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

INDIVIDUAL LIFE INSURANCE APPLICATION

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

- Answer all questions in their entirety to avoid policy amendments.
- 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 J, 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 13. Please be sure to enter all agent information and your Banner agent number.
- Give the applicant a copy of our Privacy Policy.

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.
- Do not accept money if a substandard premium class has been quoted.

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NOTICE TO PROPOSED INSURED

(Please give to the Proposed Insured)

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, 3275 Bennett Creek Avenue, Frederick, MD 21704.

Federal Fair Credit Reporting Notice

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

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

MIB, Inc. (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, Inc. member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, Inc., upon request, will supply each company with the information about you in its file.

Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information in your file. Please contact MIB, Inc. at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB, Inc.'s file, you may contact MIB, Inc. and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB, Inc.'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, Inc. may be obtained on its website at www.mib.com.

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PART 1
(Please Print)

SECTION A PROPOSED INSURED

1. Full Legal Name (Include maiden name in parentheses)

2. Sex ☐ M ☐ F

3. Date of Birth — Month | Day | Year

4. Social Security Number

5. a. Home Address (If P.O. Box, list home address in Remarks section, Question 48.)

Street _____

City, State _____ Zip _____

5. b. How Long at Current Address

6. Phone Numbers

Primary _____

Secondary _____

7. State/Country of Birth

8. U.S. Citizen ☐ Yes ☐ No Visa Type _____

If No, Date of Entry into U.S. _____

Country of Citizenship _____

9. Marital Status

☐ M ☐ S ☐ W ☐ D

10. Driver's License Number and State of Issue or State ID Number (If None, list reason.)

11. Proposed Insured Email Address

12. Occupation (Include duties)

13. a. Employer's Name and Address and Nature of Business

13. b. How Long Employed

14. Have you ever used tobacco or nicotine products in any form? ☐ Yes - give details below ☐ No

Product	Date last used (month/year)	Amount / Frequency
Cigarettes		
Cigars		
Other		

SECTION B INSURANCE APPLIED FOR

15. a. Amount of Insurance $ _____ b. Plan of Insurance _____

16. Will you be using this application to apply for more than one policy with us? ☐ Yes ☐ No
(If Yes, provide amount and plan in Remarks section, Question 48.)

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

18. Payment method: ☐ Direct Bill ☐ Electronic Funds Transfer (EFT Available for all payment frequencies)

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

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

1035 Exchange $ _____

1st Year Only $ _____ 2nd Year to Year _____ $_____ Year ____ to Year ____ $ _____

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

SECTION B INSURANCE APPLIED FOR (continued)

Additional Benefits (if available) (Use Remarks section, Question 48, if necessary.)

22. ☐ Waiver of Premium

☐ Other (description and amount) _____

☐ Other (description and amount) _____

☐ Other (description and amount) _____

SECTION C BENEFICIARY (Percentage share totals must equal 100%. If necessary, use Remarks section, Question 48. If Beneficiary is a trust, check box ☐ and complete Sections C and F.)

23. Primary

Name _____ SSN or Tax ID # _____

Address _____ Date of Birth _____

City, State _____ Zip _____ Telephone # _____

Relationship to Proposed Insured _____ % Share _____

Name _____ SSN or Tax ID # _____

Address _____ Date of Birth _____

City, State _____ Zip _____ Telephone # _____

Relationship to Proposed Insured _____ % Share _____

24. Contingent

Name _____ SSN or Tax ID # _____

Address _____ Date of Birth _____

City, State _____ Zip _____ Telephone # _____

Relationship to Proposed Insured _____ % Share _____

Name _____ SSN or Tax ID # _____

Address _____ Date of Birth _____

City, State _____ Zip _____ Telephone # _____

Relationship to Proposed Insured _____ % Share _____

SECTION D OWNER (Will be Proposed Insured unless otherwise indicated in this section. If contingent Owner is required, use Remarks section, Question 48.)

25. Owner is ☐ Trust (If checked go to Section F.) ☐ Other than Proposed Insured or Trust

Name _____ Title _____

Address _____ SSN or Tax ID # _____

City, State _____ Zip _____ Date of Birth _____

Relationship to Proposed Insured _____ Telephone # _____

Email address _____

SECTION E PAYOR (Will be Owner unless otherwise indicated in this section. If Secondary Addressee is required to receive premium notification, notice of pending lapse and termination for nonpayment, complete Question 47.)

26. Send premium notices to: ☐ Insured ☐ Other - If Other, complete the information below

Name _____ Telephone # _____

Address _____ Email address _____

City, State _____ Zip _____

Relationship to Insured/Owner(s) _____

SECTION F TRUST INFORMATION (Must complete if trust is Beneficiary and/or Owner.)

27. Exact Name of Trust _____ Trust Tax ID# _____

Current Trustee(s) _____ Date of Trust _____

Address _____

City, State _____ Zip _____ Telephone # _____

For multiple Trustees, check one of the following boxes (if no box is checked, the Company will require all signatures).

☐ A majority may act for all ☐ Anyone may act alone ☐ All must act unanimously
☐ Certain trustees must act jointly (provide names in Remarks section, Question 48).

SECTION G OTHER INSURANCE

	Yes	No
28. Have you ever had an application or informal inquiry for life insurance declined, postponed, modified, rated or offered with a reduced face amount? (If Yes, provide details in Remarks section, Question 48.)	☐	☐
29. a. Are you currently applying, or do you intend to apply, for additional life insurance coverage with other companies?	☐	☐
b. If Yes, what is the total amount of insurance you intend to accept? $ _____		
30. Have you replaced other life insurance policies in the past 2 years? (If Yes, provide details in Remarks section, Question 48.)	☐	☐
31. a. Do you currently have life insurance coverage (except group insurance)?	☐	☐

b. If Yes, provide information for each policy currently in force (except group insurance). If you indicate that you are likely to replace, end, or change existing insurance or annuity with any company or society with the insurance for which you are applying, the broker may be required to provide additional forms for your review and signature. (If necessary, use Remarks section, Question 48.)

Company	Policy Number	Face Amount	Business? Yes	Business? No	Issue Date	Replacing? Yes	Replacing? No	Beneficiary
			☐	☐		☐	☐	
			☐	☐		☐	☐	
			☐	☐		☐	☐	
			☐	☐		☐	☐	
			☐	☐		☐	☐	

SECTION H FINANCING QUESTIONS

Banner Life Insurance Company will not knowingly participate in a life insurance sale where the sale of the policy in a secondary market or the participation of investors in the policy death benefits is being considered.

	Yes	No
32. Are there any plans to sell or permanently assign this policy to another person or entity, life settlement provider or an investor? (If Yes, provide details in Remarks section, Question 48.)	☐	☐
33. Has any party to the application been offered "free insurance" or anything else of value as an encouragement to apply for this life insurance policy?	☐	☐

SECTION H FINANCING QUESTIONS (continued)

	Yes	No
34. Will the premiums for this policy be loaned or otherwise financed by any individual(s) or entity other than a party to this application, their immediate family members or employer of the Proposed Insured? (If Yes, please identify all parties involved and provide copies of all financing agreement or promissory notes and all related side agreements and schedules in Remarks section, Question 48.)	☐	☐
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, investor(s), insurance company, other secondary market provider or premium finance entity; or is any party to this application in the process of selling a policy? (If Yes, provide details in Remarks section, Question 48.)	☐	☐

SECTION I PROPOSED INSURED FINANCIAL INFORMATION

36. a. What is the purpose of this insurance? (e.g. income replacement, buy-sell, keyperson, estate conservation.)

_____

b. How was the amount of insurance determined? _____

	Yes	No
c. In the last 5 years, has the Proposed Insured filed for bankruptcy or had any charge off of bad debts?	☐	☐

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

37. a. Gross annual earned income (salary, bonuses, commissions, etc.) $_____

b. Gross annual unearned income (dividends, interest, rental income, etc.) $_____

c. Net Worth $_____

	Yes	No
d. Is the Proposed Insured self-supporting?	☐	☐

If No, amount of Household Income $ _____

If No, what is the supporting person's relationship to the Proposed Insured? _____

How much insurance is in-force on the life of the person providing the support? $_____

SECTION J BUSINESS FINANCIAL INFORMATION

Complete this section only if beneficiary or owner is a business or business partner.

38. For the relevant business, please list the following:

a. Name of Business _____

b. Company web site address, if available _____

	Current YTD	Previous Year
c. Assets	$	$
d. Liabilities	$	$
e. Gross Sales	$	$
f. Net Income after Taxes	$	$
g. Fair Market Value of the business	$	$

	Yes	No
h. In the last 5 years, has the business filed for bankruptcy or had any charge off of bad debts?	☐	☐
i. Is the Proposed Insured the sole owner of the business? (If Yes, continue to Question 39).	☐	☐

1. If no, what percentage of the business does the Proposed Insured own? _____

2. If no, are other partners/owners/executives currently insured or pending insurance? (If Yes, use Remarks section, Question 48, to indicate names, percentage of ownership and amount of coverage for each.)	☐	☐

SECTION K GENERAL QUESTIONS

	Yes	No
39. In the past 5 years, have you requested or received a Worker's Compensation, Social Security, or disability income payment?	☐	☐
40. Have you ever been convicted of, or are you currently charged with, a felony or misdemeanor, or are you currently on parole or probation?	☐	☐
41. 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 involved in an accident for which you were found to be at fault?	☐	☐
42. 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.)	☐	☐
43. Are you a member of the military, military reserve, or National Guard, whether active or inactive, or have you entered into a written agreement to become a member of the military, military reserve, or National Guard whether active or inactive, at a future date?	☐	☐
44. 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.)	☐	☐
45. Have you in the past 2 years engaged in, or within the next 2 years do you intend to engage in any of the following activities: hang gliding, hot-air ballooning, ultra-light flying, heli-skiing, mountain, ice or rock climbing, cliff or BASE (building, antennae, spans, and earth) jumping, motor vehicle racing, motorcycle or any other motorized land or water vehicle racing, or scuba or sky diving? (If Yes, complete appropriate questionnaire.)	☐	☐
46. 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.)	☐	☐

47. **Designate Secondary Addressee (Optional)** to receive premium notification, notice of pending lapse and termination for nonpayment. If additional addressees are needed, use Remarks section, Question 48.

Name _____ Telephone # _____

Address _____ Email address _____

City, State _____ Zip _____

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.

Except as provided in the Temporary Insurance Application and Agreement ,if any, I/we understand and agree that no insurance will be in effect unless and until: the policy has been delivered and accepted; the full first modal premium for the issued policy has been paid; and there has been no change in either the health or habits of the proposed insured or any answers to any of the questions in the application.

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. By providing an email address you are authorizing the Company to communicate by email as well as to deliver your policy and related documents by email subject to eligibility.

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 MIB, Inc. (formerly known as Medical Information Bureau), 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. This includes information on any records, findings and results of any genetic test. This information does not apply to records protected under 42 USC 290dd-2. 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 Banner Life Insurance Company or its reinsurer to make a brief report of my personal health information to MIB, Inc. (formerly known as Medical Information Bureau). I authorize that any information gathered during the evaluation of my application may be disclosed to: reinsurers; 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 information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by certain federal rules governing privacy and confidentiality of health information.

I understand that this authorization may be revoked at any time by sending a written request to the Company, Attn: Director of Underwriting, Banner Life Insurance Company, 3275 Bennett Creek Avenue, Frederick, Maryland 21704.

The authorization will be valid for 24 months and shall survive the insured. I agree that a copy of this authorization 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 MIB, Inc. (formerly known as 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.

_____ Signed at _____
Signature of Proposed Insured City/State

_____ _____
Print Name of Proposed Insured Date

_____ Signed at _____
Signature of Owner (if other than Proposed Insured) City/State

_____ _____ _____
Print Name of Owner Owner/Title Date

_____ Signed at _____ _____
Signature of Licensed Insurance Agent City/State Date

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PART 2
Medical History

1. Name of Proposed Insured _____ Date of Birth _____

2. a. Height _____ft. _____in. b. Weight _____ lbs.

3. Has your weight changed by more than 10 lbs. in the past year? Yes ☐ No ☐
(If Yes, use Remarks section, Question 30, to 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** ☐ Same as Primary Physician

Name _____ Specialty _____

Address _____

Telephone _____ Date last seen _____

Reason last seen and results of visit _____

6. **Family History** (Provide details to Yes answers in Question 7 below or use Remarks section, Question 29.)

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, substance abuse, suicide, sickle cell disease, Huntington disease, familial Alzheimer disease, familial adenomatous polyposis or FAP, amyotrophic lateral sclerosis (ALS or Lou Gehrig disease), or spinocerebellar ataxia? ..... Yes ☐ No ☐

7. **Complete the Family History chart below.**

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

PART 2 - Medical History (continued)

Name of Proposed Insured _____

MEDICAL HISTORY - Provide details to Yes answers in the Remarks section. Include provider name and address, date of onset, last consultation, symptoms, diagnosis and treatment.	Yes	No	**Remarks - Explain All Yes Answers** Enter question number before detailed response.
Questions 8-22, have you ever been diagnosed, treated, tested positive for, been given medical advice by, or consulted a member of the medical profession for:			
8. High blood pressure, high cholesterol, abnormal electrocardiogram, chest pain, irregular heart rhythm, palpitations, heart murmur, heart attack, angina, aneurysm, phlebitis, peripheral vascular disease, or any other disease or disorder of the heart or blood vessels?	☐	☐	
9. Hepatitis, ulcer, internal bleeding, colitis, acid reflux, GERD, Barrett's Esophagus, or any other disease or disorder of the stomach, gall bladder, esophagus, liver, pancreas, spleen, intestines, colon, rectum or anus?	☐	☐	
10. A disorder of your blood or immune system including anemia, blood clots, bleeding, immune deficiency, leukemia, lupus, or lymphoma (excluding HIV)?	☐	☐	
11. Cancer, tumor, melanoma, or any other malignant disorder?	☐	☐	
12. Diabetes or high blood sugar or any other disease or disorder of the pituitary, thyroid, or endocrine glands?	☐	☐	
13. Albumin, protein, blood or sugar in the urine or any other disease or disorder of the kidney or bladder?	☐	☐	
14. Cyst, polyp, lump, or other growth, or any disease or disorder of the skin or lymph nodes?	☐	☐	
15. Any sexually transmitted disorders or diseases?	☐	☐	
16. Asthma, shortness of breath, chronic cough or hoarseness, chronic bronchitis, emphysema, COPD (chronic obstructive pulmonary disease), sarcoidosis, pneumonia, TB (tuberculosis), sleep apnea, or any other disorder of the respiratory system?	☐	☐	
17. A disorder of the brain, back, spinal cord, or nervous system including Alzheimer's, dementia, memory loss, chronic headaches, chronic back pain, paralysis, tremors, convulsions, loss of consciousness, seizures, fainting, stroke, MS (multiple sclerosis), or TIA (transient ischemic attack), or any other disorder of the brain, back, spinal cord, or nervous system?	☐	☐	
18. Depression, anxiety, psychosis, suicidal thoughts or attempts of suicide, anorexia or bulimia, obsessive compulsive disorder, bipolar disorder, or other mental, nervous or emotional disorder?	☐	☐	
19. Arthritis, connective tissue disorder, fibromyalgia, chronic fatigue syndrome or disorder of the joints, bones, spine, skin, or muscles or loss of extremity or deformity?	☐	☐	
20. Any disease or disorder of the eyes, ears, nose, mouth, throat, head or neck?	☐	☐	
21. Females only: a. Have you ever been diagnosed, treated, tested positive for, been given medical advice by, or consulted a member of the medical profession for any disease or disorder of the uterus, cervix, ovaries, breasts, reproductive system, infertility, or complications of a pregnancy?	☐	☐	
b. Are you currently pregnant? If now pregnant, provide expected date of delivery in Remarks section.	☐	☐	

PART 2 - Medical History (continued)

Name of Proposed Insured _____	Yes	No	Remarks - Explain All Yes Answers
22. Males only: Have you been diagnosed, treated, tested positive for, been given medical advice by, or consulted a member of the medical profession for any disease or disorder of the prostate, breasts, or reproductive system, including Klinefelter syndrome?	☐	☐	
23. Have you ever tested positive for exposure to the HIV infection or been diagnosed as having ARC (AIDS-Related Complex) or AIDS (Acquired Immune Deficiency Syndrome) caused by HIV infection or other sickness or condition derived from such infection?	☐	☐	
24. Have you ever:			
a. Used amphetamines, barbiturates, cocaine, heroin, crack, marijuana, LSD, PCP, or other illegal, restricted or controlled substances, except as prescribed by a licensed physician? If Yes, provide dates of last use, name of drug(s) used, amount and frequency of use in the Remarks section.	☐	☐	
b. Been addicted to prescription medication? If Yes, provide dates of last use, name of medication(s) used, amount and frequency of use in the Remarks section.	☐	☐	
c. Been counseled, sought help or treatment, or been advised by a physician, other licensed medical practitioner, or legal authority to undergo counseling, consult or treatment for drug or related problems?	☐	☐	
d. Attended or joined any organization due to drug or related problems?	☐	☐	
25. Have you ever:			
a. Consumed alcoholic beverages? If Yes, please advise: Frequency: (daily/weekly)_____ Type: (beer, wine, liquor) _____ Number of drinks: (or ounces) _____	☐	☐	
b. Been advised by a physician or other licensed medical practitioner to limit or cease the use of alcoholic beverages?	☐	☐	
c. Been counseled, sought help or treatment, or been advised by a physician, other licensed medical practitioner, or legal authority to undergo counseling, any consult or treatment for alcohol or related problems?	☐	☐	
d. Attended or joined any organization due to alcohol or related problems?	☐	☐	
26. In the **last 5 years,** unless previously stated on this application, have you:			
a. Been treated, examined, or advised by a member of the medical profession for any disease or disorder not previously stated on this application?	☐	☐	
b. Had an electrocardiogram, x-ray, Pap smear, Human papillomavirus (HPV) test, blood test, or other diagnostic test, excluding an HIV test?	☐	☐	
c. Had surgery or biopsy, or been an inpatient or outpatient in a hospital, clinic, or other medical or mental health facility?			
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?	☐	☐	
e. Been referred to any other member of the medical profession or medical facility?	☐	☐	
f. Been unable to work, attend school or perform the normal activities of like age and gender, or been confined at home?	☐	☐	
27. Are you currently:			
a. Taking or have you been advised to take any prescribed medication (other than contraceptives)?	☐	☐	
b. Taking any herbal or non-prescription medication at least weekly? If yes, provide details in the Remarks section.	☐	☐	

PART 2 - Medical History (continued)

Name of Proposed Insured _____	Yes	No	**Remarks - Explain All Yes Answers**
28. Have you taken <u>any other medications</u> in the **past 2 years** not previously mentioned on this application? ..... If Yes, provide details in the Remarks section.	☐	☐	

29. 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 as written on this document.

_____ Signed at _____ on ____/____/_____

Signature of Proposed Insured | City/State | Date

Legal & General AMERICA

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

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 more than 70 years old (age nearest birthday) on the date of this TIAA?	☐	☐
2. Does the total amount of insurance on the Proposed Insured's life inforce and/or pending with Banner Life Insurance Company exceed $1,000,000?	☐	☐
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?	☐	☐
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?	☐	☐

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 inforce policies or 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 - 90 Day Maximum. Temporary insurance automatically ends on the Stop Date and the entire amount remitted will be returned without interest to or for the benefit of the Owner. The Stop Date is 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) 45 days after the Start Date if the Insurer has not received a properly completed Application - Part 2 and all medical examinations, tests, x-rays and electrocardiograms required by the Insurer as set forth in its published guidelines; (3) the date the Insurer mails or otherwise provides notice to the Owner or their agent that it was unable to approve the requested coverage at a Standard or better underwriting classification which does not include a Table Rating, Flat Extra charge; (4) the date the Insurer mails or otherwise provides notice to the Owner or their representative that it has declined or canceled the application; (5) the date the Insurer mails or otherwise provides a premium refund to the Owner or their representative; (6) 90 days after the Start Date, or (7) the date the policy is delivered to the Owner and delivery requirements have been completed.

TEMPORARY INSURANCE APPLICATION AND AGREEMENT (TIAA) (continued)

Policy Date. The Policy Date of any policy issued will be the Issue Date unless the policy is backdated at the Owner's request. The Amount Remitted will be applied to the first modal premium for the policy. Upon policy delivery, and the completion of any delivery requirements, the policy will replace this TIAA.

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 (Part 1, Part 2 or any supplements thereto) or this TIAA contains a misrepresentation material to the Insurer; or (2) the Proposed Insured dies by suicide.

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) I understand and agree that submission of an NSF check or a credit card, debit card, or Electronic Funds Transfer account number on which the Insurer is unable to draft sufficient funds will not constitute remittance of premium and will not activate coverage under this agreement; (4) 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; (5) I understand that completing this TIAA does not guarantee that the Insurer will issue a policy on the Proposed Insured's life; and (6) 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.

_____ _____ _____

Signature of Proposed Insured | Date of this TIAA | Signature of Owner (if other than Proposed Insured)

LICENSED INSURANCE AGENT'S STATEMENT

Amount Remitted/Authorized $_____ Person Authorizing _____

On the Date of this TIAA, I received the Amount Remitted/Authorized 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

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TEMPORARY INSURANCE APPLICATION AND AGREEMENT (TIAA) (continued)

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Signature of Proposed Insured	Date of this TIAA	Signature of Owner (if other than Proposed Insured)

LICENSED INSURANCE AGENT'S STATEMENT

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Signature of Licensed Insurance Agent	Licensed Insurance Agent Number

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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 _____

	Yes	No
4. Was the application signed after all questions were answered?	☐	☐
5. Did you personally see the Proposed Insured?	☐	☐
6. Does the Proposed Insured and Owner(s) read and understand the English Language?	☐	☐

If No, indicate how the application was completed and identify the person who assisted and/or signed for the applicant.

_____

7. Are you aware of any information that would adversely affect any Proposed Insured's eligibility, acceptability, or insurability? 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?	☐	☐

9. Premium Class Quoted ☐ Preferred Plus ☐ Preferred ☐ Standard Plus ☐ Standard
☐ Preferred Tobacco ☐ Standard Tobacco ☐ Substandard Table _____ ☐ Other (use Remarks)

10. 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? 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.
- I have not been involved in any recommendation or discussion regarding the possible sale or assignment of this policy to a life settlement, viatical or other secondary market provider. If otherwise, please explain in Remarks section.
- I have verified that all life insurance coverage in force, or in the process of being applied for, on the proposed insured has been disclosed on this application, including any coverage that has been sold or is in the process of being sold to a life settlement, viatical or other secondary market provider.

_____ Email Address _____
Signature of Licensed Insurance Agent Date

_____ Agent # _____ TIN _____
Print Name of Above Signature

_____ Share of commission _____
Print Name of Agency, if different from above

_____ Email Address _____
Signature of Additional Licensed Insurance Agent Date

_____ Agent # _____ TIN _____
Print Name for Above Additional Signature

_____ Share of commission _____
Print Name of Additional Agency, if different from above

GENERAL AGENT INFORMATION

Case Manager _____

GA Name _____ GA # _____ Email Address _____