

SERFF Tracking Number: BANN-128542621 State: Arkansas  
Filing Company: Banner Life Insurance Company State Tracking Number:  
Company Tracking Number:  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: Notice & Consent Form for AIDS Testing  
Project Name/Number: HIV Consent Form/LN-18-ARK (5-12)

## Filing at a Glance

Company: Banner Life Insurance Company

Product Name: Notice & Consent Form for AIDS Testing SERFF Tr Num: BANN-128542621 State: Arkansas

TOI: L08 Life - Other

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

Sub-TOI: L08.000 Life - Other

Co Tr Num: State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Linda Bird

Author: Ada Miller

Disposition Date: 07/09/2012

Date Submitted: 07/05/2012

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: HIV Consent Form

Status of Filing in Domicile: Authorized

Project Number: LN-18-ARK (5-12)

Date Approved in Domicile: 02/17/2012

Requested Filing Mode: Informational

Domicile Status Comments: similar form filed and approved

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Individual Market Type:

Overall Rate Impact:

Filing Status Changed: 07/09/2012

Deemer Date:

State Status Changed: 07/09/2012

Submitted By: Ada Miller

Created By: Ada Miller

Filing Description:

Corresponding Filing Tracking Number:

We are submitting Notice and Consent for AIDS Virus (HIV) Testing, form number LN-18-ARK (5-12), as an informational filing for your review. This form will accompany our Life Insurance Application form, LIA (10/08) & LU-1267 (10/08), previously approved on 10/17/08.

There have been no text changes to the form. We have refreshed the form cosmetically with our logo re-branding and added a revision date into the form number.

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

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department. If you should have any questions or require additional information, please feel free to contact me at amiller@lgamerica.

State Narrative:

## Company and Contact

### Filing Contact Information

Ada Miller, Compliance Technician amiller@lgamerica.com  
 1701 Research Boulevard 301-279-4809 [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: \$125.00  
 Retaliatory? Yes  
 Fee Explanation: 1 form x \$125  
 Per Company: No

| COMPANY                       | AMOUNT   | DATE PROCESSED | TRANSACTION # |
|-------------------------------|----------|----------------|---------------|
| Banner Life Insurance Company | \$125.00 | 07/05/2012     | 60670454      |

SERFF Tracking Number: BANN-128542621 State: Arkansas  
Filing Company: Banner Life Insurance Company State Tracking Number:  
Company Tracking Number:  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: Notice & Consent Form for AIDS Testing  
Project Name/Number: HIV Consent Form/LN-18-ARK (5-12)

## Correspondence Summary

### Dispositions

| Status          | Created By | Created On | Date Submitted |
|-----------------|------------|------------|----------------|
| Approved-Closed | Linda Bird | 07/09/2012 | 07/09/2012     |

SERFF Tracking Number: BANN-128542621 State: Arkansas  
Filing Company: Banner Life Insurance Company State Tracking Number:  
Company Tracking Number:  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: Notice & Consent Form for AIDS Testing  
Project Name/Number: HIV Consent Form/LN-18-ARK (5-12)

## Disposition

Disposition Date: 07/09/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: BANN-128542621 State: Arkansas  
 Filing Company: Banner Life Insurance Company State Tracking Number:  
 Company Tracking Number:  
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
 Product Name: Notice & Consent Form for AIDS Testing  
 Project Name/Number: HIV Consent Form/LN-18-ARK (5-12)

| Schedule            | Schedule Item  | Schedule Item Status | Public Access |
|---------------------|--|----------------------|---------------|
| Supporting Document | Flesch Certification                                 |                      | Yes           |
| Supporting Document | Application  |                      | Yes           |
| Form                | Notice and Consent Form For AIDS Virus (HIV) Testing |                      | Yes           |

SERFF Tracking Number: BANN-128542621 State: Arkansas  
 Filing Company: Banner Life Insurance Company State Tracking Number:  
 Company Tracking Number:  
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
 Product Name: Notice & Consent Form for AIDS Testing  
 Project Name/Number: HIV Consent Form/LN-18-ARK (5-12)

## Form Schedule

### Lead Form Number: LN-18-ARK (5-12)

| Schedule Item Status | Form Number      | Form Type                   | Form Name  | Action  | Action Specific Data | Readability | Attachment           |
|----------------------|------------------|-----------------------------|--|---------|----------------------|-------------|----------------------|
|                      | LN-18-ARK (5-12) | Application/Enrollment Form | Notice and Consent Form For AIDS Virus (HIV) Testing | Initial |                      | 54.300      | LN-18-ARK (5-12).pdf |



Banner Life Insurance Company  
3275 Bennett Creek Avenue  
Frederick, Maryland 21704  
(800) 638-8428

## NOTICE AND CONSENT FORM FOR AIDS VIRUS (HIV) TESTING

To evaluate your eligibility for insurance or insurance benefits, it is requested that you consent to be tested for the AIDS virus (HIV). By signing and dating this form, you agree that this test may be performed and that underwriting decisions will be based on the test results.

### Disclosure of Test Results:

All test results will be treated confidentially. The results of the test will be reported to the insurer identified on this form. Results of the tests will not otherwise be disclosed except as allowed by law or as stated below.

### Meaning of Test Results:

While positive HIV antibody test results do not mean that you have AIDS, they do mean that you may be at increased risk of developing AIDS or AIDS-related conditions. The test is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus.

Positive HIV antibody test results could adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

### Release of Results:

The results of this test may be released to the following:

- (1) the proposed insured;
- (2) the person legally authorized to consent to the test;
- (3) a licensed physician, medical practitioner, or other person designated by the proposed insured;
- (4) an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover results of tests for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular proposed insured;
- (5) a reinsurer, if the reinsurer is involved in the underwriting process, under procedures that are designed to assure confidentiality;
- (6) persons who have the responsibility to make underwriting decisions on behalf of the insurer; or
- (7) insurer's legal counsel who needs such information to effectively represent the insurer in regard to matters concerning the proposed insured.

The insurer may contact you for the name of a physician or other health care provider to whom you may authorize disclosure and with whom you may want to discuss the results.

### Consent:

I have read and I understand this Notice and Consent Form. I voluntarily consent to testing and disclosure as described above. I understand that I have the right to request and receive a copy of this form. A photocopy of this form will be as valid as the original.

\_\_\_\_\_  
Signature of Proposed Insured or Parent/Guardian

\_\_\_\_\_  
Date

SERFF Tracking Number: BANN-128542621 State: Arkansas  
Filing Company: Banner Life Insurance Company State Tracking Number:  
Company Tracking Number:  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: Notice & Consent Form for AIDS Testing  
Project Name/Number: HIV Consent Form/LN-18-ARK (5-12)

## Supporting Document Schedules

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

**Satisfied - Item:** Flesch Certification

**Comments:**

Readability Certification attached

**Attachment:**

Readability Certification.pdf

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

**Satisfied - Item:** Application

**Comments:**

Previously approved application attached

Form # LIA (10-08) & LU-1267 (10-08) approved 10/17/08, SERFF tracking number BANN-125826810

**Attachment:**

AR LIA (10-08) & LU-1267 (10-08) Life Insurance Appl.pdf

Readability Certification  
LN-18-ARK (5-12)

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

Notice and Consent Form for AIDS Virus (HIV) Testing, LN-18-ARK (5-12), yields a score of 54.3.

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

*Nancy W. Winings*

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Nancy W. Winings, FSA, MAAA  
Vice President & Actuary  
Banner Life Insurance Company

July 5, 2012  
Date

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)

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

## Filing at a Glance

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:

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:

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

### Filing Description:

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      |

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)

## Correspondence Summary

### Dispositions

| Status   | Created By | Created On | Date Submitted |
|----------|------------|------------|----------------|
| Approved | Linda Bird | 10/17/2008 | 10/17/2008     |

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 (S/08) & LU-1267 (S/08)

## Disposition

Disposition Date: 10/17/2008

Implementation Date: -

Status: Approved

Comment:

Rate data does NOT apply to filing.

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)*

| <b>Item Type</b>           | <b>Item Name</b>           | <b>Item Status</b> | <b>Public Access</b> |
|----------------------------|----------------------------|--------------------|----------------------|
| <b>Supporting Document</b> | Certification/Notice       |                    | Yes                  |
| <b>Supporting Document</b> | Application                |                    | No                   |
| <b>Form</b>                | Life Insurance Application |                    | Yes                  |

SERFF Tracking Number: BANN-125826810 State: Arkansas  
 Filing Company: Banner Life Insurance Company State Tracking Number: 40559  
 Company Tracking Number:  
 TOI: LOS 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)

## Form Schedule

Lead Form Number: LIA (8/08)

| Review Status | Form Number                   | Form Type                                   | Form Name   | Action  | Action Specific Data | Readability | Attachment                             |
|---------------|-------------------------------|---|-------------|---------|----------------------|-------------|--|
|               | LIA (10/08) & LU-1267 (10/08) | Application/ Life Insurance Enrollment Form | Application | Initial |                      | 52          | LIA (10-08).pdf<br>LU-1267 (10-08).pdf |

Internet address: [www.bannerlife.com](http://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)

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**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](http://www.mib.com).

|   |  |  |  |                           |
|---|--|--|--|---------------------------|
| <b>SECTION A PROPOSED INSURED</b>   |  |  |  |                           |
| 1. Full Name (Include maiden name in parentheses)   |  | 2. Sex<br><input type="checkbox"/> M<br><input type="checkbox"/> F | 3. Date of Birth<br>Month   Day   Year   | 4. Social Security Number |
| 5. a. Home Address<br>Street _____ City, State _____ Zip _____  |  |  |  | 5. b. How Long            |
| 6. Phone Numbers<br>Home ( )<br>Work ( )  |  | 7. State/Country of Birth  | 8. U.S. Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No Visa Type _____<br>If No, Date of Entry into U.S. _____<br>Country of Citizenship _____ |                           |
| 9. Marital Status<br><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   |  |  |  |                           |
| <b>SECTION B BENEFICIARY</b> (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 _____                     | SSN _____  |  | % Share _____             |
| Name _____  | Relationship _____                     | SSN _____  |  | % Share _____             |
| 17. Contingent  |  |  |  |                           |
| Name _____  | Relationship _____                     | SSN _____  |  | % Share _____             |
| Name _____  | Relationship _____                     | SSN _____  |  | % Share _____             |
| <b>SECTION C OWNER</b>  |  |  |  |                           |
| 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 _____  |                           |
| <b>SECTION D TRUST INFORMATION</b> (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?<br>If Yes, type of bankruptcy and discharge date or charge off date. _____ | <input type="checkbox"/> | <input type="checkbox"/> |
46. a. Gross annual earned income (salary, bonuses, etc. from W-2 forms) \$ \_\_\_\_\_
- b. Gross annual unearned income (dividends, interest, rental income, etc.) \$ \_\_\_\_\_
- |   |                          |                          |
|---|--------------------------|--------------------------|
| c. Is the Proposed Insured self-supporting?   | <input type="checkbox"/> | <input type="checkbox"/> |
| If No, how much insurance is in-force on the life of the person providing the support? \$ _____ |                          |                          |
| What is that person's relationship to the Proposed Insured? _____                               |                          |                          |

**PART 1 (continued)**

**SECTION K BUSINESS FINANCIAL INFORMATION**

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

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

f. How long has the business been established? \_\_\_\_\_

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

h. Are other partners/owners/executives being insured? (If Yes, use Remarks section, Question 48.) Yes No

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

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

j. Company web site address, if available \_\_\_\_\_

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

**IN CONNECTION WITH THIS APPLICATION FOR INSURANCE, IT IS UNDERSTOOD AND AGREED THAT:**

I/we have read the application and all statements and answers contained in Part 1 and Part 2 of this application and any supplements thereto, copies of which shall be attached to and made a part of any policy to be issued, are true and complete to the best of my/our knowledge and belief and made to induce Banner Life Insurance Company (the Company) to issue an insurance policy. The statements and answers in the application are the basis for any policy issued by the Company, and no information about me will be considered to have been given to the Company unless it is stated in the application. I agree to notify the Company of any changes to the statements and answers given in any part of the application before accepting delivery of any policy.

No agent or other person has power to: (a) accept risk; (b) make or modify contracts; (c) make, void, waive or change any conditions or provisions of the application, policy or receipt, as applicable; (d) waive any Company rights or requirements; (e) waive any information the Company requests; (f) discharge any contract of insurance; or (g) bind the Company by making promises respecting benefits upon any policy to be issued.

I agree that: **(1) I/we will notify the Insurer if any statement or answer given in any part of the application changes prior to policy delivery; and (2) except as provided in the Temporary Insurance Application and Agreement, if any, insurance will not begin unless all persons proposed for insurance are living and insurable as set forth in the application at the time a policy is delivered to and accepted by the Owner and the first modal premium is paid.**

Changes or corrections made by the Company and noted in Part 1, Question 48 above are ratified by the Owner upon acceptance of a contract containing this application with the noted changes or corrections. In those states where written consent is required by statute or State Insurance Department regulation for amendments as to plan, amount, classification, age at issue, or benefits, such changes will be made only with the Owner's written consent.

**AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION**

I hereby authorize any physician, medical professional, hospital, clinic or medical care facility; pharmacy benefit manager, prescription database; any insurance or reinsurance company; any consumer reporting agency or insurance support organization; my employer; or the Medical Information Bureau (MIB), to provide the Company and its legal representatives or affiliated insurers, all information they have pertaining to: medical consultations; treatments; hospitalizations for physical and/or mental conditions, use of drugs or alcohol; drug prescriptions; or any other information for me. Other information could include items such as: other insurance information; personal finances; habits; hazardous avocations; motor vehicle records; court records; or foreign travel, etc.

I understand that the information obtained will be used by the Company to determine my eligibility for insurance. I authorize that any information gathered during the evaluation of my application may be disclosed to: reinsurers; the MIB; other persons or organizations performing business or legal services in connection with my application or claim; any physician designated by me; or any person or entity required to receive such information by law or as I may further consent.

I understand that this consent may be revoked at any time by sending a written request to the Company, Attn: Director of Underwriting, Banner Life Insurance Company, 1701 Research Boulevard, Rockville, Maryland 20850-3191.

The consent will be valid for 24 months from the date of this application. I agree that a copy of this consent will be as valid as the original. I authorize the Company to obtain an investigative consumer report on me. I understand that I may request to be interviewed for the report and receive, upon written request, a copy of such report.

If an investigative consumer report is prepared, I elect to be interviewed:  Yes  No

**DECLARATION**

I/we have carefully read the Temporary Insurance Application and Agreement (TIAA) and understand and agree to the terms thereof including the conditions under which a limited amount of insurance may become effective prior to policy delivery. I/we understand that all premium checks are to be made payable to **Banner Life Insurance Company** (payee should not be left blank); checks are not to be made payable to the agent, agency or other third party. I/we have received the Notice to Proposed Insured, which includes the Medical Information Bureau Pre-Notice Disclosure and the Federal Fair Credit Reporting Notice.

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law. **Please see fraud warnings on page 6 prior to signing this application.**

|  |                 |                  |          |         |         |
|--|-----------------|------------------|----------|---------|---------|
| Signature of Proposed Insured  | Signed at _____ | City/State _____ | on _____ | / _____ | / _____ |
| Signature of Owner (if other than Proposed Insured)<br>If Owner is a firm or corporation, include officers' title with signature | Signed at _____ | City/State _____ | on _____ | / _____ | / _____ |
| Print Owner/Officer Name and Title (if applicable)   |                 |                  |          |         |         |
| Signature of Licensed Insurance Agent  | Signed at _____ | City/State _____ | on _____ | / _____ | / _____ |

**FRAUD WARNINGS**

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**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<br>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? .....<br>If now pregnant, what is the expected date of delivery? _____   | <input type="checkbox"/> | <input type="checkbox"/> |                                   |
| 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 <b>last 5 years</b> , unless previously stated on this application, have you:<br>a. Been treated by a member of the medical profession or at a medical facility? .....<br>b. Had an electrocardiogram, x-ray, blood test, or other diagnostic test, excluding an HIV test?.....<br>c. Had surgery or biopsy, or been an inpatient or outpatient in a hospital, clinic, or other medical or mental health facility?.....<br>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?.....<br>e. Been referred to any other member of the medical profession or medical facility?.....<br>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?.....<br>If Yes, please provide dates of use: From _____ To _____<br>Name of drug used: _____<br>Amount and frequency of use: _____  | <input type="checkbox"/> | <input type="checkbox"/> |                                   |

**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?.....<br>If Yes, provide dates of use, type and frequency.  | <input type="checkbox"/> | <input type="checkbox"/> |                                   |
| 25. Have you ever:<br>a. Consumed alcoholic beverages?.....<br>If Yes, give type and number of drinks per day and/or per week.<br>Date of last consumption: _____<br>b. Been advised by a physician or other licensed medical practitioner to limit or cease the use of alcoholic beverages? .....<br>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?.....<br>d. Attended or joined any organization due to alcohol or related problems? ..... | <input type="checkbox"/> | <input type="checkbox"/> |                                   |
| 26. Are you currently:<br>a. Taking or have you been advised to take any prescribed medication (other than contraceptives)?.....<br>b. Taking any herbal or non-prescription medication at least weekly?.....<br>If Yes, give details. _____   | <input type="checkbox"/> | <input type="checkbox"/> |                                   |
| 27. Have you taken any other medications in the <b>past 2 years</b> ?.....<br>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? .....<br>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

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

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

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

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  
If Yes, please provide details in the Remarks section below, and do not provide limited temporary life insurance.
- 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  
If Yes, please provide name and date of birth in the Remarks section below.
- 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  
If Yes, please identify all parties involved and provide copies of all financing agreements or promissory notes and all related side agreements and schedules.

**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.

**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 <b>last 5 years</b> , 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?.....<br>If Yes, provide dates of use, type and frequency.   | <input type="checkbox"/> | <input type="checkbox"/> |                                   |
| 25. Have you ever:  |                          |                          |                                   |
| a. Consumed alcoholic beverages?.....<br>If Yes, give type and number of drinks per day and/or per week.<br>Date of last consumption: _____   | <input type="checkbox"/> | <input type="checkbox"/> |                                   |
| b. Been advised by a physician or other licensed medical practitioner to limit or cease the use of alcoholic beverages?.....  | <input type="checkbox"/> | <input type="checkbox"/> |                                   |
| 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?.....  | <input type="checkbox"/> | <input type="checkbox"/> |                                   |
| 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)?.....  | <input type="checkbox"/> | <input type="checkbox"/> |                                   |
| b. Taking any herbal or non-prescription medication at least weekly?.....<br>If Yes, give details. _____  | <input type="checkbox"/> | <input type="checkbox"/> |                                   |
| 27. Have you taken any other medications in the <b>past 2 years</b> ?.....<br>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?.....<br>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? .....<br>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?.....<br>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? .....<br>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)*

## **Rate Information**

Rate data does NOT apply to filing.

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)

## Supporting Document Schedules

### Review Status:

**Satisfied -Name:** Certification/Notice

09/22/2008

### Comments:

Readability Certification is attached.

### Attachment:

Readability Certification LIA 8-08 signed.pdf

**Readability Certification  
LIA (8/08) & LU-1267 (8/08)**

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

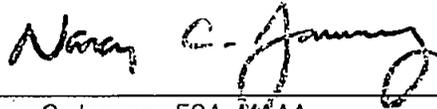
**Life Insurance Application Form LIA (8/08) and a related policy was scored as one unit yielding a combined score of 51.5.**

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

The declarative portion of the application contains the wording "to the best of my knowledge and belief".

The application contains a replacement question.

There are no discriminatory questions as to race, color, creed, etc.



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

September 16, 2008

Date