Legal & General AMERICA

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

APPLICATION

For Policy No. _____
Cash With
Application: _____

Additional Coverage

- ☐ Increase Specified Amount
  Amount of Increase $_____
- ☐ Change in Death Benefit Option
  from Type B to Type A
- ☐ Add Spouse Insurance Rider
  Amount $_____
- ☐ Add Children Insurance Rider
  Amount $_____
- ☐ Add Waiver Benefit
- ☐ Add Accidental Death Benefit
  Amount $_____
- ☐ Other
  Please Specify _____
  _____
  _____
  _____

(Please complete all sections. If additional space is needed, please attach a separate sheet.)

Section One

(Include the Insured plus those persons proposed for additional coverage.)

	First Name	Middle Initial	Last Name	Birth Date	Height	Weight	Sex
Insured							
Spouse or Other Insured							
Child							
Child							

Section Two

(Questions 1-9 apply to all persons listed above.)

1. Residence Address:

   _____
   Number/Street

   _____
   City/State Zip

2. Business:

   Occupation _____

   Employer_____

3. Family Physician:

   _____
   Name

   _____
   Number/Street

   _____
   City/State Zip

4. When was the last time you or any person listed in Section 1 consulted a physician for any reason? Please give full details including: date; reason for visit; diagnosis; treatment and results. List name and address of physician if different from your regular family physician.

For questions 5-9 check “Yes” or “No”. For all “Yes” answers, circle the items that apply. In the blank areas below give full details including: diagnosis, treatment, results, dates, duration, and names and addresses of all attending physicians (if different from your regular family physician).

5. Has any person listed in Section 1 been treated for or had any known indication of:
   a. Heart trouble, high blood pressure, or diabetes? ..... ☐ Yes ☐ No
   b. Nervous or mental disorder? ..... ☐ Yes ☐ No
   c. Cancer, tumors? ..... ☐ Yes ☐ No
   d. Any disease of the respiratory, digestive, or urinary systems? ..... ☐ Yes ☐ No

6. Has any person listed in Section 1 had any physical impairment or disease not already mentioned? ..... ☐ Yes ☐ No

7. Has any person listed in Section 1 had treatment or been advised to have treatment because of alcohol or drug abuse? ..... ☐ Yes ☐ No

8. Has any person listed in Section 1 ever had a policy for Life, Hospital, Sickness or Accident Insurance issued with exclusions, postponed, rejected or cancelled? ..... ☐ Yes ☐ No

Name	Date of Consultation	Reason for Consultation	Diagnosis and Treatment	Results of Treatment	Name and Address of Physician if Different from Regular Family Doctor

9. (a) Does any person listed in Section 1 now smoke cigarettes? ..... ☐ Yes ☐ No

   (b) Has any person listed in Section 1 smoked any cigarettes in the past twelve months? ..... ☐ Yes ☐ No

   (c) If any person listed in Section 1 answered “No” above, have they used other forms of tobacco in the last twelve months? ..... ☐ Yes ☐ No

If “Yes” give details _____

Section Three

Are the insurance coverages applied for intended to replace or change any existing insurance or annuity coverage in force? ☐ Yes ☐ No. If “Yes”, please give name of insured, policy number, name of company and amount of insurance coverage.

Insured	Policy Number	Company	Amount of Insurance

I represent that my answers to the above questions are complete and true to the best of my knowledge and belief. Except as provided in this application’s Conditional Receipt, the additional coverage or other change applied for shall in no event become effective unless this application is approved by Banner Life Insurance Company and any premium, if required, is paid while the insurability of the Insured and any other persons to be insured under the above numbered policy remains as stated in this application. I further agree that this application shall be attached to and form a part of the policy.

Dated at _____ on the _____day of _____, 20_____

_____
Signature of Insured Proposed for Additional Coverage

_____
Signature of Spouse or Other Proposed Insured

_____
Signature of Owner

I truly and accurately recorded on the application the information supplied by the Insured.

_____
Signature of Licensed Agent and Agent Number

Authorization to Obtain Information

I authorize any physician, medical practitioner, hospital, clinic, other medical or medically-related facility, insurance company, the Medical Information Bureau, Inc., consumer reporting agency or employer, having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or my minor children and any other non-medical information of me or my minor children to release to Banner Life Insurance Company or its legal representative, any and all such information.

I understand the information obtained by use of the Authorization will be used by Banner Life Insurance Company to determine eligibility for insurance. Any information obtained will not be released by Banner Life Insurance Company to any person or organizations except to reinsuring companies, the Medical Information Bureau, Inc., or other persons performing business or legal services in connection with my application, claim, or as may be otherwise lawfully required or as I may further authorize.

I know that I may request a copy of this Authorization. **I agree** that a photostatic copy of this Authorization will be as valid as the original. **I acknowledge** receipt of the MIB Disclosure and Consumer Report Notices. **I agree** this Authorization will be valid for two and one-half years from the date shown below.

Dated at _____ on the _____ day of _____, 20_____.

_____
Signature of Insured Proposed for Additional Coverage

_____
Signature of Spouse or Other Proposed Insured

_____
Signature of Children (If 18 or over)

Important Notice About The Medical Information Bureau

Providing you the insurance you need, at rates you can afford, is our primary objective. To make sure that you pay no more than necessary for your coverage, we need to have adequate information about your medical history. We obtain this information from your application plus other sources available to us, including the Medical Information Bureau (MIB).

Information you provide will be treated as confidential except that Banner Life Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. Upon request by another member insurance company to which you have applied for life insurance coverage, the MIB will supply such company with the information it may have in its files.

We would not reject your application because of data furnished by the MIB; it may simply alert us to the possible need for further information. MIB files do not contain medical reports from doctors or hospitals, nor do they indicate whether any insurance applications are accepted or rejected.

Upon receipt of a request from you, the MIB will arrange disclosure of any information it may have in your file. (Medical information will be disclosed only to your attending physician.) Should you have any questions regarding the accuracy of information in the MIB's file, you may contact the MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the MIB's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112; telephone number 617-426-3660.

Banner Life Insurance Company or its reinsurers may also release information in its file to other life insurance companies to whom you may apply for life insurance. This sharing of information is for the insurance buyer's benefit; otherwise, it would be necessary to charge everyone higher rates to compensate for those persons with serious health problems.

Important Notice About The Consumer Report

As part of our routine procedure, we may request that an investigative consumer report be prepared. Such reports typically include information as to identity, character, general reputation, personal characteristics and mode of living. The information is usually obtained through confidential conversations with neighbors, friends and other acquaintances.

You will be notified upon written request whether or not an investigative consumer report was requested. If such a report is requested; should you desire to receive and inspect a copy, you may do so by contacting this company for the name and address of the reporting agency.

Conditional Receipt

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO BANNER LIFE INSURANCE COMPANY; DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

Banner Life Insurance Company ("the Company") has received from _____ the sum of $_____ in payment of premium for the additional coverage for which an application ("the Application") corresponding in date and name with this receipt has been made to the Company.

No insurance shall take effect prior to acceptance of the additional coverage unless all of the following conditions are met:

1. Any required premium is paid;
2. All information which the company shall require in order to determine the insurability of each person proposed for insurance must be received by the Company within sixty (60) days from the date of this Conditional Receipt;
3. Each person proposed for insurance must, as of the Effective Date, be determined to have been insurable under the Company's rules and standards. Such rules and standards shall be for the type and amount of additional coverage applied for on: (a) a standard premium basis, or (b) an extra premium basis for which item 1 is applicable; and
4. The statements and answers in all parts of the Application are, without material change, true and complete to the best of the Applicant's knowledge and belief as of the Effective Date.

If all of the above conditions are met, then the additional coverage shall become effective as of the Effective Date. The insurance shall be provided by the terms and conditions of any applicable rider policy form in use by the Company on the Effective Date and of the policy to which the additional coverage will be added.

Effective Date: The Effective Date referred to herein is defined as the latest of the following dates: (a) the date of the Application; (b) the date of the first medical exam for each of the proposed insureds, if required in conjunction with the Application under the Company's rules and standards; and (c) the date of a second medical exam, if required.

Maximum Amount: The amount of additional coverage becoming effective under this Conditional Receipt is limited to the extent that the total liability of the Company for the death of each person proposed for insurance in the Application shall not exceed $500,000. Such amount includes: (a) life insurance then in force with the Company, and (b) any benefits payable by the Company as a result of accidental death.

Notice of Action: The Applicant will be notified within sixty (60) days from the date of this receipt as to whether the Application has been accepted or denied.

Termination of Liability: If the Application has not been approved within such sixty (60) day period: (a) the Company's liability under this receipt will terminate; and (b) the payment as stated in this receipt will be returned upon surrender of this receipt.

The above payment will also be returned if the Company declines to provide the additional coverage applied for in the Application. A delay in refund of the above payment shall not be construed to provide coverage. Such delay will also not create any liability on behalf of the Company other than for return of the above payment.

This receipt shall be void if altered or modified.

Dated at _____ on the _____ day of _____, 20_____

_____
Signature of Licensed Agent Agent Number

I hereby acknowledge that I have been given the Conditional Receipt, and I certify that I have read it, that the terms of the receipt have been fully explained to me by the Agent and that I understand and agree to them.

_____ _____
Signature of Proposed Insured or Applicant Signature of Spouse or Other Proposed Insured