Policy Number

WEST COAST LIFE INSURANCE COMPANY
A Protective Company

Elgin, Illinois 60123-7836

TELELIFE

APPLICATION FOR INDIVIDUAL LIFE INSURANCE

Proposed Primary Insured ❑ Proposed Other Insured ❑

Name Last First MI ❑ Male ❑ Female

Street

City State Zip

Social Security number Occupation

Birthplace Birthdate Age at nearest birthday

Home phone ( ) Business phone ( )

Where can you be reached for additional information?

❑ Home ❑ Work Best days: Best times: ❑ a.m. ❑ p.m.

Initial death benefit $

Issue Best Rate Class

Plan of insurance:

Riders: ❑ WP ❑ ADB ❑ CR ❑ Other:
(complete separate application for each CR)

Amount remitted with this application, in exchange for this Company receipt: $
Do not submit money if death benefit exceeds $500,000 or insured's age Exceeds 65 or health questions below answered yes.

Owner, if other than proposed insured (N/A for CR)	Owner's address
Relationship to Proposed Insured	Social Security or Tax ID #
Primary Beneficiary	Relationship to Proposed Insured

Does the proposed insured have life insurance inforce other than group insurance? ❑ Yes ❑ No

Is this policy to replace any existing insurance or annuity(ies)? ❑ Yes ❑ No
If yes, indicate Company name(s):

Has the owner been provided a written illustration which conforms to this application? ❑ Yes ❑ No
If "no," owner acknowledges that owner will receive an illustration conforming to the policy as issued no later than at the time of the policy delivery for policies that are illustrated.

Is Proposed Insured a U.S. Citizen? ❑ Yes ❑ No (If No:)
Country of citizenship _____
Permanent Visa? ❑ Yes ❑ No How long in U.S.?

Has Proposed Insured used tobacco in any form in the past 12 months? ❑ Yes ❑ No 60 months? ❑ Yes ❑ No

Has the proposed insured ever been told he had or been treated for: diabetes, cancer, heart disease, alcoholism, drug abuse, or high blood pressure or does proposed insured have any other health problems, habits, or hobbies that may affect insurability? (If yes, preferred rates are unlikely.) ❑ Yes ❑ No

Mode of premium payment:
❑ Annual ❑ SA ❑ Qtrly ❑ COM

Special Request:

Any person who knowingly 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 may be a crime and may subject such person to criminal and civil penalties according to state law.

Authorization To Obtain And Disclose Information: I (we) have read all the questions and answers in the application. All responses are true and complete to the best of my (our) knowledge and belief. No coverage will be in effect until: a full application has been signed by the proposed insured; and a policy has been issued; and the full first premium has been received by the company; and any amendments are signed. Any coverage will be subject to the terms and conditions of the policy. **I (we)** have received the notification about the Federal Fair Credit Reporting Act and the Medical Information Bureau. **I (we)** hereby authorize: any licensed physician or medical practitioner; any hospital, clinic or other medical or medically related facility; any insurance company; the Medical Information Bureau; and any other organization, institution or person that has any records or knowledge of me or my health, to give West Coast Life Insurance Company, its affiliates, or their reinsurers or the Medical Information Bureau, any such information. This authorization is valid for two years from the date this form is signed. An exact copy of this authorization is as valid as the original.

Signed at: (city and state) _____ _____
Signature of Proposed Insured (if age 18 or over)

Date signed: (month/day/year) _____ _____
Signature of Owner/Applicant, if other than Proposed Insured

Agent: To the best of your knowledge will this policy replace or change any existing life insurance or annuity policy(ies)? ❑ Yes ❑ No
(If "Yes," complete any required replacement forms.)
Has the Owner been provided an illustration which conforms to this application? ❑ Yes ❑ No
If "no," agent hereby certifies that no illustration was used in connection with the solicitation of the policy applied for.
Is there any third party other than the proposed insured that will obtain any ownership rights on any policy issued as a result of this application? ❑ Yes ❑ No

_____ _____
Print BGA's name Print Agent's name/Social Security Number or Agent Code

_____ _____ _____
Agent's Signature Date Agent's Telephone number

BGA's telephone:_____ BGA email address: _____

W-7563A

343 Sansome Street, San Francisco, CA 94104
PO Box 193892, San Francisco, CA 94119-3892
1-800-366-9378

Conditional Receipt

THIS RECEIPT IS TO BE GIVEN TO THE APPLICANT AT THE TIME OF APPLICATION IF ANY MONEY IS TAKEN

Received from _____ in connection with the application

dated _____for life insurance totaling $_____, on the life (lives) of _____.

1. NO COVERAGE WILL BECOME EFFECTIVE PRIOR TO DELIVERY OF THE POLICY APPLIED FOR UNLESS AND UNTIL ALL THE CONDITIONS OF THIS RECEIPT HAVE BEEN FULFILLED EXACTLY:
   a. The amount of payment taken with the application must be at least equal to the amount of the full first premium for the mode of payment selected in the application and for the amount of insurance which may become effective prior to delivery of the policy.
   b. All medical examinations, tests, x-rays and electrocardiograms required by the company must be completed and received at its home office within 60 days from the date of completion of Part 1 of this application.
   c. As of the effective date, as defined below, each person proposed for insurance in this application must be a risk insurable in accordance with the company's rules, limits and standards for the plan and the amount applied for without any modification either as to plan, amount, riders, supplemental agreements and/or the rate of premium paid.
   d. As of the effective date, the state of health and all factors affecting the insurability of each person proposed for insurance must be as stated in the application.
2. Subject to the conditions of paragraph 1, insurance, as provided by the terms and conditions of the policy applied for and in use on the effective date, but for an amount not exceeding that specified in paragraph 3, will become effective as of the effective date. "Effective date" as used herein, is the later of: (a) the date of completion of Part 1 of the application, or (b) the date of completion of all medical examination, tests, x-rays and electrocardiograms required by the company, or (c) the date of issue if any, requested in the application.
3. The total amount of insurance which may become effective on any person proposed for insurance shall not exceed $500,000 of life insurance, including any accidental death insurance benefits.
4. If one or more of the conditions of paragraph I have not been fulfilled exactly, there shall be no liability on the part of the Company except to return the applicable payment in exchange for this Receipt.
5. NO AGENT OR ANY OTHER PERSON IS AUTHORIZED BY THE COMPANY TO WAIVE OR MODIFY IN ANY WAY ANY OF THE PROVISIONS OF THIS CONDITIONAL RECEIPT. **ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO WEST COAST LIFE INSURANCE COMPANY – DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAY BLANK.**

Dated at _____ _____
Signature of Agent

this _____ day of _____, 20___

I acknowledge possession of this receipt and I certify that I have read it and the agreement in the application. The terms and conditions of this receipt, to which I agree, and the agreement in this application have been explained to me fully by the agent and I understand them.

_____
Signature of Applicant

NOTE

If all the conditions are not fulfilled exactly, the insurance will take effect when the policy is delivered to the owner stated In the application; but only if at the time of such delivery there has been no change in insurability as represented in the application.

BANK DRAFT INFORMATION

WEST COAST LIFE INSURANCE COMPANY

The company above will withdraw the premiums form the specified account. This company will be referred to hereafter as “Company”.

“You”, “your”, “I” and “me” refer to the bank account owner whose name appears below.

How automatic bank draft works: Automatic bank draft is a debit service that offers a convenient way to pay life insurance premiums. The Company will collect the life insurance premiums from you bank account electronically – you do not need to write checks or mail in any payments. Premium withdrawals will appear on your bank statement, and your statements will be your receipts for payment of your premium.

Automatic Bank Draft Agreement

I hereby authorize and request the Company to initiate electronic or other commercially accepted-type debits against the indicated bank account in the depository institution named (“Depository”) for the payment of premiums and other indicated charges due on the insurance policy, and to continue to initiate such debits in the event of a conversion, renewal, or other change to any such contract(s). I hereby agree to indemnify and hold the Company harmless from any loss, claim or liability of any kind by reason or dishonor of any debit.

I understand that this authorization will not affect the terms of the contract(s), other than the mode of payment, and that if premiums are not paid within the applicable grace period, the contract(s) will terminate, subject to any applicable nonforfeiture provision. I acknowledge that the debit appearing on my bank statement shall constitute my receipt of payment, but no payment is deemed made until the Company receives actual payment.

I agree that this authorization may be terminated by me or the Company at any time and for any reason by providing written notice of such termination to the non-terminating party and may be terminated by the Company immediately if any debit is not honored by the Depository named for any reason. This must be dated and signed by the bank account owner(s) as his/her name appears on bank records for the account provided on this authorization.

Financial Institution Name ____

Financial Institution Address ____________________ City, State__________ ZIP ______

Routing Number |: | | | | | | | | | | :|

Account Number | | | | | | | | | | | | | | | | ||·

Type of Account: ☐ Checking ☐ Saving Credit Union: ☐ Yes ☐ No

Name of Primary Proposed Insured____________________ Policy Number(s):__________

Premium Amount $__________

Frequency: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly

Preferred Withdrawal Date (1^{st} – 28^{th})________ ☐ **Please debit my account for all outstanding premiums due.**

Print Bank Account Owner(s) Name____

Signature(s) of Bank Account Owner(s) **X**________________________________

Please attach a voided check.