West Coast Life Insurance Company
A PROTECTIVE COMPANY

P.O. Box 193892, San Francisco, CA 94119-3892

Part I

LIFE INSURANCE APPLICATION

[State of Domicile - Nebraska]

SECTION I : INSUREDS

Name of Persons Applying for Coverage (Print in Full)	Relationship to Prop. Ins.	Sex	Date of Birth	Social Security Number	Birth State	Driver's License Number
Proposed Insured	**Self**					
Spouse						
Child						
Child						

Residence: ____

Street   Apt. No.

____

City   State   Zip Code   Telephone Number   Number of Years

Occupation	# of Years	(Required) Annual Income	(Required) Net Worth	Employer Name and Address	Telephone Number
Proposed Insured's Occupation					
Spouse's Occupation					

SECTION II : PLAN OF INSURANCE

Face Amount $** ____________________ **$ ____________________ **$** ____________________

Insured   Spouse   Children

Plan of Insurance *(Name of Product)* ____

If Universal Life: ☐ **OPTION I -** Level Face Amount ☐ **OPTION II -** Face Amount Plus Cash Value

If Term, Indicate Years: ☐ **10 Yrs** ☐ **15 Yrs** ☐ **20 Yrs** ☐ **25 Yrs** ☐ **30 Yrs**

If Income Replacement Term: Complete the Supplemental Application Form #WC-U-413

Not Available on all plans: 1035 Loan Transfer ☐ Yes ☐ No   Section 1035 ☐ Yes ☐ No

☐ CVAT (unless checked, the Guideline Premium Test will apply.)

Benefits: ☐ Automatic Premium Loan ☐ Waiver of Premium ☐ Accidental Death, Amount: $ ____________

☐ Child Rider, # of Units: ________ ☐ Other, Description and Amount: ____________________

Premium Payment: ☐ Annual $ ____________ ☐ Check-O-Matic $ ____________ ☐ Other ____________

☐ Additional 1st Year Payment $ ____________ ☐ Cash with Application $ ____________

Send Premium Notices To: ☐ Residence ☐ Other, Complete Line Below:

____

Name   Address   City   State   Zip

SECTION III : BENEFICIARY

Primary: Full Name ______________________________________ ____________

Relationship

____

Address   City   State   Zip

Secondary: Full Name ______________________________________ ____________

Relationship

____

Address   City   State   Zip

SECTION IV : NON-MEDICAL HISTORY *(Must be answered for all Proposed Insureds)* **Part I**

	HAS PROPOSED INSURED:	Prop. Ins. Yes No	Spouse Yes No	Children Yes No
1.	Used tobacco or nicotine of any kind over the last 5 years? Type: Frequency: Date last used:	☐ ☐	☐ ☐	☐ ☐
2.	Consulted a physician or had treatment for the use or possession of: A. Alcohol?	☐ ☐	☐ ☐	☐ ☐
	B. Narcotics, stimulants, sedatives, hallucinogenic drugs?	☐ ☐	☐ ☐	☐ ☐
3.	In the past 5 years, been convicted of (i) two or more moving violations, (ii) driving under the influence of alcohol or other drugs, or (iii) had their driver's license suspended or revoked?	☐ ☐	☐ ☐	☐ ☐
4.	Have any proposed insureds ever been convicted of, or pled guilty or no contest to a felony, or do they have any such charge pending against them?	☐ ☐	☐ ☐	☐ ☐
5.	Flown as a pilot, student pilot, or crew member, or intend to fly as such?	☐ ☐	☐ ☐	☐ ☐
6.	Been a member of , or applied to be a member of, or received a notice of required service in, the armed forces, reserves or National Guard? *(If "Yes", please list: branch of service, rank, duties, mobilization category and current duty station in Section VI below.)*	☐ ☐	☐ ☐	☐ ☐
7.	Engaged in auto, motorcycle or boat racing, parachuting, skin or SCUBA diving, skydiving, hang gliding or other hazardous avocation or hobby?	☐ ☐	☐ ☐	☐ ☐
8.	Had a request for life or health insurance declined, postponed, rated, canceled, or restricted in any way?	☐ ☐	☐ ☐	☐ ☐
9.	Any application for any other life or health insurance on your life now pending or contemplated in this or any other company?	☐ ☐	☐ ☐	☐ ☐
10.	Is there an intention that any party, other than the owner, will obtain any right, title, or interest in any policy issued on the life of the proposed insured as a result of this application?	☐ ☐	☐ ☐	☐ ☐
11.	**Is Proposed Insured:**			
	a). A citizen of any other country besides U.S.? If so, what country? ______________________	☐ ☐	☐ ☐	☐ ☐
	b). Have you lived outside of North America at any time during the last 3 years?	☐ ☐	☐ ☐	☐ ☐
	c). Intending to travel outside the United States or Canada within the next 12 months? To where: When: Why: For how long:	☐ ☐	☐ ☐	☐ ☐

SECTION V : MEDICAL HISTORY

	HAVE YOU EVER BEEN TREATED FOR OR TOLD YOU HAD:	Prop. Ins. Yes No	Spouse Yes No	Children Yes No
12.	A. Cancer, diabetes, epilepsy, heart disorder, high blood pressure, stroke, mental or nervous disorders, tumors, ulcers, or any disorder of bladder, kidney, liver or lungs?	☐ ☐	☐ ☐	☐ ☐
	B. AIDS (acquired immune deficiency syndrome) or ARC (AIDS-related complex)?	☐ ☐	☐ ☐	☐ ☐
	C. Arthritis, gout, or other disorders of muscles, joints, spine, stomach, intestines, or chest pain or asthma?	☐ ☐	☐ ☐	☐ ☐
	HAVE YOU:			
13.	Within the last 12 months, had any kind of medication prescribed?	☐ ☐	☐ ☐	☐ ☐
14.	Been advised to have, or contemplated having a surgical operation?	☐ ☐	☐ ☐	☐ ☐
15.	Within the last 5 years, suffered from any disease, or received medical or surgical treatment for any condition not listed in question 12?	☐ ☐	☐ ☐	☐ ☐
16.	List current height and weight for all persons proposed for coverage. *(If more than one child proposed for insurance, list in Section VI below.)* Height Weight	_______ _______	_______ _______	_______ _______

SECTION VI : DETAILS TO ANY "YES" ANSWERS TO QUESTIONS #1 THROUGH #15 ABOVE

(Must be answered, if applicable)

Name of Proposed Insured	Question Number	Date	Details or Reason	Name, Address, and Phone Number of Attending Doctor or Hospital

SECTION VII : EXISTING COVERAGE AND PENDING INSURANCE

(Must be answered completely on all cases.)

17. Regarding all persons proposed for insurance, list all life insurance in force on each proposed insured's life. Please be sure to include insurance whether owned by the insured or not. **If "none" please state it below.**

Name of Insured	Company	Contract Number	Type of Coverage	Life Amount	Business or Personal	Year Issued

SECTION VIII : REPLACEMENT *(Must be answered completely on all cases.)*

18. Is the policy applied for to replace an existing insurance or annuity policy(ies) in this or any other company? ☐ Yes ☐ No
(If 'yes', give details in Section XI below and complete any State required replacement forms and comparison statements.)

SECTION IX : OWNERSHIP OF POLICY

Name of Owner (if other than Proposed Insured) Social Security No. or Taxpayer I.D. No.

Address City State Zip Code

SECTION X : BUSINESS INSURANCE

a. What is the purpose of the insurance (Key Person, Buy & Sell, Split Dollar, etc.)? ________

b. What percent of business does Proposed Insured own or control? ________ %

c. What is approximate net annual income of business? $ ________

d. What is approximate net worth of business? $ ________

e. What year was the business established? ________

f. Business insurance on other Owners, Officers, Partners, or Key Persons

Name and Title	% of Business Owned	Insurance Company	Amount Now Carried or Applied For
	%		$
	%		$
	%		$

SECTION XI : REMARKS AND SPECIAL REQUESTS

Home Office Endorsements:

DECLARATIONS

I (We) represent that all statements and answers made in all parts of this application are full, complete and true to the best of my (our) knowledge and belief. It is agreed that:

1. All such statements and answers shall be the basis for and a part of any policy issued on this application.
2. No agent or medical examiner can accept risks or make or change contracts or waive West Coast Life's rights or requirements.
3. No insurance shall take effect unless the Proposed Insured(s) is (are) alive and in the same condition of health as described in this application when the policy is delivered to the Owner and the full first premium is paid. However, if the full first premium is paid as set forth in the attached Conditional Coverage Receipt and this Receipt is delivered to the Owner, the terms of this Receipt shall apply.
4. Acceptance of a policy by the Owner shall constitute ratification of any changes made by West Coast Life under "Home Office Endorsements." In those states where it is required, changes in plan of insurance, amount, age at issue, classification of risk or benefits will be made only with the Owner's written consent.

I UNDERSTAND THAT THIS COVERAGE INCLUDES A BINDING ARBITRATION AGREEMENT. THE ARBITRATION AGREEMENT REQUIRES THAT ANY DISAGREEMENT RELATED TO THIS COVERAGE, INCLUDING ITS SALES AND SOLICITATION, MUST BE RESOLVED BY ARBITRATION AND NOT IN A COURT OF LAW. THE RESULTS OF THE ARBITRATION, A PANEL OF 3 ARBITRATORS WHO ARE INDEPENDENT, NEUTRAL PARTIES, GIVES A DECISION AFTER HEARING THE POSITIONS OF THE PARTIES. WHEN YOU ACCEPT THIS INSURANCE COVERAGE, YOU AGREE TO RESOLVE ANY DISAGREEMENT RELATED TO THE COVERAGE BY BINDING ARBITRATION INSTEAD OF A TRIAL IN COURT INCLUDING A TRIAL BY JURY. ARBITRATION TAKES THE PLACE OF RESOLVING DISPUTES BY A JUDGE AND JURY AND THE DECISION OF THE ARBITRATION PANEL CANNOT BE REVIEWED IN COURT BY A JUDGE AND JURY.

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. An insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Affairs.

Signed At ______________________________ (City and State)

Date ______________________________

(X) ______________________________
Signature of Proposed Insured

(X) ______________________________
Signature of Spouse, If Proposed for Insurance

(X) ______________________________
Signature of Owner, If Other than Proposed Insured

(X) ______________________________
Signature of Agent

WCL-100A-CO (9/08)

AGENT'S REPORT

I CERTIFY THAT: (1) THE ANSWERS GIVEN IN THIS APPLICATION ARE COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF; (2) I KNOW OF NOTHING AFFECTING THE RISK WHICH IS NOT SET FORTH IN MY AGENT'S CONTRACT OR THIS LIFE INSURANCE APPLICATION; AND (3) I CAREFULLY EXPLAINED EACH QUESTION BEFORE RECORDING EACH ANSWER AND BEFORE THE APPLICATION WAS SIGNED.

1. Do you understand that no final underwriting offer is valid unless a policy has been issued and delivered? ☐ Yes ☐ No
2. How long have you known insured? ______________________________ Years ________________________ Months
3. Is insured a relative or does the insured have a business relationship with you? ☐ Yes ☐ No
4. Does proposed insured appear healthy and free from visible or known impairments or disability? ☐ Yes ☐ No
5. Do you have any reason to believe that the life insurance policy applied for will replace any life insurance or annuity from West Coast Life or another company? ☐ Yes ☐ No
   (If YES, Provide policy number(s) and company(ies) below, and complete any comparison statements required by law.)

   ____

6. Have you advised the proposed policyowner or do you know of any advice that has been given to the proposed policyowner to transfer the ownership of the policy being applied for to a life settlement company or other entity associated with stranger owned or investment owned life insurance (commonly called SOLI or IOLI) or are you otherwise aware that the policyowner may be contemplating such a transfer? ☐ Yes ☐ No
7. Is Premium Financing involved in this case? *(If YES, please submit a cover letter describing the parameters.)* ☐ Yes ☐ No
8. Family History

Primary Proposed Insured	Age if Living	Age at Death	Cardiac Conditions or Heart Disease?		Cancer History?		Type
Father			☐ No	☐ Yes, age of onset _______	☐ No	☐ Yes, age of onset ________ If Yes, date of onset __________	
Mother			☐ No	☐ Yes, age of onset _______	☐ No	☐ Yes, age of onset ________ If Yes, date of onset __________	
Siblings			☐ No	☐ Yes, age of onset _______	☐ No	☐ Yes, age of onset ________ If Yes, date of onset __________	

9. INDICATE CLASSIFICATION BASIS FOR THIS SALE: ☐ Super Preferred ☐ Preferred ☐ Standard
   ☐ Rated Table A, B, C, D, E, F, H (circle one) ☐ Other ____________________________ ☐ Non-Tobacco ☐ Tobacco

Place any special remarks here:

I have verified the identity of the Owner by picture I.D. (Does not apply to direct marketing situations.) Identification type: _________________________

Please include Driver's License Number if Owner is other than the Proposed Insured. ____
In Georgia, please include a copy of the Driver's License with application.

BGA Name: ____

BGA Contract Number: ____________________________________

For Underwriting and New Business Contact Purposes:

BGA Fax Number: ____

BGA E-Mail Address: ____

Agent's Signature	Agent's Commission Code No.	Business Phone	
Agent's Printed Name	Agent's E-Mail Address	Date	Place
Agent's Signature	Agent's Commission Code No.	Business Phone	
Agent's Printed Name	Agent's E-Mail Address	Date	Place

WEST COAST LIFE INSURANCE COMPANY
P.O. Box 193892
San Francisco, CA 94119-3892

DESCRIPTION OF INFORMATION PRACTICES

(Including Medical Information Bureau Notice and Fair Credit Reporting Act Notice)

In considering your application for insurance, information from various sources must be considered. These include the results of your physical examination, if required, and any reports West Coast Life may receive from doctors and hospitals who have attended you.

Information regarding your insurability will be treated as confidential. West Coast Life, 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 such 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 the 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, Massachusetts 02184-8734.

West Coast Life, 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.

Furthermore, as part of our procedures for processing your insurance application, an investigative consumer report may be prepared by one or more of the commercial agencies offering this service whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics and mode of living except as may be related directly or indirectly to your sexual orientation. You have the right to be personally interviewed if we order an investigative consumer report. You also have the right to receive a copy of the report, and by making a written request to West Coast Life within a reasonable period of time to receive additional detailed information about the nature and scope of this investigation.

As a general practice, we will not disclose personal or privileged information about you to anyone else without your consent, unless a legitimate business need exists or disclosure is required or permitted by law. You are entitled, upon request, to receive a more detailed statement of our information practices. You also have the right to access the personal information about you that we have in our records. You may see and copy the information, or we will send it to you, whichever you prefer. You also have the right to request correction of personal information we may have about you which you think is wrong. To exercise these rights, please write to us at the address appearing at the end of this notice.

Ask our agent for assistance, or call or write us at West Coast Life Insurance Company, Attention: Chief Underwriter, Underwriting Department, P.O. Box 193892, San Francisco, CA 94119-3892. Telephone 800-366-9378

THIS NOTICE MUST BE GIVEN TO PROPOSED INSURED

Producer Compensation Disclosure

Agents/Producers receive compensation from an insurer or third party, which may differ depending upon the product or insurer. Additional compensation may be received by the Agent/Producer based on other factors including premium volume placed with the company and loss or claim experience.

WCL-DIP (9/08)

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.

I understand that authorizing the drafting of the initial premium and providing the account information does not provide any life insurance coverage on myself or any applicant listed on the application for life insurance unless I have signed, dated and met the terms and conditions of the West Coast Life Conditional Receipt/Temporary Receipt* AND the signed and dated receipt is received by the Company along with the application for life insurance.

*Temporary Receipt ONLY available in KS.

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**____________________ Date ____________________

Day- time Phone Number ____________________

Please complete and return to our office with a **voided check** by one of the following methods:

Return By Mail: **West Coast Life Insurance Company**
P.O. Box 193892
San Francisco, CA 94119

Return By Fax: **205-268-6829 Attn: Post Issue Department**

WCL-414 (9/08)

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 $_________________ for an amount equal to the premium due on the policy applied for, or 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 OR CASH EQUIVALENTS (MONEY ORDERS, TRAVELERS CHECKS, CASHIER'S CHECKS, THIRD PARTY CHECKS, AGENCY CHECKS) WILL NOT BE ACCEPTED. PREMIUM CANNOT BE ACCEPTED FOR CASES IN WHICH THE PROPOSED INSURED INTENDS TO LEAVE THE UNITED STATES WITHIN THE NEXT 60 DAYS.

NOTE: Premium may not be collected if 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 $1,000,000 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 $1,000,000.** 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 not honored by the drawee bank upon presentation;
(B) 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: ______________________________

Home Office Copy

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 $_________________ for an amount equal to the premium due on the policy applied for, or 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 OR CASH EQUIVALENTS (MONEY ORDERS, TRAVELERS CHECKS, CASHIER'S CHECKS, THIRD PARTY CHECKS, AGENCY CHECKS) WILL NOT BE ACCEPTED. PREMIUM CANNOT BE ACCEPTED FOR CASES IN WHICH THE PROPOSED INSURED INTENDS TO LEAVE THE UNITED STATES WITHIN THE NEXT 60 DAYS.

NOTE: Premium may not be collected if 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 $1,000,000 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 $1,000,000.** 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 not honored by the drawee bank upon presentation;
(B) 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: ______________________________________

Applicant Copy

WEST COAST LIFE INSURANCE COMPANY • P. O. Box 193892 • San Francisco, CA 94119-3892

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

1. This authorization to obtain and disclose information complies with HIPAA regulations that exempt the minimum necessary rules as they apply to life insurance. I (we) authorize West Coast Life Insurance Company (West Coast Life) and its reinsurers to obtain directly through designated third parties and use any information about or relating to me (us) that may affect my (our) insurability. West Coast Life and its reinsurers may obtain and use health and medical information to include all dates of service, including but not limited to information about chart notes, EKG's, drug use, alcohol use, nicotine use, physical and mental diseases and illness, and psychiatric disorders. West Coast Life and its reinsurers may also obtain and use non-health and non-medical information, including but not limited to financial information, credit reports, consumer reports, driving record, criminal record, and information about avocations and aviation activity. All of this information may be used to evaluate an application for insurance, a claim for insurance benefits, or both. Information relating to communicable diseases and other risk factors relating to me or to my spouse and life partner may be used to evaluate an application for insurance on either me or my spouse and life partner. The West Coast Life sales agent or regional sales office representing me on my (our) application for insurance may obtain the information described in this paragraph directly from any of the persons or organizations listed in paragraph 2 in order to expedite the delivery of the information to West Coast Life.
2. I (we) authorize the following persons and organizations to release and disclose the information described in paragraph 1 to West Coast Life, directly through designated third parties or its agents acting on its behalf; (i) my (our) doctor(s); (ii) medical practitioners; (iii) pharmacists and Pharmacy Benefit Managers; (iv) medical and related facilities, including hospitals, clinics, facilities run by the Veteran's Administration, Kaiser Permanente, The Cleveland Clinic Foundation including all satellite facilities and The Mayo Clinic; (v) insurers; (vi) reinsurers; (vii) Medical Information Bureau, Inc. **(MIB)**; (viii) my (our) current and previous employers; and (ix) commercial consumer reporting agencies **(CRA)**. All of these persons and organizations other than **MIB** may release the information described above to a **CRA** acting for West Coast Life. **MIB** may not release the information described in paragraph 1 to a **CRA**.
3. I (we) authorize West Coast Life to draw and test my (our) blood, and/or oral fluids, and urine as may be necessary to obtain information to be used to underwrite my (our) application for insurance. These tests may include, but are not limited to, tests for cholesterol and related blood lipids, diabetes, liver or kidney disorders, immune disorders (other than HIV/AIDS; reference number 5 below), and the presence of drugs, nicotine, or their metabolites. This authorization does not include genetic testing. Unless otherwise required by law or regulation, West Coast Life may, but is not obligated to, release any of these test results directly to me or to my spouse and life partner.
4. I (we) authorize West Coast Life to release and disclose the information described in paragraphs 1 and 3 to its affiliates, its reinsurers, persons or organizations providing services relating to insurance underwriting for West Coast Life, **MIB**, and as otherwise required by law. West Coast Life may release and disclose the information described in paragraphs 1 and 3 to other insurers if I (we) have applied or apply to the other insurers for insurance. West Coast Life may release and disclose the information described in paragraphs 1 and 3 to the sales agent representing me on my (our) application for insurance if it is necessary to provide an explanation of the reasons for West Coast Life's decision to impose special underwriting requirements, whenever my application cannot be approved as submitted, or in connection with a claim for benefits.
5. **SPECIAL REQUIREMENT FOR HIV/AIDS TESTING**. If West Coast Life intends to test for the presence of antibodies to the Human Immunodeficiency Virus (HIV), which is the virus that has been associated with Acquired Immune Deficiency Syndrome (AIDS), West Coast Life may require me (us) to authorize that testing separately. I (we) hereby authorize West Coast Life to obtain and use the results of any HIV tests that I (we) separately authorize, and if permitted by law, to disclose the results of those tests to its reinsurers and **MIB**.
6. This authorization shall be valid for 12 months from the date shown below or, in the event of a claim for benefits, for the duration of such claim.
7. During the evaluation of my (our) insurance application, I (we) understand that I (we) have the right to revoke the authorizations in paragraphs 1 through 5 by writing to West Coast Life at P.O. Box 193892 • San Francisco, CA 94119-3892.
   If this authorization is revoked, this would result in the file being closed and no coverage provided.
8. ☐ I (we) have been given a copy of this authorization form and West Coast Life's Description of Information Practices.
   ☐ I (we) would like to be interviewed if an investigative consumer report will be made. *(Please check if you wish to be interviewed.)*
   ☐ If performed, I (we) would like copies of my (our) blood profile test results.
9. I (we) understand that information about me (us) may be disclosed under this authorization to persons or organizations that are not subject to the Health Insurance Portability and Accountability Act **(HIPAA)** and that the information would then no longer be protected by **HIPAA** and any related regulations.
   I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction. Any modifications to this authorization may preclude our ability to process this application.
10. I understand I do not have to sign this authorization in order to obtain **health care benefits (treatment, payment or enrollment).**

THIS AUTHORIZATION MUST BE SIGNED WITHOUT MODIFICATION AND RETURNED WITH THE APPLICATION BEFORE PROCESSING.

		Date of Authorization: ______________
Proposed Insured 1 (Signature)	Date of Birth	When applicable, print name(s) of minor(s) below:
Print Name	Social Security #	
Proposed Insured 2 (Signature)	Date of Birth	
Print Name	Social Security #	**Health Care Provider**
Parent or Legal Guardian (Signature)		Physician Name
		Physician Name