

SERFF Tracking Number: ALSB-127006353 State: Arkansas
 Filing Company: Lincoln Benefit Life Company State Tracking Number: 47902
 Company Tracking Number:
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
 Product Name: FIC413 series
 Project Name/Number: FIC413 series/FIC413 series

Filing at a Glance

Company: Lincoln Benefit Life Company

Product Name: FIC413 series

TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Filing Type: Form

SERFF Tr Num: ALSB-127006353 State: Arkansas

SERFF Status: Closed-Approved-
 Closed State Tr Num: 47902

Co Tr Num:

State Status: Approved-Closed

Author: Devyn Porstner

Reviewer(s): Linda Bird

Date Submitted: 02/04/2011

Disposition Date: 02/16/2011

Disposition Status: Approved-
 Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: FIC413 series

Project Number: FIC413 series

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Individual

Individual Market Type:

Filing Status Changed: 02/16/2011

State Status Changed: 02/16/2011

Created By: Devyn Porstner

Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Devyn Porstner

Filing Description:

RE: FIC413S Application for Life Insurance, Part 1 and 2, Simplified Issue

FIC413L Application for Life Insurance, Part 1 and 2 Fully
 Underwritten

FIC413 Application for Life Insurance Part 1

FIC413PQS Application for Life Insurance Part 2, Simplified Issue

FIC413PQL Application for Life Insurance Part 2, Fully Underwritten

FIC413ATTSIG Additional Signatures – Application for Life Insurance

FIC413TIA Temporary Insurance Report

FIC413PF Premium Finance Supplement to Life Application

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Product Name: FIC413 series
Project Name/Number: FIC413 series/FIC413 series
NAIC#: 008-60186

Dear Mr. Shields:

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 FIC413S, FIC413L, FIC413, FIC413PQS, and FIC413PQL are new business applications that will be used to apply for coverage of any existing or future life insurance policies.

Application forms FIC413S and FIC413PQS are for use with simplified issue products. FIC413L and FIC413PQL are for use with our fully-underwritten products. Only one set of applications will be used with a product at any one time.

Forms FIC413S, FIC413L, and FIC413 contain customer specific information, disclosures and owner/agent signature sections.

Forms FIC413PQS and FIC413PQL consist of an underwriting questionnaire and will be used with Form FIC413.

Form FIC413ATTSIG provides additional signature lines for multiple owners, insured's and/or children.

Form FIC413TIA is a receipt and temporary insurance agreement.

Form FIC413PF 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.

These applications may be taken through electronic enrollment procedures by our licensed agents using a pen-based signature pad, PIN numbers, and any other valid electronic signature method.

During the application process, the agent may ask specific follow-up questions if the applicant provides a "yes" response to certain health and other insurability questions on Forms FIC413S, FIC413L, FIC413PQS and FIC413PQL. Forms FIC413PQS and FIC413PQL may also be completed through a telephone interview with the proposed insured, conducted by a call center on our behalf, including specific follow-up questions as appropriate to explain "yes" answers to health and other insurability questions. In this mode of completion, with the proposed insured's permission, the call center may obtain an audio signature. If the policy is issued, all information obtained by the agent or the call center

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through specific follow-up questions will be included in the final application that is issued as part of the policy.

Explanation of Multiple Companies Listed on Forms

Lincoln Benefit Life Company, Allstate Life Insurance Company (Allstate Life) and American Heritage Life Insurance Company will use the above referenced forms. We have provided separate filings for each company. The reason these forms have been filed for use by three companies is for the benefit of our agents who sell all three 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,
Devyn Marie Stoltz
State Filing Project Manager
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:

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Product Name: FIC413 series
Project Name/Number: FIC413 series/FIC413 series
(800) 525-2799 ext. [Phone] FEIN Number: 47-0221457

Filing Fees

Fee Required? Yes
Fee Amount: \$400.00
Retaliatory? No
Fee Explanation: 50 per form X 8 forms
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Lincoln Benefit Life Company	\$400.00	02/04/2011	44406817

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State: Arkansas

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Company Tracking Number:

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Product Name: FIC413 series

Project Name/Number: FIC413 series/FIC413 series

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	02/16/2011	02/16/2011

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Temporary Insurance Agreement	Devyn Porstner	02/04/2011	02/04/2011

SERFF Tracking Number: ALSB-127006353

State: Arkansas

Filing Company: Lincoln Benefit Life Company

State Tracking Number: 47902

Company Tracking Number:

TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Product Name: FIC413 series

Project Name/Number: FIC413 series/FIC413 series

Disposition

Disposition Date: 02/16/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Statement of Variability		Yes
Form	Application for Life Insurance		Yes
Form	Application for Life Insurance		Yes
Form	Application for Life Insurance		Yes
Form	Application for Life Insurance		Yes
Form	Application for Life Insurance		Yes
Form	Additional Signatures		Yes
Form (revised)	Temporary Insurance Agreement		Yes
Form	Premium Finance Supplement		Yes
Form	Temporary Insurance Agreement		Yes

SERFF Tracking Number: ALSB-127006353

State: Arkansas

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Sub-TOI: L08.000 Life - Other

Product Name: FIC413 series

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Amendment Letter

Submitted Date: 02/04/2011

Comments:

We have revised the bracketing of the FIC413TIA.

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
FIC413TIA	Application/ETemporary nrollment Form	Insurance Agreement	Initial				66.000	FIC413TIA TIA (0111) (2).pdf

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Form Schedule

Lead Form Number: FIC413 series

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	FIC413L	Application/ Enrollment Form	Application for Life Insurance	Initial		52.000	FIC413L Part 1 and Long underwriting (0111).pdf
	FIC413S	Application/ Enrollment Form	Application for Life Insurance	Initial		66.000	FIC413S Part 1 and short underwriting (0111).pdf
	FIC413	Application/ Enrollment Form	Application for Life Insurance	Initial		60.000	FIC413 Part 1 (0111).pdf
	FIC413PQS	Application/ Enrollment Form	Application for Life Insurance	Initial		59.000	FIC413PQS Part 2 short underwriting (0111).pdf
	FIC413PQL	Application/ Enrollment Form	Application for Life Insurance	Initial		68.000	FIC413PQL Part 2 long underwriting (0111).pdf
	FIC413AATSIG	Application/ Enrollment Form	Additional Signatures	Initial		53.000	FIC413ATTSIG Sig Overflow (0111)_Layout 1.pdf
	FIC413TIA	Application/ Enrollment Form	Temporary Insurance Agreement	Initial		66.000	FIC413TIA TIA (0111) (2).pdf
	FIC413PF	Application/ Enrollment Form	Premium Finance Supplement	Initial		61.000	FIC413PF Premium Finance Supplement

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Filing Company: *Lincoln Benefit Life Company* *State Tracking Number:* *47902*
Company Tracking Number:
TOI: *L08 Life - Other* *Sub-TOI:* *L08.000 Life - Other*
Product Name: *FIC413 series*
Project Name/Number: *FIC413 series/FIC413 series*

(2).pdf

APPLICATION FOR LIFE INSURANCE

- Lincoln Benefit Life Company ("The Company"), Lincoln, NE 68501
- Allstate Life Insurance Company ("The Company"), Northbrook, IL 60062
- American Heritage Life Insurance Company ("The Company"), Jacksonville, FL 32203

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 <input type="checkbox"/> M <input type="checkbox"/> F	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		

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) <input type="text"/> <input type="text"/>	5. Relationship to Primary Proposed Insured
6. E-mail Address	

SECTION E. PREMIUM PAYOR - If other than Owner

1. Name (First, Middle, Last)	2. SSN/TIN
3. Home Address (include street, city, state, zip)	
4. Relationship to Primary Proposed Insured	5. 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

1. Are all Proposed Insureds, Beneficiaries, Owners, and Payors United States citizens or holders of a permanent resident card? <input type="checkbox"/> Yes <input type="checkbox"/> 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 type="checkbox"/> 3
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SECTION H. THE POLICY - Continued

4. Additional Benefits, Riders, Options: **ALL RIDERS MAY NOT BE APPLICABLE FOR ALL PRODUCTS**

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)
 Extended Coverage Guarantee Rider Lifetime Coverage Guarantee Rider

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.

- Are there any life insurance or annuity contracts, including group life, on any Proposed Insured
 - in force or applied for in any company, other than this application? Yes No
 - which have been or will be terminated because of the proposed policy? Yes No
 - 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
 - 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"/>
Person Covered		Company		
Life Amount Including Riders	Issue Date (MM/YYYY)	Policy Number	Plan Type	Check if Replacing <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

- In the past 5 years, have any Proposed Insureds:
 - used, received treatment or counseling for using, or been arrested for possession, sale or delivery of, any illegal drug? Yes No
 - been diagnosed or treated for heart disease, stroke, or cancer (other than non-melanoma skin cancer)? Yes No
 - been diagnosed or treated by a medical professional for Acquired Immune Deficiency Syndrome (AIDS)? Yes No
 - been charged with, or been on probation or parole for, any felony? Yes No
- 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

FOR FULL UNDERWRITING ONLY

APPLICATION FOR LIFE INSURANCE - PART 2

SECTION A. GENERAL QUESTIONS AND HEALTH AND MEDICAL HISTORY

1. PRIMARY PROPOSED INSURED

a. Name (First, Middle, Last)	b. SSN/TIN <div style="display: flex; justify-content: space-around;"> <input style="width: 20px; height: 20px;" type="text"/> </div>	c. Annual Income
d. Employer Name	e. Occupation and Duties	f. Employer Phone Number
g. Height and Weight: Ft. In. Lbs.	h. Do you currently use tobacco or nicotine? <input type="checkbox"/> Yes <input type="checkbox"/> No	
i. If "yes" to 1h, 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 _____	j. If "no" to 1h, 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)? _____	

2. ADDITIONAL/JOINT INSURED

a. Name (First, Middle, Last)	b. SSN/TIN <div style="display: flex; justify-content: space-around;"> <input style="width: 20px; height: 20px;" type="text"/> </div>	c. Annual Income
d. Employer Name	e. Occupation and Duties	f. Employer Phone Number
g. Height and Weight: Ft. In. Lbs.	h. Do you currently use tobacco or nicotine? <input type="checkbox"/> Yes <input type="checkbox"/> No	
i. If "yes" to 2h, 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 _____	j. If "no" to 2h, 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)? _____	

- 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? (If "yes" submit applicable questionnaire) Yes No
 - b. engaged in sky or scuba diving, vehicle racing, mountain or rock climbing? (If "yes" submit applicable questionnaire) 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:

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.

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

SSN/TIN

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

SSN/TIN

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Signature of Primary Proposed Insured

SSN/TIN

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Signature of Additional/Joint Proposed Insured

SSN/TIN

--	--	--	--	--	--	--	--	--	--

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

SIGN HERE

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 and American Heritage Life Insurance Company, P.O. Box 43187, Jacksonville, FL 32203.

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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 and American Heritage Life Insurance Company, P.O. Box 43187, Jacksonville, FL 32203. 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.

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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
- American Heritage Life Insurance Company ("The Company"), Jacksonville, FL 32203

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 <input type="checkbox"/> M <input type="checkbox"/> F	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		

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) <input type="text"/> <input type="text"/>	5. Relationship to Primary Proposed Insured
6. E-mail Address	

SECTION E. PREMIUM PAYOR - If other than Owner

1. Name (First, Middle, Last)	2. SSN/TIN
3. Home Address (include street, city, state, zip)	
4. Relationship to Primary Proposed Insured	5. 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) <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
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SECTION H. THE POLICY - Continued

4. Additional Benefits, Riders, Options: **ALL RIDERS MAY NOT BE APPLICABLE FOR ALL PRODUCTS**

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

APPLICATION FOR LIFE INSURANCE - PART 2

SECTION J. PERSONAL DATA QUESTIONNAIRE

1. a) Has the Proposed Insured or Additional/Joint Proposed Insured ever been charged with a felony, treated for or arrested for the use or possession of alcohol, narcotics, or mind altering drugs not prescribed by a member of the medical profession, or has the Proposed Insured or Additional/Joint Proposed Insured ever used illegal drugs or narcotics? Yes No
- b) In the last 3 years, has the Proposed Insured or Additional/Joint Proposed Insured participated in scuba or sky diving, hang gliding, mountain or rock climbing, vehicle racing of any kind, or has the Proposed Insured or Joint Proposed Insured flown as a pilot or crew member or have the intent to do so? Yes No
- c) In the last 3 years, has the Proposed Insured or Additional Joint Proposed Insured had their driver's license suspended or revoked, been arrested for reckless driving or driving under the influence of drugs or alcohol, received 3 or more moving violations, or been involved in 3 or more motor vehicle accidents? Yes No
2. Have any Proposed Insureds ever had any life, health or disability insurance application(s) declined or extra-rated? Yes No
3. Do any Proposed Insureds currently own their primary place of residence? Yes No

4. a) Have any Proposed Insureds ever been diagnosed with, or sought treatment or advice from a member of the medical profession for:
- i) AIDS (Acquired Immune Deficiency Syndrome)? Yes No
 - ii) any type of cancer or tumor (including leukemia, Hodgkin's Disease, lymphoma)? Yes No
 - iii) a stroke or a heart attack? Yes No
 - iv) heart condition, disorder of the heart, artery disease, hypertension or high blood pressure? Yes No
- b) Have any Proposed Insureds ever had any medical or surgical procedures (including major organ transplant) advised or recommended by a member of the medical profession but not done at this time? Yes No
5. In the last 10 years have any Proposed Insureds been diagnosed with, or sought treatment or advice from a member of the medical profession for:
- a) diabetes? Yes No
 - b) epilepsy or seizures? Yes No
 - c) asthma, emphysema or other lung disorder? Yes No
 - d) any disorder of digestive tract, liver, or pancreas? Yes No
 - e) anemia or other disorder of blood or blood cells (excluding HIV status)? Yes No
 - f) kidney disorder? Yes No
 - g) rheumatoid arthritis? Yes No
 - h) mental or nervous disorder, disorder of the brain or central nervous system (including Alzheimer's disease, dementia, muscular dystrophy or multiple sclerosis)? Yes No
 - i) paralysis, chronic fatigue syndrome, fibromyalgia, Parkinson's, lupus? Yes No
6. In the last 3 months, have any Proposed Insureds been unable to perform the duties of his/her regular occupation for more than ten consecutive days due to illness, injury, full or partial disability (excluding normal pregnancy)? Yes No

Details of "yes" answers to Questions 1, 2, 4, 5, and 6 above:

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")	<input type="text"/>
	SSN/TIN
Signature of Joint Owner (and title, if applicable, such as "Trustee" or "President")	<input type="text"/>
	SSN/TIN
Signature of Primary Proposed Insured	<input type="text"/>
	SSN/TIN
Signature of Additional/Joint Proposed Insured	<input type="text"/>
	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
-------------------------	-------------------	--------------------

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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 <input type="checkbox"/> M <input type="checkbox"/> F	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		

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) <input type="text"/> <input type="text"/>	5. Relationship to Primary Proposed Insured
6. E-mail Address	

SECTION E. PREMIUM PAYOR - If other than Owner

1. Name (First, Middle, Last)	2. SSN/TIN
3. Home Address (include street, city, state, zip)	
4. Relationship to Primary Proposed Insured	5. 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) <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
--	---------------------	---

SECTION H. THE POLICY - Continued

4. Additional Benefits, Riders, Options: **ALL RIDERS MAY NOT BE APPLICABLE FOR ALL PRODUCTS**

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)
 Extended Coverage Guarantee Rider Lifetime Coverage Guarantee Rider
 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"/>
Person Covered			Company	
Life Amount Including Riders	Issue Date (MM/YYYY)	Policy Number	Plan Type	Check if Replacing <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

FOR FULL UNDERWRITING ONLY

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] and American Heritage Life Insurance Company, [P.O. Box 43187, Jacksonville, FL 32203].

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] and American Heritage Life Insurance Company, [P.O. Box 43187, Jacksonville, FL 32203]. 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

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

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.

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

For Applicants in Florida: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

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

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

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

For Applicants in Tennessee, Virginia and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

APPLICATION FOR LIFE INSURANCE

- Lincoln Benefit Life Company ("The Company"), Lincoln, NE 68501
- Allstate Life Insurance Company ("The Company"), Northbrook, IL 60062
- American Heritage Life Insurance Company ("The Company"), Jacksonville, FL 32203

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. Annual Income
d. Employer Name	e. Occupation and Duties	f. Employer Phone Number
g. Height and Weight: Ft. In. Lbs.	h. In the last 12 months has the Primary Proposed Insured used tobacco or nicotine in any form? <input type="checkbox"/> Yes <input type="checkbox"/> No	

2. ADDITIONAL/JOINT INSURED

a. Name (First, Middle, Last)	b. SSN/TIN <input type="text"/> <input type="text"/>	c. Annual Income
d. Employer Name	e. Occupation and Duties	f. Employer Phone Number
g. Height and Weight: Ft. In. Lbs.	h. In the last 12 months has the Additional/Joint Proposed Insured used tobacco or nicotine in any form? <input type="checkbox"/> Yes <input type="checkbox"/> No	

3. a) Has the Proposed Insured or Additional/Joint Proposed Insured ever been charged with a felony, treated for or arrested for the use or possession of alcohol, narcotics, or mind altering drugs not prescribed by a member of the medical profession, or has the Proposed Insured or Additional/Joint Proposed Insured ever used illegal drugs or narcotics? Yes No
- b) In the last 3 years, has the Proposed Insured or Additional/Joint Proposed Insured participated in scuba or sky diving, hang gliding, mountain or rock climbing, vehicle racing of any kind, or has the Proposed Insured or Additional/Joint Proposed Insured flown as a pilot or crew member or have the intent to do so? Yes No
- c) In the last 3 years, has the Proposed Insured or Additional Joint Proposed Insured had their driver's license suspended or revoked, been arrested for reckless driving or driving under the influence of drugs or alcohol, received 3 or more moving violations, or been involved in 3 or more motor vehicle accidents? Yes No
4. Have any Proposed Insureds ever had any life, health or disability insurance application(s) declined or extra-rated? Yes No
5. Do any Proposed Insureds or Additional/Joint Proposed Insureds currently own their primary place of residence? Yes No

SECTION B. HEALTH AND MEDICAL HISTORY

1. a) Have any Proposed Insureds ever been diagnosed with, or sought treatment or advice from a member of the medical profession for:
- i) AIDS (Acquired Immune Deficiency Syndrome)? Yes No
 - ii) any type of cancer or tumor (including leukemia, Hodgkin's Disease, lymphoma)? Yes No
 - iii) a stroke or a heart attack? Yes No
 - iv) heart condition, disorder of the heart, artery disease, hypertension or high blood pressure? Yes No
- b) Have any Proposed Insureds ever had any medical or surgical procedures (including major organ transplant) advised or recommended by a member of the medical profession but not done at this time? Yes No

2. In the last 10 years have any Proposed Insureds been diagnosed with, or sought treatment or advice from a member of the medical profession for:
- a) diabetes? Yes No
 - b) epilepsy or seizures? Yes No
 - c) asthma, emphysema or other lung disorder? Yes No
 - d) any disorder of digestive tract, liver, or pancreas? Yes No
 - e) anemia or other disorder of blood or blood cells (excluding HIV status)? Yes No
 - f) kidney disorder? Yes No
 - g) rheumatoid arthritis? Yes No
 - h) mental or nervous disorder, disorder of the brain or central nervous system (including Alzheimer's disease, dementia, muscular dystrophy or multiple sclerosis)? Yes No
 - i) paralysis, chronic fatigue syndrome, fibromyalgia, Parkinson's, lupus? Yes No
3. In the last 3 months, have any Proposed Insureds been unable to perform the duties of his/her regular occupation for more than ten consecutive days due to illness, injury, full or partial disability (excluding normal pregnancy)? Yes No

Details of "yes" answers to Section A Questions 3 and 4 and Section B Questions 1, 2, and 3 above:

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

APPLICATION FOR LIFE INSURANCE

- Lincoln Benefit Life Company ("The Company"), Lincoln, NE 68501
 Allstate Life Insurance Company ("The Company"), Northbrook, IL 60062
 American Heritage Life Insurance Company ("The Company"), Jacksonville, FL 32203

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. Annual Income	
d. Employer Name			e. Occupation and Duties				f. Employer Phone Number	
g. Height and Weight: Ft. In. Lbs.			h. Do you currently use tobacco or nicotine? <input type="checkbox"/> Yes <input type="checkbox"/> No					
i. If "yes" to 1h, 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 _____					j. If "no" to 1h, 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)? _____			

2. ADDITIONAL/JOINT INSURED

a. Name (First, Middle, Last)			b. SSN/TIN <input type="text"/> <input type="text"/>				c. Annual Income	
d. Employer Name			e. Occupation and Duties				f. Employer Phone Number	
g. Height and Weight: Ft. In. Lbs.			h. Do you currently use tobacco or nicotine? <input type="checkbox"/> Yes <input type="checkbox"/> No					
i. If "yes" to 2h, 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 _____					j. If "no" to 2h, 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)? _____			

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? (If "yes" submit applicable questionnaire) Yes No
- b. engaged in sky or scuba diving, vehicle racing, mountain or rock climbing? (If "yes" submit applicable questionnaire) 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

1. 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 2 - 7 for all Proposed Insured(s) including children proposed for CLTR, and give details below.

2. 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
3. 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
4. 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
5. Are any Proposed Insureds taking any prescription medications not previously disclosed? Yes No

PRIMARY PROPOSED INSURED

6a. Name and Address of Primary Physician or Medical Facility (if none, state "None") 6b. Phone Number

6c. 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

7a. Name and Address of Primary Physician or Medical Facility (if none, state "None") 7b. Phone Number

7c. 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
FIC413PQL

SIGN HERE

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

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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)

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- Lincoln Benefit Life Company ("The Company"), Lincoln, NE 68501**
- Allstate Life Insurance Company ("The Company"), Northbrook, IL 60062**
- American Heritage Life Insurance Company ("The Company"), Jacksonville, FL 32203**

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

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- 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

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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.
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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) _____

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

Signature of Agent

SIGN HERE

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 - 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.
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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]**
- American Heritage Life Insurance Company ("The Company"), [Jacksonville, FL 32203]**

PREMIUM FINANCE SUPPLEMENT TO LIFE APPLICATION

	<input style="width: 20px; height: 20px;" type="text"/>
Primary Proposed Insured	Date of Birth (MM/DD/YYYY)

	<input style="width: 20px; height: 20px;" type="text"/>
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 FIC413 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

SERFF Tracking Number: ALSB-127006353

State: Arkansas

Filing Company: Lincoln Benefit Life Company

State Tracking Number: 47902

Company Tracking Number:

TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Product Name: FIC413 series

Project Name/Number: FIC413 series/FIC413 series

Supporting Document Schedules

Item Status:

Status

Date:

Satisfied - Item: Flesch Certification

Comments:

Attachment:

CW Readability Certification LBL no Agnt Rpt.pdf

Item Status:

Status

Date:

Satisfied - Item: Statement of Variability

Comments:

Attachments:

FIC413 FIC413L and FIC413S SOV _0211_.pdf

FIC413ATTSIG SOV _0211_.pdf

FIC413PQS FIC413PQL FIC413TIA FIC413PF SOV _0211_.pdf

CERTIFICATION OF READABILITY

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

<u>Form Number</u>	<u>Flesch Score</u>
FIC413	60
FIC413L	52
FIC413S	66
FIC413PQL	68
FIC413PQS	59
FIC413PF	61
FIC413TIA	66
FIC413ATTSIG	53

Robert Transon
Assistant Vice President

January 31, 2011
Date

Statement of Variability
Allstate Life Insurance Company, Lincoln Benefit Life Company and
American Heritage Life Insurance Company
 FIC413 series, FIC413L series, and FIC413S series

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.
2/3	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
Allstate Life Insurance Company Lincoln Benefit Life Company and
American Heritage Life Insurance Company
FIC413ATTSIG series

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Page	Bracketed Items	Description of Variability
1	Substitute W-9	This section may be modified to include new information as required by state or federal tax requirements.

Statement of Variability
Allstate Life Insurance Company, Lincoln Benefit Life Company and
American Heritage Life Insurance Company
FIC413PQS series, FIC413PQL series, FIC413TIA series, FIC413PF series

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SERFF Tracking Number: ALSB-127006353 State: Arkansas
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 Product Name: FIC413 series
 Project Name/Number: FIC413 series/FIC413 series

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)
02/04/2011	Form	Temporary Insurance Agreement	02/04/2011	FIC413TIA TIA (0111).pdf (Superseded)

- Lincoln Benefit Life Company ("The Company"), Lincoln, NE 68501**
- Allstate Life Insurance Company ("The Company"), Northbrook, IL 60062**
- American Heritage Life Insurance Company ("The Company"), Jacksonville, FL 32203**

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