

SERFF Tracking Number: BANN-127066735 State: Arkansas
Filing Company: Banner Life Insurance Company State Tracking Number: 48386
Company Tracking Number:
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: Accelerated Death Benefit Disclosure
Project Name/Number: Accelerated Death Benefit Disclosure/ADB DISC-1

Filing at a Glance

Company: Banner Life Insurance Company

Product Name: Accelerated Death Benefit SERFF Tr Num: BANN-127066735 State: Arkansas

Disclosure

TOI: L08 Life - Other

SERFF Status: Closed-Accepted State Tr Num: 48386

For Informational Purposes

Sub-TOI: L08.000 Life - Other

Co Tr Num:

State Status: Filed-Closed

Filing Type: Form

Reviewer(s): Linda Bird

Author: Ada Miller

Disposition Date: 04/04/2011

Date Submitted: 04/01/2011

Disposition Status: Accepted For

Informational Purposes

Implementation Date:

Implementation Date Requested: 04/01/2011

State Filing Description:

General Information

Project Name: Accelerated Death Benefit Disclosure

Status of Filing in Domicile: Authorized

Project Number: ADB DISC-1

Date Approved in Domicile:

Requested Filing Mode: Informational

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Individual Market Type:

Overall Rate Impact:

Filing Status Changed: 04/04/2011

State Status Changed: 04/04/2011

Deemer Date:

Created By: Ada Miller

Submitted By: Ada Miller

Corresponding Filing Tracking Number:

Filing Description:

The above-referenced disclosure is being submitted for informational purposes to be completed along with the application form, LIA (10/08) & LU-1267 (10/08), previously approved on 10/17/08.

This Disclosure form #ADB DISC-1 relates to the Accelerated Death Benefit Rider, ADB (06-10), previously approved by your department on 8/24/10. This disclosure will replace the previously approved disclosure notice, ADB DISC, as it provides additional information and a more extensive description of the accelerated death benefit.

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

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Company and Contact

Filing Contact Information

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

Filing Company Information

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

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? No
 Fee Explanation: 1 filing x \$50
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Banner Life Insurance Company	\$50.00	04/01/2011	46177612

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Accepted For Linda Bird Informational Purposes		04/04/2011	04/04/2011

SERFF Tracking Number: *BANN-127066735* *State:* *Arkansas*
Filing Company: *Banner Life Insurance Company* *State Tracking Number:* *48386*
Company Tracking Number:
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Product Name: *Accelerated Death Benefit Disclosure*
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Disposition

Disposition Date: 04/04/2011

Implementation Date:

Status: Accepted For Informational Purposes

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		Yes
Supporting Document	Previously Approved Accelerated Death Benefit		Yes
Form	Accelerated Death Benefit Disclosure		Yes

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Form Schedule

Lead Form Number: ADB DISC-1

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	ADB DISC-1	Application/ Accelerated Death Enrollment Benefit Disclosure Form	Initial		57.200	ADB DISC-1.pdf

Name of Proposed Insured _____ Policy Number _____

Receipt of accelerated death benefits may affect eligibility for Public Assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children and Supplemental Security Income (SSI). Receipt of accelerated death benefits may be taxable. Prior to applying for accelerated death benefits, policy owners should consult with a personal tax advisor and the appropriate social services agency. There is no additional premium or cost of insurance required for the Accelerated Death Benefit Rider; instead a lien is associated with the acceleration and an administrative charge, not to exceed \$250, is required upon the exercise of the benefit. Review your Policy and the Accelerated Death Benefit Rider for complete limitations, terms, and conditions. The accelerated death benefit feature is subject to state variations; it may not be available in all states.

- We will pay an accelerated death benefit, at the Policy Owner's request, if the Policy Owner provides to us evidence acceptable to us that the Insured is living and has a medical condition that is reasonably expected to result in a life expectancy of twelve months or less.
- The maximum accelerated death benefit is the lesser of: (i) \$500,000.00, or (ii) 75% of the policy's primary death benefit as of the date the company approves payment of the accelerated death benefit, less any outstanding loan balance. The accelerated death benefit will be paid in a lump sum.
- The requested accelerated death benefit amount, plus an administrative fee not to exceed \$250, will create a lien against the policy. Interest on the amount of the Policy lien accrues daily and is added to the amount of the Policy lien. **The amount payable at the Insured's death is reduced by the amount of the Policy lien.**
- **Receipt of an accelerated death benefit will: 1) limit availability of partial and full cash surrender values and additional loans, 2) not affect future required premium payments or future cost of insurance rates and values, and 3) not affect the accumulation values, loan balance, or future loan interest charges.**
- **Continued premium payment is required to keep the Policy in force. Unpaid premiums will be added to the Policy lien. Prior to maturity, the Policy will not terminate unless the lien equals or exceeds the Policy's death benefit proceeds. Upon termination or maturity of the Policy, no further death benefits will be paid and available cash surrender values will be limited.**

The sample illustration assumes: (1) \$500,000 death benefit; (2) \$5,000 loan value. Owner requests maximum accelerated death benefit. The maximum accelerated death benefit equals $.75 \times \$500,000$, less outstanding policy loan (\$5,000) = \$370,000. Lien amount = \$370,000 + \$250 administrative fee = \$370,250. This example is illustrative only and not intended to show actual values. Net Death Benefit = Death Benefit less Lien amount less any policy loan (if applicable). The Available Cash Surrender Value is the maximum available for full surrenders, partial surrenders, or loans.

	Immediately Before Acceleration	Immediately After Acceleration Death Benefit Payment of \$370,000
Death Benefit (Gross)	\$500,000	\$500,000
Premium	\$200 per month	\$200 per month
Lien Amount	\$0	\$370,250
Policy Loan	\$5,000	\$5,000
Account Value	\$32,000	\$32,000
Cash Surrender Value	\$30,000	\$30,000
Available Cash Surrender Value	\$25,000	\$0
Net Death Benefit	\$495,000	\$124,750

Note: your policy may not provide for Cash Surrender Values and/or Loans. In such case, the maximum accelerated death benefit is the lesser of: i) 75% of the policy death benefit or ii) \$500,000.

I acknowledge that I have received and read this Disclosure Statement and I understand that only the actual provisions of the Accelerated Death Benefit Rider will control payment of an accelerated death benefit.

Owner Signature _____ Date _____ Agent Signature _____ Date _____

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Supporting Document Schedules

Item Status: **Status**
Date:

Satisfied - Item: Flesch Certification

Comments:

Readability Certification attached
 Guaranty Association Act form attached

Attachments:

Flesch Readability Certification.pdf
 LU-1112 (9-08) AR Guaranty Notice.pdf

Item Status: **Status**
Date:

Satisfied - Item: Application

Comments:

Life Applications LIA (10/08) & LU-1267 (10/08) was previously approved on 10/17/08 by your department.

Attachments:

LIA (10-08).pdf
 LU-1267 (10-08).pdf
 AR LIA Approval.pdf

Item Status: **Status**
Date:

Satisfied - Item: Previously Approved Accelerated
 Death Benefit

Comments:

Previously approved ADB form to which the new disclosure statement relates.

Attachments:

ADB (06-10).pdf
 ADB (06-10) & ADB DISC BANN-126745774.pdf

Readability Certification
ADB DISC-1 Accelerated Death Benefit Disclosure

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

Accelerated Death Benefit Disclosure, Form ADB DISC-1, yielded a score of 57.2.

It is not in less than 10-point type, one-point leaded.

The style, arrangement, and overall appearance of the policy gives no undue prominence to any portion of the text of the policy or to any endorsements or riders



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

February 24, 2011

Date



Banner Life Insurance Company
1701 Research Boulevard
Rockville, Maryland

LIMITATIONS AND EXCLUSIONS UNDER THE ARKANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting insurance companies that are well managed and financially stable.

DISCLAIMER

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in the state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

The Arkansas Life and Health Insurance Guaranty Association
c/o The Liquidation Division
1023 West Capitol
Little Rock, Arkansas 72201

Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201

The state law that provides for this safety-net is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"). Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity, or health insurance contract or policy, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons owning such policies are NOT protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contract holders, not individuals);
- Unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC") (whether the FPBC is yet liable or not);
- Portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution;
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a non-affiliate benefit plan or its trustees).

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of \$300,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall \$300,000 limit, the Association will not pay more than \$300,000 in health insurance benefits, \$300,000 in present value of annuity benefits, or \$300,000 in life insurance death benefits or net cash surrender values - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a \$1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.

Internet address: www.bannerlife.com

INSTRUCTIONS

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

DO

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

DO NOT

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

Thank you for applying to Banner Life Insurance Company. The soliciting insurance broker (broker) should be able to answer any questions you may have. This broker is an independent broker, not an employee of Banner Life Insurance Company, and is not authorized to make or modify contracts or to waive any requirements or any information that we may request.

Underwriting

Once we receive your application, we will begin an evaluation process called underwriting to determine whether you are eligible for insurance and, if so, the rate you should pay for that insurance. We may find that we are unable to give you the insurance you have applied for or that we are able to give it to you only on a modified basis or at a rate greater than our lowest rate.

Your application will be our primary source of information; therefore, it must be true, complete, and accurate. You must inform us of a change to any answer in any part of your application before accepting delivery of a policy; in fact, you agree to do so when you sign your application. We may seek information from other sources to help us evaluate the information you give us on your application.

Contestability

We strongly urge you to review the completed application closely for accuracy. A claim may be denied, the policy may be void or your coverage may be lost if the application is incomplete or if it contains false statements or material misrepresentations. Any policy that may be issued will indicate when and under what circumstances it may be contested. Please be aware that if the application contains material misrepresentations or conceals material facts, and you submitted it with the intent to defraud or to facilitate fraud against us, you may also be guilty of insurance fraud, which is a crime. You must inform us of a change to any answer in any part of your application before accepting delivery of a policy; in fact, you agree to do so when you sign your application.

Replacement of Existing Coverage

If you intend to replace existing coverage, tell the broker of your intention and answer "yes" to the replacement question in the application; state law may require the broker to give you information that will help you compare the policy you are applying for with the policy you intend to replace. If you are undecided about keeping existing coverage, indicating an intention to replace existing coverage may help you get the information you need to make a decision. If you do replace existing coverage, the new policy may contain new suicide and contestable periods. The following would be considered replacement: you stop paying premiums on an existing policy or surrender an existing policy before or shortly after applying to us or you borrow from an existing policy to pay premiums for the insurance for which you are applying. State law may define replacement to include other situations. Ask the broker if you are unsure.

Insurance Information Practices

We will rely primarily on information provided by you. We may supplement that information with information from other sources such as medical professionals who have treated you. In some cases, we may ask a consumer reporting agency to collect information and submit an investigative consumer report to us as explained in this Notice under Federal Fair Credit Reporting Notice. You may request to be interviewed in connection with the preparation of this report.

In certain limited situations, we are allowed by law to disclose necessary items of personal information to third parties without your specific authorization.

You have the right to be told about, and receive copies if you wish, of items of personal information about you that appear in our files, including information contained in investigative consumer reports. You also have the right to seek correction of information you believe to be inaccurate.

We will send you a more detailed explanation of our information practices if you send us a written request. You may send your request to the Director of Underwriting, Banner Life Insurance Company, 1701 Research Boulevard, Rockville, MD 20850-3191.

Federal Fair Credit Reporting Notice

As part of our underwriting, we may ask that an investigative consumer report be prepared. An independent source known as a consumer reporting agency will prepare the report. The report will typically include information as to your character, general reputation, mode of living, and personal characteristics. The agency may conduct personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted in order to get this information. If you write to us within a reasonable time after you receive this Notice, we will tell you whether or not a report was requested. If a report was requested, we will tell you the name, address, and telephone number of the agency to whom the request was made. Upon request, the agency will furnish information as to the nature and scope of its investigation. If you would like to inspect and to receive a copy of the report, you may do so by contacting the agency directly.

NOTICE TO PROPOSED INSURED**(Please give to the Proposed Insured)****(continued)**

MIB (Medical Information Bureau) Pre-Notice Disclosure

Information regarding your insurability will be treated as confidential. Banner Life Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply each company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734.

Banner Life Insurance Company, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

SECTION A PROPOSED INSURED			
1. Full Name (Include maiden name in parentheses) _____	2. Sex <input type="checkbox"/> M <input type="checkbox"/> F	3. Date of Birth Month _____ Day _____ Year _____	4. Social Security Number _____
5. a. Home Address Street _____ City, State _____ Zip _____			5. b. How Long _____
6. Phone Numbers Home () _____ Work () _____	7. State/Country of Birth _____	8. U.S. Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No Visa Type _____ If No, Date of Entry into U.S. _____ Country of Citizenship _____	
9. Marital Status <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> W <input type="checkbox"/> D	10. Driver's License Number and State of Issue or State ID Number _____		
11. Occupation (Include duties) _____	12. Annual Income _____	13. Total Net Worth _____	
14. a. Employer's Name and Address and Nature of Business _____			14. b. How Long Employed _____
15. Have you ever used tobacco or nicotine products in any form? <input type="checkbox"/> Yes - give details below <input type="checkbox"/> No			
Product	Date last used (month/year)	Amount / Frequency	
Cigarettes	_____	_____	
Cigars	_____	_____	
Other	_____	_____	
SECTION B BENEFICIARY (Share percentage totals must equal 100%. If necessary, use Remarks section, Question 48. If Beneficiary is a trust, check box <input type="checkbox"/> and complete Section D.)			
16. Primary			
Name _____	Relationship _____	% Share _____	
SSN _____	Date of Birth _____	_____	
Name _____	Relationship _____	% Share _____	
SSN _____	Date of Birth _____	_____	
17. Contingent			
Name _____	Relationship _____	% Share _____	
SSN _____	Date of Birth _____	_____	
Name _____	Relationship _____	% Share _____	
SSN _____	Date of Birth _____	_____	
SECTION C OWNER			
18. Owner is <input type="checkbox"/> Proposed Insured <input type="checkbox"/> Trust (also complete Section D) <input type="checkbox"/> Other than Proposed Insured or Trust			
Complete if the Proposed Insured is not the Owner. (If contingent Owner is required, use Remarks section, Question 48).			
Name _____	SSN or Tax ID # _____	Date of Birth _____	
Address _____	City, State _____	Zip _____	
Contact Phone # _____	Relationship to Proposed Insured _____		
If Owner is a business, web site address _____	Email address _____		
SECTION D TRUST INFORMATION (If trust is Beneficiary and/or Owner).			
19. Exact Name of Trust _____	Trust Tax ID# _____		_____
Current Trustee(s) _____	Date of Trust _____		

PART 1 (continued)

SECTION E PAYOR

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

Name _____ Relationship to Insured/Owners _____

Address _____
Street City State Zip

Contact Phone # _____ Email address _____

SECTION F INSURANCE APPLIED FOR

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

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

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

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

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

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

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

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

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

Additional Benefits (if available)

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

SECTION G OTHER INSURANCE

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

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

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

Company	Policy Number	Face Amount	Business?		Issue Date	Replacing?		Beneficiary
			Yes	No		Yes	No	
			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	

31. Have you ever had an application for life or health insurance declined, postponed, modified, rated or offered with a reduced face amount? (If Yes, provide details in Remarks section, Question 48.) Yes No

32. Will you, or are you likely to, replace, end, or change existing insurance or annuity with any company or society with the insurance for which you are applying? (If Yes, the broker may be required to provide additional forms for your review and signature.)

33. Are there any plans to sell or permanently assign the policy to another person or entity, life settlement provider or an investor, or will it replace a policy that has already been sold to another life settlement company or investor? (If Yes, provide details in Remarks section, Question 48.)

PART 1 (continued)

SECTION H GENERAL QUESTIONS (Explain all Yes answers in Remarks section, Question 48.)		Yes	No
34. Has any person promised or agreed to give or have they given to any party to the application, any inducement, fee or compensation as an incentive to purchase the policy?		<input type="checkbox"/>	<input type="checkbox"/>
35. Has any party to the application ever sold, transferred or assigned any life insurance policy to a third party, such as a viatical settlement entity, life settlement entity, insurance company, other secondary market provider, or premium financing entity?		<input type="checkbox"/>	<input type="checkbox"/>
36. Has any party to the application ever received inducement, fee or compensation as an incentive to purchase, sell, transfer or assign a policy?		<input type="checkbox"/>	<input type="checkbox"/>
37. In the past 5 years, have you requested or received a Worker's Compensation, Social Security, or disability income payment?		<input type="checkbox"/>	<input type="checkbox"/>
38. Have you ever been convicted of, or are you currently charged with, a felony or misdemeanor, or are you currently on parole or probation?		<input type="checkbox"/>	<input type="checkbox"/>
39. In the past 5 years, has your driver's license been suspended or revoked, or have you been convicted of 2 or more moving violations or accidents?		<input type="checkbox"/>	<input type="checkbox"/>
40. In the past 5 years, have you been convicted of, or plead guilty or no contest to, driving while impaired, intoxicated, or under the influence of alcohol or drugs? (If Yes, complete Alcohol/Drug Usage Questionnaire.)		<input type="checkbox"/>	<input type="checkbox"/>
41. Are you a member, or do you intend to become a member, of the armed forces, including the reserves?		<input type="checkbox"/>	<input type="checkbox"/>
SECTION I OTHER ACTIVITIES		Yes	No
42. Do you hold a current pilot license, or have you in the past 5 years flown, or within the next 2 years do you intend to fly, other than as a passenger in any type of aircraft? (If Yes, complete Aviation Questionnaire.)		<input type="checkbox"/>	<input type="checkbox"/>
43. Have you in the past 2 years engaged in, or within the next 2 years do you intend to engage in, certain activities such as hang gliding, hot-air ballooning, ultra-light flying, heli-skiing, mountain, ice or rock climbing, cliff or base jumping, motor vehicle racing, motorcycle or any other motorized land or water vehicle racing, or scuba or sky diving? (If Yes, complete appropriate questionnaire.)		<input type="checkbox"/>	<input type="checkbox"/>
44. Do you intend to travel outside the U.S. or Canada, or change your country of residence in the next 12 months? (If Yes, list countries, cities, duration and purpose of travel in Remarks section, Question 48.)		<input type="checkbox"/>	<input type="checkbox"/>
SECTION J PROPOSED INSURED FINANCIAL INFORMATION			
Complete this section when applying for face amount over \$1,000,000 or when the Proposed Insured is over age 65:			
45. a. What is the purpose of this insurance? (e.g. income replacement, buy-sell, keyperson, estate conservation)			

b. How was the need for the face amount determined?	_____	Yes	No
c. In the last 5 years, has the Proposed Insured filed for bankruptcy or had any charge off of bad debts?		<input type="checkbox"/>	<input type="checkbox"/>
If Yes, type of bankruptcy and discharge date or charge off date. _____			
46. a. Gross annual earned income (salary, bonuses, etc. from W-2 forms)	\$ _____		
b. Gross annual unearned income (dividends, interest, rental income, etc.)	\$ _____		
c. Is the Proposed Insured self-supporting?		<input type="checkbox"/>	<input type="checkbox"/>
If No, how much insurance is in-force on the life of the person providing the support?		\$ _____	
What is that person's relationship to the Proposed Insured? _____			

PART 1 (continued)**SECTION K BUSINESS FINANCIAL INFORMATION**

Complete this section when applying for face amount over \$1,000,000 and if Beneficiary or Owner is a business:

	Current YTD	Previous Year
47. a. Assets	\$	\$
b. Liabilities	\$	\$
c. Gross Sales	\$	\$
d. Net Income after Taxes	\$	\$
e. Fair Market Value of the business	\$	\$

f. How long has the business been established? _____

g. What percentage of the business does the Proposed Insured own? _____

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

Yes No

i. In the last 5 years, has the business filed for bankruptcy or had any charge off of bad debts?

If Yes, type of bankruptcy and discharge date or charge off date. _____

j. Company web site address, if available _____

48. Remarks: Explanations and/or special requests. Use Part 1 Supplement to Application if necessary.

FRAUD WARNINGS

Arkansas, Kentucky, Louisiana, New Mexico, and Ohio

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

Colorado

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

Florida

Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement or claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Georgia, Nebraska, South Carolina, Texas

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

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

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

Maryland

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

New Jersey

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

Oklahoma

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

Pennsylvania

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

1. Name of Proposed Insured _____ Date of Birth _____
 2. Height ____ ft. ____ in. 3. Weight _____ lbs.
 If your weight has changed by over 10 lbs. in the last year, indicate amount and reason _____

PHYSICIAN INFORMATION

4. **Primary Physician**

Name _____
 Address _____
 Telephone _____ Date last seen _____
 Reason last seen and results of visit _____

5. **Physician Last Consulted**

Name _____ Specialty _____
 Address _____
 Telephone _____ Date last seen _____
 Reason last seen and results of visit _____

6. Has a parent or sibling ever been diagnosed or treated by a member of the medical profession for heart or kidney disease, stroke, diabetes, cancer, melanoma, suicide, Huntington's Disease, Sickle Cell Disease or Familial Adenomatous Polyposis (FAP)? If Yes, give details in the Family History chart below. Yes No

Family History: Include the age at onset/event for each medical condition.

	Medical Conditions	Age at Onset/Event	Age if Living	Cause of Death	Age at Death
Father					
Mother					
Brothers					
Sisters					

MEDICAL HISTORY - Provide details to Yes answers in the Remarks section. Include provider, date, symptoms, diagnosis and treatment.

Yes No **Remarks - Explain All Yes Answers**
 Enter question number before detailed response.

Questions 7-22, have you ever consulted a member of the medical profession regarding or have you been diagnosed or treated for:

7. High blood pressure, high cholesterol, abnormal electrocardiogram, chest pain, irregular heart rhythm, palpitations, heart murmur, heart attack, angina, phlebitis, peripheral vascular disease, or any other disease or disorder of the heart or blood vessels?
8. Hepatitis, ulcer, internal bleeding, colitis, acid reflux, GERD, or any other disease or disorder of the stomach, gall bladder, esophagus, liver, pancreas, spleen, intestines, colon, or rectum?
9. A disorder of your blood or immune system including anemia, blood clots, bleeding, immune deficiency, leukemia, or lymphoma (excluding HIV)?

PART 2 - Medical History (continued)

Name of Proposed Insured _____	Yes	No	Remarks - Explain All Yes Answers
10. Cancer, tumor, melanoma, or any other malignant disorder?.....	<input type="checkbox"/>	<input type="checkbox"/>	
11. Diabetes or high blood sugar or any other disease or disorder of the pituitary, thyroid, or endocrine glands?	<input type="checkbox"/>	<input type="checkbox"/>	
12. Albumin, protein, blood or sugar in the urine or any other disease or disorder of the kidney or bladder?	<input type="checkbox"/>	<input type="checkbox"/>	
13. Cyst, polyp, lump, or other growth, or any disease or disorder of the skin or lymph nodes?	<input type="checkbox"/>	<input type="checkbox"/>	
14. Any disease or disorder of the uterus, cervix, ovaries, or breasts?.....	<input type="checkbox"/>	<input type="checkbox"/>	
15. Any disease or disorder of the prostate or reproductive system?	<input type="checkbox"/>	<input type="checkbox"/>	
16. Any sexually transmitted disorders or diseases?.....	<input type="checkbox"/>	<input type="checkbox"/>	
17. Pregnancy, complications of pregnancy or infertility?	<input type="checkbox"/>	<input type="checkbox"/>	
If now pregnant, what is the expected date of delivery? _____			
18. Asthma, shortness of breath, chronic cough or hoarseness, bronchitis, emphysema, COPD (chronic obstructive pulmonary disease), sarcoidosis, pneumonia, TB (tuberculosis), sleep apnea, or any other disorder of the respiratory system?	<input type="checkbox"/>	<input type="checkbox"/>	
19. A disorder of the brain, spinal cord, or nervous system including chronic headaches, convulsions or loss of consciousness, seizures, tremors, paralysis, fainting, stroke, MS (multiple sclerosis), or TIA (transient ischemic attack)?	<input type="checkbox"/>	<input type="checkbox"/>	
20. Depression, anxiety, psychosis, suicidal thoughts or attempts of suicide, anorexia or bulimia, obsessive compulsive disorder, bipolar disorder, or other mental, nervous or emotional disorder?.....	<input type="checkbox"/>	<input type="checkbox"/>	
21. Arthritis or disorder of the bones, skin or muscles?.....	<input type="checkbox"/>	<input type="checkbox"/>	
22. Any disease or disorder of the eyes, ears, nose or throat?.....	<input type="checkbox"/>	<input type="checkbox"/>	
23. In the last 5 years , unless previously stated on this application, have you:			
a. Been treated by a member of the medical profession or at a medical facility?	<input type="checkbox"/>	<input type="checkbox"/>	
b. Had an electrocardiogram, x-ray, blood test, or other diagnostic test, excluding an HIV test?	<input type="checkbox"/>	<input type="checkbox"/>	
c. Had surgery or biopsy, or been an inpatient or outpatient in a hospital, clinic, or other medical or mental health facility?	<input type="checkbox"/>	<input type="checkbox"/>	
d. Been advised by a member of the medical profession to have surgery, medical treatment, biopsy, or diagnostic testing, excluding HIV testing, that has not yet been completed?.....	<input type="checkbox"/>	<input type="checkbox"/>	
e. Been referred to any other member of the medical profession or medical facility?	<input type="checkbox"/>	<input type="checkbox"/>	
f. Been unable to work, attend school or perform the normal activities of like age and gender, or been confined at home?	<input type="checkbox"/>	<input type="checkbox"/>	
24. a. Have you ever used amphetamines, barbiturates, cocaine, heroin, crack, marijuana, LSD, PCP, or other illegal, restricted or controlled substances, except as prescribed by a licensed physician?	<input type="checkbox"/>	<input type="checkbox"/>	
If Yes, please provide dates of use: From _____ To _____			
Name of drug used: _____			
Amount and frequency of use: _____			

Name of Proposed Insured _____ Date of Birth _____

Notice to Proposed Insured and Owner. Payment of the Amount Remitted may only be made at the same time that both the Application - Part 1 and this TIAA are completed. If the Insurer does not respond to you within 90 days, notify the Insurer at the above address. **Make the Amount Remitted payable to Banner Life Insurance Company. Do not make it payable to the licensed insurance agent or leave the payee blank. We do not accept cash or cash equivalents (money orders, cashiers checks) or "starter" checks.**

TEMPORARY INSURANCE APPLICATION (Answer all questions.)

Insurer The Insurer is Banner Life Insurance Company.

Temporary insurance cannot begin and you should make no payment if any question below is answered "Yes" or left blank.

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1. Is the Proposed Insured less than 15 days old or more than 70 years old (age nearest birthday) on the date of this TIAA?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Does the total amount of insurance on the Proposed Insured's life now applied for or pending with Banner Life Insurance Company exceed \$1,000,000? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. In the past 90 days, has the Proposed Insured been admitted, or medically advised by a member of the medical profession to be admitted, to a hospital or other licensed health care facility, had surgery performed or recommended, or been medically advised to have any diagnostic test (excluding an AIDS-related test) that was not completed?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. In the past 5 years, has the Proposed Insured been diagnosed, treated for, or been advised to be treated for: heart disease; stroke; cancer; alcohol or drug dependence or abuse; or insulin dependent diabetes? | <input type="checkbox"/> | <input type="checkbox"/> |

THIS AGREEMENT PROVIDES A LIMITED AMOUNT OF LIFE INSURANCE COVERAGE FOR A LIMITED AMOUNT OF TIME, SUBJECT TO THE TERMS AND CONDITIONS SET FORTH BELOW.

TEMPORARY INSURANCE AGREEMENT

Agreement. Subject to the terms of the policy applied for and this TIAA, the Insurer agrees to pay the Limited Amount to the beneficiaries listed in the Application - Part 1 upon receipt of due proof that the Proposed Insured died, except due to suicide, and provided all eligibility requirements and conditions for coverage under this Agreement have been met. The consideration for temporary insurance is the Temporary Insurance Application and payment of an amount equal to the first modal premium for the plan applied for or completion of the payment options form.

Limited Amount. The Limited Amount is the lesser of: (1) the amount of insurance applied for in the Application or (2) \$1,000,000 minus the amount of insurance on the Proposed Insured's life with the Insurer under any other applications for insurance now pending or other temporary insurance agreements.

Start Date. Temporary insurance equal to the Limited Amount will begin on the Start Date subject to the terms of this TIAA. The Start Date is the Date of this TIAA.

Stop Date. Temporary insurance automatically ends on the **earliest** of the following: (1) the date the Owner withdraws the application for insurance or refuses to accept any policy issued or offered; (2) the date the Insurer mails or otherwise provides notice to the Owner or his/her agent that it was unable to approve the requested coverage at the premium amount quoted and a counter offer is made by the Insurer; (3) the date the Insurer mails or otherwise provides notice to the Owner or his/her representative that it has declined or cancelled the application; (4) the date the Insurer mails or otherwise provides a premium refund to the Owner or his/her representative; (5) the date the policy is delivered to the Owner and delivery requirements have been completed.

Policy Date. The policy date of any policy issued will be the Start Date unless the policy is backdated at the Owner's request. The prepayment for this temporary insurance will be applied to the first premium due if the policy is issued.

Other Limitations. The Insurer's liability will be limited to a return of the Amount Remitted if: (1) any part of the life insurance application or this TIAA contains a misrepresentation material to the Insurer; or (2) the Proposed Insured dies by suicide.

**TEMPORARY INSURANCE APPLICATION
AND AGREEMENT (TIAA)**

(continued)

I represent that: (1) I have read and received a copy of this TIAA and agree to all of its terms and conditions; (2) I understand and agree that temporary insurance will not begin if any question in this TIAA is answered Yes or left blank and any collection of premium will not activate coverage under this agreement; (3) the answers given in this TIAA are true and correct, and I understand that, if they are false, temporary insurance may be denied or declined; (4) I understand that completing this TIAA does not guarantee that the Insurer will issue a policy on the Proposed Insured's life; (5) I understand that the licensed insurance agent is not authorized to change or waive the terms of this TIAA or to collect premium if the Proposed Insured is ineligible for coverage under this Agreement; and (6) I understand that any premium submitted with this TIAA will be refunded if the Insurer does not approve the requested coverage.

Signature of Proposed Insured

Date of this TIAA

Signature of Owner (if other than Proposed Insured)

LICENSED INSURANCE AGENT'S STATEMENT

Amount Remitted \$ _____ Person from Whom Received _____

On the Date of this TIAA, I received the Amount Remitted in exchange for this TIAA. The TIAA bears the same date as the Application - Part 1. I agree that I am not authorized to change or waive the terms of this TIAA and represent that I have not attempted to do so. I have read and explained the terms of this TIAA to the Proposed Insured and Owner. I have left a copy with the Owner.

Signature of Licensed Insurance Agent

Licensed Insurance Agent Number

Name of Proposed Insured _____ Date of Birth _____

Notice to Proposed Insured and Owner. Payment of the Amount Remitted may only be made at the same time that both the Application - Part 1 and this TIAA are completed. If the Insurer does not respond to you within 90 days, notify the Insurer at the above address. **Make the Amount Remitted payable to Banner Life Insurance Company. Do not make it payable to the licensed insurance agent or leave the payee blank. We do not accept cash or cash equivalents (money orders, cashiers checks) or "starter" checks.**

TEMPORARY INSURANCE APPLICATION (Answer all questions.)

Insurer The Insurer is Banner Life Insurance Company.

Temporary insurance cannot begin and you should make no payment if any question below is answered "Yes" or left blank.

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1. Is the Proposed Insured less than 15 days old or more than 70 years old (age nearest birthday) on the date of this TIAA?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Does the total amount of insurance on the Proposed Insured's life now applied for or pending with Banner Life Insurance Company exceed \$1,000,000? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. In the past 90 days, has the Proposed Insured been admitted, or medically advised by a member of the medical profession to be admitted, to a hospital or other licensed health care facility, had surgery performed or recommended, or been medically advised to have any diagnostic test (excluding an AIDS-related test) that was not completed?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. In the past 5 years, has the Proposed Insured been diagnosed, treated for, or been advised to be treated for: heart disease; stroke; cancer; alcohol or drug dependence or abuse; or insulin dependent diabetes? | <input type="checkbox"/> | <input type="checkbox"/> |

THIS AGREEMENT PROVIDES A LIMITED AMOUNT OF LIFE INSURANCE COVERAGE FOR A LIMITED AMOUNT OF TIME, SUBJECT TO THE TERMS AND CONDITIONS SET FORTH BELOW.

TEMPORARY INSURANCE AGREEMENT

Agreement. Subject to the terms of the policy applied for and this TIAA, the Insurer agrees to pay the Limited Amount to the beneficiaries listed in the Application - Part 1 upon receipt of due proof that the Proposed Insured died, except due to suicide, and provided all eligibility requirements and conditions for coverage under this Agreement have been met. The consideration for temporary insurance is the Temporary Insurance Application and payment of an amount equal to the first modal premium for the plan applied for or completion of the payment options form.

Limited Amount. The Limited Amount is the lesser of: (1) the amount of insurance applied for in the Application or (2) \$1,000,000 minus the amount of insurance on the Proposed Insured's life with the Insurer under any other applications for insurance now pending or other temporary insurance agreements.

Start Date. Temporary insurance equal to the Limited Amount will begin on the Start Date subject to the terms of this TIAA. The Start Date is the Date of this TIAA.

Stop Date. Temporary insurance automatically ends on the **earliest** of the following: (1) the date the Owner withdraws the application for insurance or refuses to accept any policy issued or offered; (2) the date the Insurer mails or otherwise provides notice to the Owner or his/her agent that it was unable to approve the requested coverage at the premium amount quoted and a counter offer is made by the Insurer; (3) the date the Insurer mails or otherwise provides notice to the Owner or his/her representative that it has declined or cancelled the application; (4) the date the Insurer mails or otherwise provides a premium refund to the Owner or his/her representative; (5) the date the policy is delivered to the Owner and delivery requirements have been completed.

Policy Date. The policy date of any policy issued will be the Start Date unless the policy is backdated at the Owner's request. The prepayment for this temporary insurance will be applied to the first premium due if the policy is issued.

Other Limitations. The Insurer's liability will be limited to a return of the Amount Remitted if: (1) any part of the life insurance application or this TIAA contains a misrepresentation material to the Insurer; or (2) the Proposed Insured dies by suicide.

**TEMPORARY INSURANCE APPLICATION
AND AGREEMENT (TIAA)**

(continued)

I represent that: (1) I have read and received a copy of this TIAA and agree to all of its terms and conditions; (2) I understand and agree that temporary insurance will not begin if any question in this TIAA is answered Yes or left blank and any collection of premium will not activate coverage under this agreement; (3) the answers given in this TIAA are true and correct, and I understand that, if they are false, temporary insurance may be denied or declined; (4) I understand that completing this TIAA does not guarantee that the Insurer will issue a policy on the Proposed Insured's life; (5) I understand that the licensed insurance agent is not authorized to change or waive the terms of this TIAA or to collect premium if the Proposed Insured is ineligible for coverage under this Agreement; and (6) I understand that any premium submitted with this TIAA will be refunded if the Insurer does not approve the requested coverage.

Signature of Proposed Insured

Date of this TIAA

Signature of Owner (if other than Proposed Insured)

LICENSED INSURANCE AGENT'S STATEMENT

Amount Remitted \$ _____ Person from Whom Received _____

On the Date of this TIAA, I received the Amount Remitted in exchange for this TIAA. The TIAA bears the same date as the Application - Part 1. I agree that I am not authorized to change or waive the terms of this TIAA and represent that I have not attempted to do so. I have read and explained the terms of this TIAA to the Proposed Insured and Owner. I have left a copy with the Owner.

Signature of Licensed Insurance Agent

Licensed Insurance Agent Number

AGENT'S REPORT

- 1. Name of Proposed Insured _____ Date of Birth _____
2. Number of years you have known the primary Proposed Insured _____
3. Who first suggested the purchase of this insurance? [] Agent [] Owner/Applicant [] Proposed Insured [] Other _____
4. Was the application signed after all questions were answered?..... [] Yes [] No
5. Did you personally see the Proposed Insured?..... [] Yes [] No
6. Did anyone sign or assist in the completion of Part 1 or Part 2 of the Application for or on behalf of the Proposed Insured? [] Yes [] No
7. Are you aware of any information that would adversely affect any Proposed Insured's eligibility, acceptability, or insurability?... [] Yes [] No
8. Did you provide the client with the Temporary Life Insurance Application and Agreement (TIAA) form?..... [] Yes [] No
9. Premium Class Quoted _____
10. Are there any personal or business companion applications?..... [] Yes [] No
11. a. To the best of your knowledge, does the policy applied for involve the replacement of existing insurance? [] Yes [] No
b. If Yes, has the Proposed Insured replaced other life insurance policies in the past 2 years?..... [] Yes [] No
12. Are there any plans to sell or assign this policy to another person or entity, life settlement provider or investor, or will it replace a policy that has already been sold to a life settlement company or investor? [] Yes [] No
13. Will the premium for this policy be loaned or otherwise financed by an individual(s) or entity other than the Proposed Insured or immediate family members of the Proposed Insured? [] Yes [] No

Remarks _____

STATEMENTS BY AGENT

I certify that:

- I asked and carefully explained each question to the Proposed Insured and Owner/applicant before recording each answer prior to the application being signed;
• The answers given in this application and Agent's Report are complete and accurate to the best of my knowledge and belief;
• The Proposed Insured and applicant know that any fraudulent statement or material misrepresentation in the application may result in loss of coverage under the policy;
• I have given the Notice to Proposed Insured attached to this application to the Proposed Insured;
• If the insurance applied for will or may replace any existing life insurance policy or annuity contract, I have completed any and all proper state required replacement form(s);
• I have explained to the Proposed Insured that if money is submitted with this application, conditions of the Temporary Insurance Application and Agreement must be met.
• If I become aware of a change in the health or habits of the Proposed Insured occurring after the date of the application but before the policy is delivered, I promise to inform the Company of the change and agree to withhold delivery of the policy until instructed by the Company to do so.

Signature of Licensed Insurance Agent _____ Date _____

Phone No. () _____

Print Name of Above Signature _____

Agent # _____ SSN _____

Print Name of Agency, if different from above _____

Share of commission _____

Signature of Additional Licensed Insurance Agent _____ Date _____

Phone No. () _____

Print Name for Above Additional Signature _____

Agent # _____ SSN _____

Print Name of Additional Agency, if different from above _____

Share of commission _____

GENERAL AGENT INFORMATION

GA name _____ GA # _____ Case Manager _____

1. Name of Proposed Insured _____ Date of Birth _____
 2. Height _____ ft. _____ in. 3. Weight _____ lbs.
 If your weight has changed by over 10 lbs. in the last year, indicate amount and reason _____

PHYSICIAN INFORMATION

4. **Primary Physician**

Name _____
 Address _____
 Telephone _____ Date last seen _____
 Reason last seen and results of visit _____

5. **Physician Last Consulted**

Name _____ Specialty _____
 Address _____
 Telephone _____ Date last seen _____
 Reason last seen and results of visit _____

6. Has a parent or sibling ever been diagnosed or treated by a member of the medical profession for heart or kidney disease, stroke, diabetes, cancer, melanoma, suicide or Huntington's Disease, Sickle Cell Disease or Familial Adenomatous Polyposis (FAP)? If Yes, give details in the Family History chart below. Yes No

Family History: Include the age at onset/event for each medical condition.

	Medical Conditions	Age at Onset/Event	Age if Living	Cause of Death	Age at Death
Father					
Mother					
Brothers					
Sisters					

MEDICAL HISTORY - Provide details to Yes answers in the Remarks section. Include provider, date, symptoms, diagnosis and treatment.

Yes No **Remarks - Explain All Yes Answers**
 Enter question number before detailed response.

Questions 7-22, have you ever consulted a member of the medical profession regarding or have you been diagnosed or treated for:

7. High blood pressure, high cholesterol, abnormal electrocardiogram, chest pain, irregular heart rhythm, palpitations, heart murmur, heart attack, angina, phlebitis, peripheral vascular disease, or any other disease or disorder of the heart or blood vessels? Yes No
8. Hepatitis, ulcer, internal bleeding, colitis, acid reflux, GERD, or any other disease or disorder of the stomach, gall bladder, esophagus, liver, pancreas, spleen, intestines, colon, or rectum? Yes No
9. A disorder of your blood or immune system including anemia, blood clots, bleeding, immune deficiency, leukemia, or lymphoma (excluding HIV)? Yes No

PART 2 - Medical History (continued)

Name of Proposed Insured _____	Yes	No	Remarks - Explain All Yes Answers
10. Cancer, tumor, melanoma, or any other malignant disorder?.....	<input type="checkbox"/>	<input type="checkbox"/>	
11. Diabetes or high blood sugar or any other disease or disorder of the pituitary, thyroid, or endocrine glands?	<input type="checkbox"/>	<input type="checkbox"/>	
12. Albumin, protein, blood or sugar in the urine or any other disease or disorder of the kidney or bladder?	<input type="checkbox"/>	<input type="checkbox"/>	
13. Cyst, polyp, lump, or other growth, or any disease or disorder of the skin or lymph nodes?	<input type="checkbox"/>	<input type="checkbox"/>	
14. Any disease or disorder of the uterus, cervix, ovaries, or breasts?.....	<input type="checkbox"/>	<input type="checkbox"/>	
15. Any disease or disorder of the prostate or reproductive system?	<input type="checkbox"/>	<input type="checkbox"/>	
16. Any sexually transmitted disorders or diseases?.....	<input type="checkbox"/>	<input type="checkbox"/>	
17. Pregnancy, complications of pregnancy or infertility?	<input type="checkbox"/>	<input type="checkbox"/>	
If now pregnant, what is the expected date of delivery? _____			
18. Asthma, shortness of breath, chronic cough or hoarseness, bronchitis, emphysema, COPD (chronic obstructive pulmonary disease), sarcoidosis, pneumonia, TB (tuberculosis), sleep apnea, or any other disorder of the respiratory system?	<input type="checkbox"/>	<input type="checkbox"/>	
19. A disorder of the brain, spinal cord, or nervous system including chronic headaches, convulsions or loss of consciousness, seizures, tremors, paralysis, fainting, stroke, MS (multiple sclerosis), or TIA (transient ischemic attack)?.....	<input type="checkbox"/>	<input type="checkbox"/>	
20. Depression, anxiety, psychosis, suicidal thoughts or attempts of suicide, anorexia or bulimia, obsessive compulsive disorder, bipolar disorder, or other mental, nervous or emotional disorder?.....	<input type="checkbox"/>	<input type="checkbox"/>	
21. Arthritis or disorder of the bones, skin or muscles?.....	<input type="checkbox"/>	<input type="checkbox"/>	
22. Any disease or disorder of the eyes, ears, nose or throat?.....	<input type="checkbox"/>	<input type="checkbox"/>	
23. In the last 5 years , unless previously stated on this application, have you:			
a. Been treated by a member of the medical profession or at a medical facility?	<input type="checkbox"/>	<input type="checkbox"/>	
b. Had an electrocardiogram, x-ray, blood test, or other diagnostic test, excluding an HIV test?	<input type="checkbox"/>	<input type="checkbox"/>	
c. Had surgery or biopsy, or been an inpatient or outpatient in a hospital, clinic, or other medical or mental health facility?	<input type="checkbox"/>	<input type="checkbox"/>	
d. Been advised by a member of the medical profession to have surgery, medical treatment, biopsy, or diagnostic testing, excluding HIV testing, that has not yet been completed?.....	<input type="checkbox"/>	<input type="checkbox"/>	
e. Been referred to any other member of the medical profession or medical facility?	<input type="checkbox"/>	<input type="checkbox"/>	
f. Been unable to work, attend school or perform the normal activities of like age and gender, or been confined at home?	<input type="checkbox"/>	<input type="checkbox"/>	
24. a. Have you ever used amphetamines, barbiturates, cocaine, heroin, crack, marijuana, LSD, PCP, or other illegal, restricted or controlled substances, except as prescribed by a licensed physician?	<input type="checkbox"/>	<input type="checkbox"/>	
If Yes, please provide dates of use: From _____ To _____			
Name of drug used: _____			
Amount and frequency of use: _____			

PART 2 - Medical History (continued)

Name of Proposed Insured _____	Yes	No	Remarks - Explain All Yes Answers
24. b. Have you ever been addicted to prescription medication or been advised by a physician to discontinue using habit forming drugs?..... If Yes, provide dates of use, type and frequency.	<input type="checkbox"/>	<input type="checkbox"/>	
25. Have you ever: a. Consumed alcoholic beverages?..... If Yes, give type and number of drinks per day and/or per week. Date of last consumption: _____ b. Been advised by a physician or other licensed medical practitioner to limit or cease the use of alcoholic beverages? c. Been counseled, sought help or treatment, or been advised by a physician or other licensed medical practitioner to undergo counseling or treatment for alcohol problems?..... d. Attended or joined any organization due to alcohol or related problems?	<input type="checkbox"/>	<input type="checkbox"/>	
26. Are you currently: a. Taking or have you been advised to take any prescribed medication (other than contraceptives)?..... b. Taking any herbal or non-prescription medication at least weekly?..... If Yes, give details. _____	<input type="checkbox"/>	<input type="checkbox"/>	
27. Have you taken any other medications in the past 2 years ?..... If Yes, list in Remarks section at right.	<input type="checkbox"/>	<input type="checkbox"/>	
28. Have you tested positive for exposure to the HIV infection or been diagnosed as having ARC (AIDS-Related Complex) or AIDS (Auto Immune Deficiency Syndrome) caused by HIV infection or other sickness or condition derived from such infection?.....	<input type="checkbox"/>	<input type="checkbox"/>	
29. In the past 5 years, have you been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for any disease or disorder not previously stated on this application? If Yes, give details. _____	<input type="checkbox"/>	<input type="checkbox"/>	
30. Additional remarks (please indicate which question number remarks reference)			

I have read the answers as written before signing, the answers are true and complete to the best of my knowledge and belief, and there are no exceptions to any answers other than written on this document.

 Signature of Proposed Insured

Signed at _____ on ____/____/____
 City/State Date

Name of Proposed Insured _____ Date of Birth _____

Instructions to the Examiner -

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

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

Please mail blood and urine specimens promptly.

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

3. Blood Pressure (record 3 readings)

Systolic	_____	_____	_____
Diastolic	_____	_____	_____

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

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

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

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

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

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

Name of Proposed Insured _____

PART 3 - Medical Examiner's Report (continued)

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

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

Examined at _____,
Street address, City and State

this _____ day of _____, 20____ at _____ AM/PM.

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

Paramed Company _____ Telephone number _____

Address _____

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

Filing at a Glance

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

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

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

Implementation Date Requested: 01/01/2009

General Information

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

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

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

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

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

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

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

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

Company and Contact

Filing Contact Information

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

Filing Company Information

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

Filing Fees

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

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

ACCELERATED DEATH BENEFIT RIDER

This rider provides for an accelerated death benefit payment to the Owner of the policy during the lifetime of the Insured subject to eligibility requirements. An accelerated death benefit payment, hereafter referred to as an ADB, will reduce the policy's death benefit proceeds otherwise payable and limit the availability of any policy cash surrender value and/or any available loan value. This rider is not intended or designed to provide health, nursing home, or long-term care. There are no restrictions on the use of an ADB.

The policy owner should seek assistance from a tax advisor regarding the tax status of any ADB payment.

.....

In this Benefit Rider, Banner Life Insurance Company will be referred to as "we", "our" or "us" or "company". The "policy" is the policy to which this rider is attached. Coverage pursuant to this rider begins on the same date as the coverage for the policy. This rider is subject to all terms and conditions of the policy, except as provided in this rider. The rider is made part of the policy on the policy issue date. For purposes of this rider, the insured is as defined in the policy.

BENEFIT

We will make an accelerated death payment subject to the provisions of this rider. An ADB payment will require:

1. The Owner's written request, sent to our home office, for an ADB payment.
2. Proof that is acceptable to us that the Owner is eligible for receipt of an ADB payment.
3. A signed acknowledgement of concurrence for payment from all irrevocable beneficiaries and any assignee on the policy. If the company paying the ADB is itself the assignee under the policy, no signed acknowledgement is required.
4. A full release of any collateral assignment of the policy with the exception of collateral assignment to the company.
5. That, if the policy is a term insurance, it cannot have less than twelve months remaining until the maturity date on the date that payment is to be made.
6. That the policy has not been voided and is not being contested.

The ADB will be paid to the Owner or Owner's estate while the insured is living, unless the benefit has been otherwise assigned or designated by the Owner. The payment of the accelerated death benefit is due immediately upon receipt of the due written proof sufficient by the company to confirm eligibility for the ADB.

We will not make an ADB if the policy is being continued as extended term insurance or reduced paid-up insurance on the date payment is to be made.

BENEFIT LIMITS

The maximum accelerated death benefit is the lesser of:

1. 75% of the policy's primary death benefit as determined on the date that the company approves payment of the ADB; and
2. \$500,000.

This amount is further reduced by any outstanding policy loan, with accrued interest, on the date of payment of the ADB.

ADB ELIGIBILITY REQUIREMENTS

To be eligible for an ADB payment the Owner must provide to us:

1. evidence acceptable to us that the Insured is living and has a medical condition that is reasonably expected to result in a life expectancy of twelve months or less; this evidence must include, but is not limited to, certification by a physician that we approve who is licensed to practice medicine in the United States or Canada and is acting within the scope of that license.

2. evidence that election of this benefit is voluntary and without coercion on the part of any third party, including any creditor or government agency.
3. evidence that only one of the Insureds is living, if the policy is a last survivor policy.

Additionally, the company has the right to require a second or third medical opinion to confirm benefit eligibility. Such second and third opinions are at the company's expense. The second medical opinion may include a physical examination by a physician designated by the company. In the case of conflicting opinions, eligibility for benefits shall be determined by a third medical opinion that is provided by a physician that is mutually acceptable to the Owner and the Company.

EFFECT OF THE ACCELERATED DEATH BENEFIT

The ADB will be treated as a lien against the policy's death benefit. Such lien will limit the availability of any surrender benefit and any future policy loans, policy withdrawals or policy surrenders.

Prior to, and concurrent with, the election to receive an ADB, the owner and irrevocable beneficiary will be given a statement demonstrating the effect of an ADB on the policy's cash surrender values, death benefit, and policy loans.

The lien amount will at any time equal:

1. the amount of the ADB payment to the owner; plus
2. the administrative fee; plus
3. the amount of any premium required to remove the policy from the grace period; plus
4. any unpaid required premiums added to the lien as described below; plus
5. accrued lien interest charges as described below.

For the amount of the lien equal to the policy's cash surrender value at the time the lien is in effect, interest will be charged at the policy loan interest rate stated in the policy. For the amount of the lien in excess of such cash surrender value, interest will be charged at a rate that is no greater than the greater of:

1. the current yield on a 90-day treasury bill on the date of the ADB payment; and
2. the current maximum adjustable policy loan interest rate allowed by law on the date of payment in the state in which the policy was delivered.

After the company makes an ADB payment, the Owner will be liable for premium payments required to keep the policy, and applicable riders, in force through the date of death of the Insured. Any such premium payments, if not paid to the company, will be added to the lien. Cost of insurance charges, if applicable, will continue to be charged against the policy (unless being waived because of a waiver of monthly deduction benefit that is in effect). Waiver of premium benefits, if in effect following payment of an ADB, will continue to apply.

Subsequent to payment of an ADB, upon the death of the insured the proceeds payable will equal the death benefit proceeds, as defined in the policy, less the total lien in effect at the date death.

If the policy has an accidental death benefit provision, that provision shall not be affected by the payment of the accelerated death benefit.

ADDITIONAL PROVISIONS

There is no premium or cost of insurance charge for this rider. However, an administrative fee that will not exceed \$250 will apply at the time the ADB is paid and it will be added to the lien.

The policy's primary death benefit is the death benefit provided by the policy. It does not include any accidental death benefits, the death benefit provided by any riders, or death benefits payable due to the death of anyone other than the Insured. If the policy does not provide for policy loans, the loan value is defined as zero. If the policy does not provide cash surrender values, the cash surrender value is defined as zero.

INCONTESTABILITY

The policy's incontestability provision will apply to this rider.

PAYMENT OPTIONS

The ADB will be payable to the Owner as a lump sum payment.

If the policy has a cash surrender value, the available ADB will be at least 75% of any such cash surrender value, where such cash surrender value reflects the deduction of any outstanding policy indebtedness.

If the insured dies after the owner elects to receive an ADB, but before the Owner receives such benefits, the election is cancelled and the death benefit is paid pursuant to the policy.

REINSTATEMENT

The policy's reinstatement provision will apply to this rider.

TERMINATION

This rider will terminate on the earliest of:

1. the date of maturity or termination of the policy;
2. when a nonforfeiture option has become effective under the policy; or
3. at the date the Owner's written request for termination is signed; this request must be received in our home office.

If at any time the total lien amount equals or exceeds the policy's death benefit proceeds as defined in the policy, the policy will terminate. Termination will occur 31 days after the company has mailed a notice of termination to the last known address of the Owner, unless all or part of the lien amount is repaid with 31 days after the noticed is mailed. We will accept a partial repayment only if the death benefit proceeds of the policy would exceed the lien amount after the partial repayment is applied.

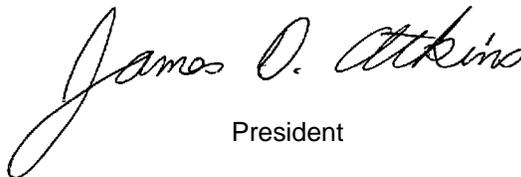
Termination shall not prejudice the payment of benefits if the insured became eligible for an ADB while the policy was in force.

This rider is subject to the conditions of this policy. Where a conflict between the rider and the policy exists, the conditions of the rider will control.

The issue date of this benefit is the policy date, or a later date if shown here.

Signed for us at our home office in Rockville, Maryland.


Secretary


President

SERFF Tracking Number: BANN-126745774 State: Arkansas
Filing Company: Banner Life Insurance Company State Tracking Number: 46547
Company Tracking Number:
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: Accelerated Death Benefit Rider
Project Name/Number: Accelerated Death Benefit Rider/ADB (06-10)

Filing at a Glance

Company: Banner Life Insurance Company

Product Name: Accelerated Death Benefit Rider SERFF Tr Num: BANN-126745774 State: Arkansas

TOI: L08 Life - Other

SERFF Status: Closed-Approved- State Tr Num: 46547

Closed

Sub-TOI: L08.000 Life - Other

Co Tr Num:

State Status: Approved-Closed

Filing Type: Form

Co Status:

Reviewer(s): Linda Bird

Author: Ada Miller

Disposition Date: 08/24/2010

Date Submitted: 08/19/2010

Disposition Status: Approved-

Closed

Implementation Date Requested: On Approval

Implementation Date:

General Information

Project Name: Accelerated Death Benefit Rider

Project Number: ADB (06-10)

Requested Filing Mode: Review & Approval

Status of Filing in Domicile: Authorized

Date Approved in Domicile: 08/11/2010

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

Market Type: Individual

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 08/24/2010

Created By: Ada Miller

Corresponding Filing Tracking Number:

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 08/24/2010

Company Status Changed:

Deemer Date:

Submitted By: Ada Miller

Filing Description:

The above-referenced form is being submitted for your review and approval. Upon approval, ADB (06-10), if elected, will be attached to our term and universal life products. The term product, RT-97, was approved by your department on 10/22/97 for the 10, 15, & 20 year term; and 11/20/97 for the 30 year term. Our universal products were approved as follows: UL-09 AR approved on 1/21/10, and U2010 AR approved on 7/16/10.

Implementation date for this rider is August 31, 2010.

The Accelerated Death Benefit Rider provides for the advance payment of some or all of the death proceeds payable under a life insurance policy upon the occurrence of a qualifying event. An Actuarial Memorandum and Certification are

SERFF Tracking Number: BANN-126745774 State: Arkansas
 Filing Company: Banner Life Insurance Company State Tracking Number: 46547
 Company Tracking Number:
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
 Product Name: Accelerated Death Benefit Rider
 Project Name/Number: Accelerated Death Benefit Rider/ADB (06-10)

included. A sample of policy schedule page 3 is also attached and will be used if this rider is elected.

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

Company and Contact

Filing Contact Information

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

Filing Company Information

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

Filing Fees

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Banner Life Insurance Company	\$125.00	08/19/2010	38881180

SERFF Tracking Number: BANN-126745774 State: Arkansas
 Filing Company: Banner Life Insurance Company State Tracking Number: 46547
 Company Tracking Number:
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
 Product Name: Accelerated Death Benefit Rider
 Project Name/Number: Accelerated Death Benefit Rider/ADB (06-10)

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	08/24/2010	08/24/2010

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Linda Bird	08/23/2010	08/23/2010	Ada Miller	08/24/2010	08/24/2010

SERFF Tracking Number: BANN-126745774 State: Arkansas
Filing Company: Banner Life Insurance Company State Tracking Number: 46547
Company Tracking Number:
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: Accelerated Death Benefit Rider
Project Name/Number: Accelerated Death Benefit Rider/ADB (06-10)

Disposition

Disposition Date: 08/24/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: BANN-126745774 State: Arkansas
 Filing Company: Banner Life Insurance Company State Tracking Number: 46547
 Company Tracking Number:
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
 Product Name: Accelerated Death Benefit Rider
 Project Name/Number: Accelerated Death Benefit Rider/ADB (06-10)

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Actuarial Memorandum		No
Supporting Document	Sample Policy Schedule Pages		Yes
Supporting Document	Disclosure Statement		Yes
Form	Accelerated Death Benefit Rider		Yes

SERFF Tracking Number: BANN-126745774 State: Arkansas
Filing Company: Banner Life Insurance Company State Tracking Number: 46547
Company Tracking Number:
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: Accelerated Death Benefit Rider
Project Name/Number: Accelerated Death Benefit Rider/ADB (06-10)

Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 08/23/2010
Submitted Date 08/23/2010
Respond By Date 09/23/2010

Dear Nancy January,

This will acknowledge receipt of the captioned filing.

Objection 1

No Objections

Comment: The Accelerated Benefit Rider issued with life insurance policies require a disclosure statement as outlined in Rule and Regulation 60s8.

Please feel free to contact me if you have questions.

Sincerely,

Linda Bird

SERFF Tracking Number: BANN-126745774 State: Arkansas
Filing Company: Banner Life Insurance Company State Tracking Number: 46547
Company Tracking Number:
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: Accelerated Death Benefit Rider
Project Name/Number: Accelerated Death Benefit Rider/ADB (06-10)

Response Letter

Response Letter Status Submitted to State
Response Letter Date 08/24/2010
Submitted Date 08/24/2010

Dear Linda Bird,

Comments:

Thank you for your response.

Response 1

Comments: We have attached a disclosure statement under the Supporting Documentation.

Related Objection 1

Comment:

The Accelerated Benefit Rider issued with life insurance policies require a disclosure statement as outlined in Rule and Regulation 60s8.

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: Disclosure Statement

Comment: Sample disclosure statement is attached.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

thank you for your further review.

Sincerely,
Ada Miller

SERFF Tracking Number: BANN-126745774 State: Arkansas
 Filing Company: Banner Life Insurance Company State Tracking Number: 46547
 Company Tracking Number:
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
 Product Name: Accelerated Death Benefit Rider
 Project Name/Number: Accelerated Death Benefit Rider/ADB (06-10)

Form Schedule

Lead Form Number: ADB (06-10)

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	ADB (06-10)	Policy/Cont ract/Fratern al Benefit Rider Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		66.200	ADB (06-10).pdf

ACCELERATED DEATH BENEFIT RIDER

This rider provides for an accelerated death benefit payment to the Owner of the policy during the lifetime of the Insured subject to eligibility requirements. An accelerated death benefit payment, hereafter referred to as an ADB, will reduce the policy's death benefit proceeds otherwise payable and limit the availability of any policy cash surrender value and/or any available loan value. This rider is not intended or designed to provide health, nursing home, or long-term care. There are no restrictions on the use of an ADB.

The policy owner should seek assistance from a tax advisor regarding the tax status of any ADB payment.

.....

In this Benefit Rider, Banner Life Insurance Company will be referred to as "we", "our" or "us" or "company". The "policy" is the policy to which this rider is attached. Coverage pursuant to this rider begins on the same date as the coverage for the policy. This rider is subject to all terms and conditions of the policy, except as provided in this rider. The rider is made part of the policy on the policy issue date. For purposes of this rider, the insured is as defined in the policy.

BENEFIT

We will make an accelerated death payment subject to the provisions of this rider. An ADB payment will require:

1. The Owner's written request, sent to our home office, for an ADB payment.
2. Proof that is acceptable to us that the Owner is eligible for receipt of an ADB payment.
3. A signed acknowledgement of concurrence for payment from all irrevocable beneficiaries and any assignee on the policy. If the company paying the ADB is itself the assignee under the policy, no signed acknowledgement is required.
4. A full release of any collateral assignment of the policy with the exception of collateral assignment to the company.
5. That, if the policy is a term insurance, it cannot have less than twelve months remaining until the maturity date on the date that payment is to be made.
6. That the policy has not been voided and is not being contested.

The ADB will be paid to the Owner or Owner's estate while the insured is living, unless the benefit has been otherwise assigned or designated by the Owner. The payment of the accelerated death benefit is due immediately upon receipt of the due written proof sufficient by the company to confirm eligibility for the ADB.

We will not make an ADB if the policy is being continued as extended term insurance or reduced paid-up insurance on the date payment is to be made.

BENEFIT LIMITS

The maximum accelerated death benefit is the lesser of:

1. 75% of the policy's primary death benefit as determined on the date that the company approves payment of the ADB; and
2. \$500,000.

This amount is further reduced by any outstanding policy loan, with accrued interest, on the date of payment of the ADB.

ADB ELIGIBILITY REQUIREMENTS

To be eligible for an ADB payment the Owner must provide to us:

1. evidence acceptable to us that the Insured is living and has a medical condition that is reasonably expected to result in a life expectancy of twelve months or less; this evidence must include, but is not limited to, certification by a physician that we approve who is licensed to practice medicine in the United States or Canada and is acting within the scope of that license.

2. evidence that election of this benefit is voluntary and without coercion on the part of any third party, including any creditor or government agency.
3. evidence that only one of the Insureds is living, if the policy is a last survivor policy.

Additionally, the company has the right to require a second or third medical opinion to confirm benefit eligibility. Such second and third opinions are at the company's expense. The second medical opinion may include a physical examination by a physician designated by the company. In the case of conflicting opinions, eligibility for benefits shall be determined by a third medical opinion that is provided by a physician that is mutually acceptable to the Owner and the Company.

EFFECT OF THE ACCELERATED DEATH BENEFIT

The ADB will be treated as a lien against the policy's death benefit. Such lien will limit the availability of any surrender benefit and any future policy loans, policy withdrawals or policy surrenders.

Prior to, and concurrent with, the election to receive an ADB, the owner and irrevocable beneficiary will be given a statement demonstrating the effect of an ADB on the policy's cash surrender values, death benefit, and policy loans.

The lien amount will at any time equal:

1. the amount of the ADB payment to the owner; plus
2. the administrative fee; plus
3. the amount of any premium required to remove the policy from the grace period; plus
4. any unpaid required premiums added to the lien as described below; plus
5. accrued lien interest charges as described below.

For the amount of the lien equal to the policy's cash surrender value at the time the lien is in effect, interest will be charged at the policy loan interest rate stated in the policy. For the amount of the lien in excess of such cash surrender value, interest will be charged at a rate that is no greater than the greater of:

1. the current yield on a 90-day treasury bill on the date of the ADB payment; and
2. the current maximum adjustable policy loan interest rate allowed by law on the date of payment in the state in which the policy was delivered.

After the company makes an ADB payment, the Owner will be liable for premium payments required to keep the policy, and applicable riders, in force through the date of death of the Insured. Any such premium payments, if not paid to the company, will be added to the lien. Cost of insurance charges, if applicable, will continue to be charged against the policy (unless being waived because of a waiver of monthly deduction benefit that is in effect). Waiver of premium benefits, if in effect following payment of an ADB, will continue to apply.

Subsequent to payment of an ADB, upon the death of the insured the proceeds payable will equal the death benefit proceeds, as defined in the policy, less the total lien in effect at the date death.

If the policy has an accidental death benefit provision, that provision shall not be affected by the payment of the accelerated death benefit.

ADDITIONAL PROVISIONS

There is no premium or cost of insurance charge for this rider. However, an administrative fee that will not exceed \$250 will apply at the time the ADB is paid and it will be added to the lien.

The policy's primary death benefit is the death benefit provided by the policy. It does not include any accidental death benefits, the death benefit provided by any riders, or death benefits payable due to the death of anyone other than the Insured. If the policy does not provide for policy loans, the loan value is defined as zero. If the policy does not provide cash surrender values, the cash surrender value is defined as zero.

INCONTESTABILITY

The policy's incontestability provision will apply to this rider.

PAYMENT OPTIONS

The ADB will be payable to the Owner as a lump sum payment.

If the policy has a cash surrender value, the available ADB will be at least 75% of any such cash surrender value, where such cash surrender value reflects the deduction of any outstanding policy indebtedness.

If the insured dies after the owner elects to receive an ADB, but before the Owner receives such benefits, the election is cancelled and the death benefit is paid pursuant to the policy.

REINSTATEMENT

The policy's reinstatement provision will apply to this rider.

TERMINATION

This rider will terminate on the earliest of:

1. the date of maturity or termination of the policy;
2. when a nonforfeiture option has become effective under the policy; or
3. at the date the Owner's written request for termination is signed; this request must be received in our home office.

If at any time the total lien amount equals or exceeds the policy's death benefit proceeds as defined in the policy, the policy will terminate. Termination will occur 31 days after the company has mailed a notice of termination to the last known address of the Owner, unless all or part of the lien amount is repaid with 31 days after the noticed is mailed. We will accept a partial repayment only if the death benefit proceeds of the policy would exceed the lien amount after the partial repayment is applied.

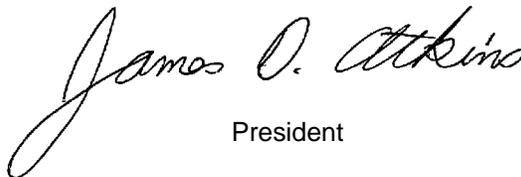
Termination shall not prejudice the payment of benefits if the insured became eligible for an ADB while the policy was in force.

This rider is subject to the conditions of this policy. Where a conflict between the rider and the policy exists, the conditions of the rider will control.

The issue date of this benefit is the policy date, or a later date if shown here.

Signed for us at our home office in Rockville, Maryland.


Secretary


President

SERFF Tracking Number: BANN-126745774 State: Arkansas
Filing Company: Banner Life Insurance Company State Tracking Number: 46547
Company Tracking Number:
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: Accelerated Death Benefit Rider
Project Name/Number: Accelerated Death Benefit Rider/ADB (06-10)

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: Flesch certification attached. Attachment: ADB Readability Certification.pdf		
Satisfied - Item: Actuarial Memorandum Comments: Actuarial memorandum and certification attached. Attachments: Actuarial Memorandum - Accelerated Death Benefit.pdf Actuarial Certification.pdf		
Satisfied - Item: Sample Policy Schedule Pages Comments: Sample policy schedule pages if rider is elected. Attachment: UL09 ADB PSP.pdf		
Satisfied - Item: Disclosure Statement Comments: Sample disclosure statement is attached. Attachment: ADB DISC.pdf		

Readability Certification
ICC10 ADB Accelerated Death Benefit

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

Accelerated Death Benefit Rider, Form ICC10 ADB, yielded a score of 66.2.

It is not in less than 10-point type, one-point leaded.

The style, arrangement, and overall appearance of the policy gives no undue prominence to any portion of the text of the policy or to any endorsements or riders



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

June 2, 2010
Date

**ACCELERATED DEATH BENEFIT RIDER
POLICY FORM: ADB**

ACTUARIAL MEMORANDUM

- a) This rider provides for an accelerated death benefit [ADB] payment to the policy owner of the policy during the lifetime of the Insured, subject to eligibility requirements. To be eligible for an ADB payment the Owner must provide to the company:
- 1) evidence acceptable that the Insured is living and, has a medical condition that reasonably results in a life expectancy of twelve months or less .
 - 2) evidence that election of this benefit is voluntary and without coercion on the part of any third party, including any creditor or government agency.

Receipt of an accelerated death benefit will: 1) reduce the policy's death benefit, 2) not affect the accumulation values, 3) limit future partial and cash surrender values, 4) not affect future required premium payments, 5) not affect future cost of insurance rates and values, and 6) not affect future loan interest charges.

- b) There is a maximum \$250 administrative fee which is applied when an accelerated death benefit payment is made. This fee is used to cover the costs of issuing and processing of ADB benefit.
- c) The portion of the lien amount which is less than or equal to the cash surrender value at the time of the ADB payment will be charged interest at the policy loan interest rate.

The portion of the lien amount which is in excess to the cash surrender value at the time of the ADB payment will be charged the greater of:

- i) the current yield on a 90-day treasury bill on the date of the ADB payment; and
- ii) the current maximum adjustable policy loan interest rate allowed by law in the state in which the policy was delivered.

- d) There is not a present value calculation involved in the calculation of the ADB.
- e) There are no separate premium or costs of insurance (COI) for the ADB.
- f) The maximum accelerated death benefit is the lesser of:
- i) \$500,000.00 and
 - ii) 75% of the death benefit, less any outstanding loan balance.
- Premium requirements are unaffected by the presence of an ADB.

- g) Sample calculation:

1) ASSUMPTIONS

Assume issued with a universal life insurance product UL09 issued 1/1/2010.

Policy has \$1,000,000.00 death benefit.

Insured is male with issue age 35.

Assume policy requires a premium payment of \$1,000 each month.

Assume policy loan interest is 5%

7/1/2040 Values:

Account Value	\$250,000.00
Surrender Charges	\$ 0.00
Loan Balance	\$100,000.00
Cash Surrender Value	\$150,000.00

Policyholder requests a maximum ADB on 7/1/2040; insured dies on 12/1/2040.

2) CALCULATIONS

Lien interest:

1) The portion of the lien amount which is less than or equal to the cash surrender value at the time of the ADB is charged a maximum 5% lien rate (=policy loan interest rate).

2) Assume maximum adjustable loan interest allowed by law on date of ADB is 4%; assume 90-day treasury bill rate on date of ADB is 3.25%.

The portion of the lien amount, which is the excess of ADB over cash surrender value at time ADB is taken, is charged a maximum 4% lien rate (equals greater of 4% and 3.25%).

On 7/1/2040, policy owner takes out an ADB. (account value at the time is \$250,000.00 and he has a loan balance of 100,000.00)

Maximum available ADB equals lesser of: i) 75% of \$1,000,000.00 or ii) \$500,000.00), less the outstanding loan = 500,000.00 - 100,000.00 = 400,000.00.

Policy owner requested maximum ADB for which he is eligible. Thus, policy owner is sent an ADB payment of \$400,000.00.

Initial lien:

ADB \$250 Admin fee is added to the \$ 400,000.00. 7/1/2040 lien= \$400,250.00.

Policy owner needs to continue to make additional premium payments of 1,000.00 each month to keep the policy in force. If not paid, these premium payments are added to the lien.

Death claim processing:

Assume insured deceased on 12/1/2040.

Number of days from ADB to date of death = 153 days [7/1/2010 to 12/1/2101]

Outstanding policy loan on 12/1/2040= $100,000 * ((1.05)^{(153/365)}) = \$102,066.23$

1) ADB lien on 12/1/2040

a) Lien on amount up to cash surrender value (min [\$400,250.00, \$150,000.00] = \$150,000.00) uses 5%:
 $150,000.00 * (1.05)^{(153/365)} = \$153,099.35$

b) Lien on amount of ADB over cash surrender value (= \$400,250.00 - \$150,000.00 = \$250,250.00) uses 4%:

$$250,250.00 * (1.04)^{(153/365)} = \$254,398.23$$

c) Total ADB lien 12/1/40 = $153,099.35 + 254,398.23 = \$407,497.58$

2) Death Benefit proceeds on 12/1/2040 = Death Benefit of \$1,000,000 less outstanding loan and less outstanding ADB lien.

$$= \$1,000,000.00 - \$102,066.23 - \$407,497.58 = \underline{\$490,436.19}$$

Note regarding loan and coi [cost of insurance charges].

1) The loan value is unaffected by the ADB; and

2) The cost of insurance rates is equal to the COI rates times the net amount of risk. The net amount of risk is unaffected by the ADB; thus coi charges continue unaffected by the presence of the ADB.

h) not applicable

i) not applicable



Nancy C. January, F.S.A., M.A.A.A.

Vice President and Actuary

Date June 10, 2010

Actuarial Certification
Accelerated Death Benefit Rider
Policy Form: ADB (06-10)

This is to certify that the value and premium of the Accelerated Death Benefit is incidental to the life coverage.

A handwritten signature in black ink that reads "Nancy C. January". The signature is written in a cursive style with a large, looping final flourish.

Nancy C. January, F.S.A., M.A.A.A.
Vice President and Actuary

June 4, 2010
Date

POLICY SCHEDULE

Policy Number: 010000000

Insured:	JOHN DOE	Planned Annual Premium:	\$1,000.00
Issue Age/Sex	35 Male	Issue Date:	MAR 1, 2008
Owner:	JOHN DOE	Policy Date:	MAR 1, 2008
Premiums Payable	TO AGE 121	Maturity Date:	MAR 1, 2094

SCHEDULE OF BENEFITS

<u>FORM NUMBER</u>	<u>TYPE OF COVERAGE</u>	<u>AMOUNT</u>	<u>ANNUAL PREMIUM</u>	<u>RATING CLASSIFICATION</u>
UL09	FLEXIBLE PREMIUM ADJUSTABLE LIFE	\$100,000.00	\$1,000.00	STANDARD NON-TOBACCO
ADB (06-10)	ACCELERATED DEATH BENEFIT			

Note:
Due to the flexible nature of this Flexible Premium Adjustable Life policy, it is possible that coverage will terminate before the maturity date. This can occur if no premiums are paid after payment of the initial premium or if subsequent premiums are too infrequent or insufficient to provide continued coverage to the maturity date.

POLICY SCHEDULE

Policy Number: 010000000

Insured:	JOHN DOE	Planned Annual Premium:	\$1,000.00
Issue Age/Sex	35 Male	Issue Date:	MAR 1, 2008
Owner:	JOHN DOE	Policy Date:	MAR 1, 2008
Premiums Payable	TO AGE 121	Maturity Date:	MAR 1, 2094

SCHEDULE OF BENEFITS

<u>FORM NUMBER</u>	<u>TYPE OF COVERAGE</u>	<u>AMOUNT</u>	<u>ANNUAL PREMIUM</u>	<u>RATING CLASSIFICATION</u>
UL09	FLEXIBLE PREMIUM ADJUSTABLE LIFE	\$100,000.00	\$1,000.00	STANDARD NON-TOBACCO RATED TABLE 4 200%
ADB (06-10)	ACCELERATED DEATH BENEFIT			

Note:
Due to the flexible nature of this Flexible Premium Adjustable Life policy, it is possible that coverage will terminate before the maturity date. This can occur if no premiums are paid after payment of the initial premium or if subsequent premiums are too infrequent or insufficient to provide continued coverage to the maturity date.

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Premiums Payable	TO AGE 121	Maturity Date:	MAR 1, 2094

SCHEDULE OF BENEFITS

<u>FORM NUMBER</u>	<u>TYPE OF COVERAGE</u>	<u>AMOUNT</u>	<u>ANNUAL PREMIUM</u>	<u>RATING CLASSIFICATION</u>
UL09	FLEXIBLE PREMIUM ADJUSTABLE LIFE TEMPORARY FLAT EXTRA \$5.00 PER 1000 FOR 2 YEARS	\$100,000.00	\$1,000.00	STANDARD NON-TOBACCO RATED
ADB (06-10)	ACCELERATED DEATH BENEFIT			

Note:
Due to the flexible nature of this Flexible Premium Adjustable Life policy, it is possible that coverage will terminate before the maturity date. This can occur if no premiums are paid after payment of the initial premium or if subsequent premiums are too infrequent or insufficient to provide continued coverage to the maturity date.

DISCLOSURE REGARDING ACCELERATED DEATH BENEFIT RIDER

- a) This rider provides for an accelerated death benefit [ADB] payment to the policy owner of the policy during the lifetime of the Insured, subject to eligibility requirements. To be eligible for an ADB payment, the Owner must provide to the company:
 - 1) evidence acceptable that the Insured is living and, has a medical condition that reasonably results in a life expectancy of twelve months or less, and
 - 2) evidence that election of this benefit is voluntary and without coercion on the part of any third party, including any creditor or government agency.

Receipt of an accelerated death benefit will:

- 1) reduce the policy's death benefit,
 - 2) not affect the accumulation values,
 - 3) limit future partial and cash surrender values,
 - 4) not affect future required premium payments,
 - 5) not affect future cost of insurance rates and values, and
 - 6) not affect future loan interest charges.
- b) There is a maximum \$250 administrative fee which is applied when an accelerated death benefit payment is made. This fee is used to cover the costs of issuing and processing of ADB benefit.
 - c) The portion of the lien amount which is less than or equal to the cash surrender value at the time of the ADB payment will be charged interest at the policy loan interest rate.

The portion of the lien amount which is in excess to the cash surrender value at the time of the ADB payment will be charged the greater of:

- i) the current yield on a 90-day treasury bill on the date of the ADB payment; and
 - ii) the current maximum adjustable policy loan interest rate allowed by law in the state in which the policy was delivered on the date of the ADB payment.
- d) The maximum accelerated death benefit is the lesser of:
 - i) \$500,000.00 and
 - ii) 75% of the death benefit,less any outstanding loan balance.

Premium requirements are unaffected by the presence of an ADB.

Upon the death of the insured, the death benefits payable are reduced by the total accelerated death benefit lien.

The accelerated death benefit feature is subject to state variations; it may not be available in all states. Review your policy and the Accelerated Death Benefit Rider for complete limitations, terms, and conditions.

Receipt of accelerated death benefits may be taxable. Consult your tax advisor regarding possible tax consequences of an accelerated death benefit.

Owner Signature

Date

Agent Signature

Date