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 diagnosed or been treated by a licensed medical professional for: diabetes, cancer, heart disease, alcoholism, drug abuse, or high blood pressure? (If yes, preferred rates are unlikely.) ❑ Yes ❑ No

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

Special Request:

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

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 / Florida License ID #

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

BGA's telephone:_____ BGA email address: _____

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

Conditional Receipt Agreement *

This agreement provides only a limited amount of insurance, for a limited period of time, and then only if all the terms and conditions of this Agreement are met. No Agent of the Company can alter or waive any of the provisions of this Agreement. No insurance is provided under the terms of this document in the event of death of the Insured by suicide. In the event of suicide, the Company's sole liability will be the return of any money received.

Received: ☐ Check in the amount of $_____ ☐ Credit Card Authorization for an amount equal to the premium due on the policy applied for, or ☐ Check-O-Matic Plan (COM), as conditional payment of the first premiums for an insurance policy on the life of Proposed Insured(s) _____.

An application for life insurance on each person proposed for insurance is being made today to West Coast Life Insurance Company. This conditional payment is received under and is subject to the exact conditions set out below, all of which are a part of this Agreement.

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO WEST COAST LIFE INSURANCE COMPANY. DO NOT MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK. CASH AND MONEY ORDERS WILL NOT BE ACCEPTED.

NOTE: Premium may not be collected where the face amount applied for on this application plus any other in force life insurance and accidental death benefits, including those applied for, with this Company on this Insured exceeds $500,000 net amount at risk or on Proposed Insureds under 15 days of age or over age 65.

CONDITIONS UNDER WHICH INSURANCE MAY BECOME EFFECTIVE PRIOR TO POLICY DELIVERY

Unless each and every condition below has been fulfilled exactly, no insurance will become effective prior to policy delivery to the Owner:

(A) on the Effective Date the Proposed Insured(s) is (are) insurable exactly as applied for under the Company's printed underwriting rules for the plan, amount and premium rate class applied for;
(B) that the amount paid with the application and shown above is equal to the first full modal premium for the premium rate class applied for;
(C) the Proposed Insured(s) has/have completed all examinations and/or tests requested by the Company; and
(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.

EFFECTIVE DATE OF COVERAGE

If the above conditions are met, Insurance provided under this Agreement shall take effect on the latest of:

(A) the date of the application;
(B) the date requested in the application; or
(C) the date of the last of any medical examinations or tests required under the rules and practices of the Company.

AMOUNT OF COVERAGE

The total amount of insurance which may become effective prior to delivery of the policy to the Owner **shall not exceed the amount of initial premium plus $500,000.** This amount includes other life insurance and accidental death benefits then in force or applied for with this Company.

TERMINATION AND REFUND OF PREMIUM

There shall be no insurance coverage under this Agreement and this Agreement shall be void if:

(A) premium payment is
  (1) by check, and it is not honored by the drawee bank upon presentation;
  (2) by COM, and the deduction is not honored by the drawee bank;
  (3) by credit card and the payment is not honored by the credit card Company.
(B) if the application to which this Agreement was attached is not approved as applied for by the Company within ninety business days from its date.

The Company's only liability in such event(s) will be to return any money received.

NOTICE TO APPLICANT: You should retain a copy of this Agreement. The Original will be retained by West Coast Life.

Date: _____ Agent: _____

Date: _____ Applicant/Owner: _____

Original – Home Office Copy – Applicant

**** NOT FOR USE IN ALABAMA, PENNSYLVANIA AND VERMONT***.

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 (1st – 28th)____________ ☐ **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.