applied for on this date. Coverage under this Agreement is limited as provided in the Amount of Insurance section below.

NO INSURANCE WILL TAKE EFFECT EXCEPT AS DESCRIBED BELOW

WHEN TEMPORARY INSURANCE STARTS

If payment of at least one-twelfth of the annual premium for the policy applied for, including any riders and supplemental benefits, has been accepted by us and the application for life insurance has been completed on or before the date of this Agreement, temporary insurance under the Agreement will start on the later of: (1) the date of the Agreement, or (2) the date when all required lab specimens (blood, urine, or oral fluid) have been provided and all required medical exams have been completed.

WHEN TEMPORARY INSURANCE WILL STOP

Temporary insurance under this Agreement will stop on the first of the dates below:

1. The date we write to the Owner that we have stopped considering the application, which is our absolute right.
2. The date we agree to issue the coverage as applied for in the application. The insurance will then be provided by the policy.
3. The date we offer to issue insurance other than as applied for in the application. We may offer to issue insurance other than as applied for in the application on any person(s) proposed for this insurance.

We will refund all payments for which this Agreement was given if we stop considering the application.

AMOUNT OF INSURANCE

If temporary insurance under this Agreement is in effect, it will have the same benefits, provisions, and limitations and be for the same amount as the plan applied for. But we will provide no more than a combined total of \$1,000,000 of temporary life insurance and accidental death benefit on any one life under this and any other Temporary Insurance Agreements, regardless of the insurance applied for under this application.

CONDITIONS UNDER WHICH THERE IS NO COVERAGE

1. No insurance coverage starts under this Agreement, and we will only pay a refund of the payment made with the application, if anyone proposed for insurance has:
 - a. in the past 5 years, used, received treatment or counseling for using, or been arrested for possession, sale or delivery of, any illegal drug; or
 - b. in the past 5 years, been diagnosed or treated for heart disease, stroke, or cancer (other than non-melanoma skin cancer); or
 - c. in the past 5 years, been diagnosed or treated by a medical professional for Acquired Immune Deficiency Syndrome (AIDS); or
 - d. in the past 5 years, been charged with, or been on probation or parole for, any felony; or
 - e. in the past 90 days, been hospitalized overnight (other than for normal childbirth), had inpatient surgery, or been advised by a medical professional to be hospitalized or have inpatient surgery.
2. No coverage starts under this Agreement if any Primary, Additional, or Joint Insured(s) are less than 15 days or more than 70 years of age.
3. No insurance coverage starts under this Agreement if, in the answers in the application, there is any fraud or misrepresentation material to our acceptance of the risk. If there is fraud and/or material misrepresentation, we will only pay a refund of the payment made with this application.
4. No insurance coverage starts under this Agreement if a person proposed for this insurance dies by suicide while sane or self-destruction while insane. In this event, we will only pay a refund of the payment made for that person's insurance. Temporary Insurance will continue on all other Proposed Insureds whose coverage is not contingent on the insurance of the person who died.
5. No insurance coverage starts under this Agreement if no payment is received, if a check or draft given as a payment is not honored by the bank or, in the case of a credit card payment, the charge is refused by the credit card issuer.

No one can waive or change any of the terms of this Agreement. I (We) have read and received a copy of this Agreement, and understand and agree to its terms.

Date (MM/DD/YYYY) _____

SIGN HERE

Signature of Owner (Primary Proposed Insured unless other Owner named in Section D of the application)

Signature of Agent

Lincoln Benefit Life Company ("The Company") [Lincoln, NE 68501]

Allstate Life Insurance Company ("The Company") [Northbrook, IL 60062]

RECEIPT AND TEMPORARY INSURANCE AGREEMENT - Referred to as "Agreement"

- This Agreement must be completed if payment is submitted with the application.
- All checks must be made payable to The Company indicated above (Allstate Life Insurance Company or Lincoln Benefit Life Company). Do not make checks payable to the agent or leave the payee blank.
- This Agreement shall not be completed and is not valid if:
 - The amount of insurance applied for on any one life exceeds \$1,000,000.
 - Any question(s) in Section J of the application are answered "yes" or not answered.
 - Any Primary, Additional, or Joint Insured is less than 15 days or more than 70 years of age.

\$ _____ has been received from _____ (Payor) as a payment for the life insurance on

_____ (Insured/Additional/Joint Insured) applied for on this date. Coverage under this Agreement is limited as provided in the Amount of Insurance section below.

NO INSURANCE WILL TAKE EFFECT EXCEPT AS DESCRIBED BELOW

WHEN TEMPORARY INSURANCE STARTS

If payment of at least one-twelfth of the annual premium for the policy applied for, including any riders and supplemental benefits, has been accepted by us and the application for life insurance has been completed on or before the date of this Agreement, temporary insurance under the Agreement will start on the later of: (1) the date of the Agreement, or (2) the date when all required lab specimens (blood, urine, or oral fluid) have been provided and all required medical exams have been completed.

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2. The date we agree to issue the coverage as applied for in the application. The insurance will then be provided by the policy.
3. The date we offer to issue insurance other than as applied for in the application. We may offer to issue insurance other than as applied for in the application on any person(s) proposed for this insurance.

We will refund all payments for which this Agreement was given if we stop considering the application.

AMOUNT OF INSURANCE

If temporary insurance under this Agreement is in effect, it will have the same benefits, provisions, and limitations and be for the same amount as the plan applied for. But we will provide no more than a combined total of \$1,000,000 of temporary life insurance and accidental death benefit on any one life under this and any other Temporary Insurance Agreements, regardless of the insurance applied for under this application.

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1. No insurance coverage starts under this Agreement, and we will only pay a refund of the payment made with the application, if anyone proposed for insurance has:
 - a. in the past 5 years, used, received treatment or counseling for using, or been arrested for possession, sale or delivery of, any illegal drug; or
 - b. in the past 5 years, been diagnosed or treated for heart disease, stroke, or cancer (other than non-melanoma skin cancer); or
 - c. in the past 5 years, been diagnosed or treated by a medical professional for Acquired Immune Deficiency Syndrome (AIDS); or
 - d. in the past 5 years, been charged with, or been on probation or parole for, any felony; or
 - e. in the past 90 days, been hospitalized overnight (other than for normal childbirth), had inpatient surgery, or been advised by a medical professional to be hospitalized or have inpatient surgery.
2. No coverage starts under this Agreement if any Primary, Additional, or Joint Insured(s) are less than 15 days or more than 70 years of age.
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No one can waive or change any of the terms of this Agreement. I (We) have read and received a copy of this Agreement, and understand and agree to its terms.

Date (MM/DD/YYYY) _____

SIGN HERE

Signature of Owner (Primary Proposed Insured unless other Owner named in Section D of the application)

Signature of Agent

PREMIUM FINANCE SUPPLEMENT TO LIFE APPLICATION

Primary Proposed Insured

Date of Birth (MM/DD/YYYY)

Policy Owner (if other than Primary Proposed Insured)

Policy Number (if assigned)

Additional/Joint Insured

This Supplement is required if Section F, Question 1, of the life application (Form FIC400 series) is answered "yes." It is not required if premiums are being loaned by an employer as part of a split-dollar financing arrangement. In the questions below, "you" refers to both the proposed insured and the proposed policy owner(s) unless otherwise indicated. Where the answer requires explanation, please indicate the party(ies) to whom the explanation applies.

1. Name and address of the premium finance lender:

2. Marketing name of the premium finance program, if other than the lender's name:

3. Name of the organization or individual arranging the loan, if other than the lender:

4. Do the terms of the loan require payment of at least the interest on an annual or more frequent basis?
(If "no," when and how are interest and principal required to be paid?) Yes No

5. Do you intend to repay the loan from current income?
(If "no," please describe the assets you intend to liquidate or other financial resources you intend to use to repay the loan.) Yes No

6. Were you given a copy of a loan term sheet that shows the interest rate, loan origination fees, maturity date, and
prepayment penalties? (If "yes," please provide a copy.) Yes No

7. Is the life insurance policy the only collateral for the loan? (If "no," please describe the other assets you are pledging
as collateral.) Yes No

8. Are you being loaned any additional amount beyond the amount required to pay the premiums for the proposed policy?
(If "yes," please provide details.) Yes No

CONTINUATION OF PREMIUM FINANCE SUPPLEMENT TO LIFE APPLICATION

9. Have you (or a family member or other party of your choice) been offered any cash payment, free trip, or other inducements in exchange for purchasing the life insurance or taking out the loan? (If "yes," please give details.) Yes No

10. Do you anticipate satisfying all or part of the loan by transferring or selling the life insurance policy or any rights in the policy to the lender or any other party? (If "yes," give details.) Yes No

11. Within the last two years, have you (the proposed insured(s)) authorized a life expectancy assessment to be performed, or have you been told that a life expectancy assessment is required in connection with this policy or the premium finance loan? (If "yes," give details.) Yes No

I (each undersigned) declare that all answers and statements written on this application supplement are full and correct to the best of my knowledge and belief. I understand and agree that this application supplement will be made a part of the application and of any policy issued as a result of the application.

SIGN HERE

Date (MM/DD/YYYY)

Signature of Owner, if other than Insured (and title, if applicable, such as "Trustee" or "President")

Signature of Joint Owner

Signature of Primary Proposed Insured

Signature of Additional/Joint Insured

Signature of Agent

ADDITIONAL SIGNATURES -APPLICATION FOR LIFE INSURANCE

DECLARATIONS SECTION (CONTINUED)

ALL QUESTIONS WERE ASKED OF ME AND, IF APPLICABLE, THE ADDITIONAL/JOINT INSURED AND PARENTS OF ANY CHILDREN LISTED ON THIS APPLICATION. I (WE) HAVE READ ALL INFORMATION BEFORE SIGNING.

I declare that the answers and statements written above are full and correct to the best of my knowledge and belief. I understand and agree that the statements above, along with the application, will be the basis for any insurance issued.

Substitute Form W-9 - Under penalties of perjury, I certify that:

- 1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
- 2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
- 3. I am a U.S. person (including U.S. resident alien).

The Internal Revenue Service does not require your consent to any provisions of this document other than the certification required to avoid backup withholding.

SIGN HERE

Signature of Joint Owner (and title, if applicable, such as "Trustee" or "President") SSN/TIN

Signature of Joint Owner (and title, if applicable, such as "Trustee" or "President") SSN/TIN

Signature of Joint Owner (and title, if applicable, such as "Trustee" or "President") SSN/TIN

Signature of Joint Owner (and title, if applicable, such as "Trustee" or "President") SSN/TIN

Signature of Additional/Joint Proposed Insured SSN/TIN

Signature of Parent/Legal Guardian (if any Insured is under Age 15)

Signature of Parent/Legal Guardian (if any Insured is under Age 15)

Signature of Parent/Legal Guardian (if any Insured is under Age 15)

Signature of Parent/Legal Guardian (if any Insured is under Age 15)

Signature of Parent/Legal Guardian (if any Insured is under Age 15)

SERFF Tracking Number: ALSB-126838291

State: Arkansas

Filing Company: Lincoln Benefit Life Company

State Tracking Number: 47004

Company Tracking Number: FIC400 SERIES

TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Product Name: FIC400 Series

Project Name/Number: FIC400 Series/FIC400 Series

Supporting Document Schedules

Item Status:

Status

Date:

Satisfied - Item: Flesch Certification

Comments:

Attachment:

Readabilty Certification wo Agent Report.pdf

Item Status:

Status

Date:

Satisfied - Item: Statement of Variability

Comments:

Attachments:

FIC400 and FIC400T SOV _1010_.pdf

FIC400ATTSIG SOV _1010_.pdf

FIC400PQ, FIC400TIA, FIC400PF SOV _1010_.pdf

CERTIFICATION OF READABILITY

I, Robert Transon, Assistant Vice President certify that these forms achieve a Flesch reading score as listed below:

<u>Form Number</u>	<u>Flesch Score</u>
FIC400	52
FIC400T	62.2
FIC400PQ	66
FIC400TIA.....	65.9
FIC400ATTSIG	53
FIC400PF.....	61

Robert Transon
Assistant Vice President

10/05/2010
Date

Statement of Variability
Lincoln Benefit Life Company
 FIC400 and FIC400T

Items in the above-referenced form(s) are bracketed to indicate variable information. Some items vary to reflect policy-specific information. For other items, this Statement of Variability defines a permissible range that may be used for newly-issued policies without the necessity of a re-filing, thereby allowing the company to promptly respond to changes, such as in the market, company experience, or the regulatory environment. Any decision to apply a new factor within the permitted range, will affect newly-issued policies only, and not in-force business. Further, any such changes will be administered in a uniform, non-discriminatory manner.

Page	Bracketed Items	Description of Variability
1	Company Address	Company address may vary over time.
2	Citizenship	This section is bracketed so that if Federal laws governing these requirements are changed, we will have the flexibility to revise accordingly.
3	The Policy	a. Death Benefit Options – To modify, delete or add additional death benefit options on a non-discriminatory basis. b. Additional Benefits – To modify, delete or add additional benefit, riders and options. c. Additional Insured Rider(s) – To modify, delete or add additional Insured Rider(s). d. Premium Mode/Method – To modify, delete or add additional premium mode options.
4/6	Declarations	a. “Maine, Missouri, New Jersey, Oregon and South Carolina” in Item A – To allow for flexibility to add or delete states as necessary based on state requirements. b. “(In West Virginia, Maryland, and Pennsylvania,)” in Item B – To allow for flexibility to add or delete states as necessary based on state requirements.
4/6	Substitute W-9	This section may be modified to include new information as required by state or federal tax requirements.
5/7	Notice Regarding the MIB	To allow for flexibility for the address, telephone number and email address of the MIB.
5/7	Insurance Information Practices	To allow for flexibility for the address of the underwriting company.
5/7	Notice Under the Fair Credit Reporting Act	To allow for flexibility for the address of the underwriting company.
5/7	Non-Sufficient Funds (NSF) Fee	To allow for the flexibility to modify or remove this section in its entirety on a non-discriminatory basis. Also to allow for the modification of the fee dollar amount.
5/7	Fraud Warnings	To allow for flexibility to make changes to comply with applicable state fraud warning requirements.

Statement of Variability
Lincoln Benefit Life Company
FIC400ATTSIG

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Statement of Variability
Lincoln Benefit Life Company
FIC400PQ, FIC400TIA, FIC400PF

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<i>SERFF Tracking Number:</i>	<i>ALSB-126838291</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Lincoln Benefit Life Company</i>	<i>State Tracking Number:</i>	<i>47004</i>
<i>Company Tracking Number:</i>	<i>FIC400 SERIES</i>		
<i>TOI:</i>	<i>L08 Life - Other</i>	<i>Sub-TOI:</i>	<i>L08.000 Life - Other</i>
<i>Product Name:</i>	<i>FIC400 Series</i>		
<i>Project Name/Number:</i>	<i>FIC400 Series/FIC400 Series</i>		

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)
09/30/2010		Supporting Statement of Variability Document	10/11/2010	FIC400 and FIC400T SOV _1010_.pdf (Superseded) FIC400ATTSIG SOV _1010_.pdf (Superseded) FIC400PQ, FIC400TIA, FIC400PF SOV _1010_.pdf (Superseded)

Statement of Variability
Allstate Life Insurance Company
 FIC400 and FIC400T

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Statement of Variability
Allstate Life Insurance Company
FIC400ATTSIG

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Statement of Variability
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FIC400PQ, FIC400TIA, FIC400PF

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