Legal & General AMERICA

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

INDIVIDUAL LIFE INSURANCE APPLICATION
(Please Print)

SECTION A PROPOSED INSURED

1. Full 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 Section J - Details.)
Street _____
City, State _____ Zip _____

5. b. How Long

6. Phone Numbers
Home _____
Work _____

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. Annual Income

14. Total Net Worth

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

15. b. How Long Employed

SECTION B BENEFICIARY (Share percentage totals must equal 100%. If necessary, use Section J - Details.

If Beneficiary is a trust, check box ☐ and complete Sections B and D.)

16. Primary
Name _____ SSN or Tax ID # _____ Date of Birth _____
Address _____ City, State _____ Zip _____
Relationship to the Proposed Insured _____ % Share _____

Name _____ SSN or Tax ID # _____ Date of Birth _____
Address _____ City, State _____ Zip _____
Relationship to the Proposed Insured _____ % Share _____

17. Contingent
Name _____ Relationship _____ % Share _____
SSN _____ Date of Birth _____

Name _____ Relationship _____ % Share _____
SSN _____ Date of Birth _____

SECTION C OWNER (Will be Proposed Insured unless otherwise indicated in this section.)

18. Owner is ☐ Trust (If checked must complete Sections C and D.) ☐ Other than Proposed Insured or Trust
Name _____ SSN or Tax ID # _____ Date of Birth _____
Address _____ City, State _____ Zip _____
Contact Phone # _____ Relationship to Proposed Insured _____
Email address _____ If Owner is a business, web site address _____

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

19. Exact Name of Trust _____ Trust Tax ID# _____
Current Trustee(s) _____ Date of Trust _____

Policy Number (if assigned) _____

SECTION E PAYOR

20. Send premium notices to: ☐ Employer ☐ Other - If Other, complete the information below

Name _____ Relationship to Insured/Owner(s) _____

Address _____ City, State _____ Zip _____

Contact Phone # _____ Email address _____

SECTION F INSURANCE APPLIED FOR

21. Amount of Insurance $ _____

22. Frequency of premium payment: ☐ Annual ☐ Semi-annual ☐ Quarterly ☐ Monthly

SECTION G OTHER INSURANCE

23. a. Are you currently applying, or do you intend to apply, for additional life insurance coverage? ..... ☐ Yes ☐ No

b. If Yes, what is the total amount of insurance you intend to accept? $ _____

24. Have you replaced other life insurance policies in the past 2 years? ..... ☐ Yes ☐ No
(If Yes, provide details in Section J - Details.)

25. a. Do you currently have life insurance coverage (except group insurance)? ..... ☐ Yes ☐ No

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 Section J - Details.)

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

SECTION H PROPOSED INSURED'S HISTORY

26. In the past 90 days, has the Proposed Insured been at work on a full-time basis performing all duties of his/her regular occupation for at least 30 hours per week? (If No, provide details in Section J - Details.) ..... ☐ Yes ☐ No

27. In the past 90 days, has the Proposed Insured been absent from his/her customary place of employment for 5 or more work days due to illness or medical treatment? (If Yes, explain in Section J - Details.) ..... ☐ Yes ☐ No

SECTION I PROPOSED INSURED'S HISTORY (Complete only if age 71 or older, or as required. Provide explanations for Yes answers in Section J - Details.)

Medical facility includes medical center, hospital, mental health facility, or any facility for drug or alcohol treatment. **Care Provider** includes, but is not limited to, persons licensed as physicians; chiropractors; physical therapists; psychologists; drug , alcohol, or mental health counselors.

28. In the past 5 years, has the Proposed Insured had his/her driver's license suspended or revoked, or been the driver of a motor vehicle involved in an accident in which they were found to be at fault? ..... ☐ Yes ☐ No

29. In the past 5 years, has the Proposed Insured been examined or treated by a care provider, been examined or treated at a hospital or other medical facility, or been counseled or treated for alcohol or other drug use? ..... ☐ Yes ☐ No

30. Has the Proposed Insured ever been treated for any of the following:

a. Stroke, high blood pressure, chest pain, or disease of the heart or blood vessels? ..... ☐ Yes ☐ No

b. Cancer? ..... ☐ Yes ☐ No

c. Respiratory disease, kidney disease, liver disease, or diabetes? ..... ☐ Yes ☐ No

d. Mental or nervous disorder? ..... ☐ Yes ☐ No

SECTION J DETAILS - Include question #, reasons, dates, diagnosis, duration, names and addresses of medical facilities/care providers.

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 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.

I agree that: **I/we will notify the Insurer if any statement or answer given in any part of the application changes prior to policy delivery. Insurance will not begin unless all persons proposed for insurance are living and insurable as set forth in the application at the time a policy is delivered to and accepted by the Owner and the first modal premium is paid.**

Changes or corrections made by the Company and noted in Section J - Details 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.

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 the Medical Information Bureau (MIB, Inc.), 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. 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 that any information gathered during the evaluation of my application may be disclosed to: reinsurers; the MIB, Inc.; 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 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 Bee Creek Avenue, Frederick, Maryland [illegible] understand that information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

The authorization will be valid for 30 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 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 Medical Information Bureau Pre-Notice Disclosure and the Federal Fair Credit Reporting Notice.

I authorize and appoint the Payor named in this application to act as my Agent for the sole purpose of receiving, accepting, and acknowledging delivery of any resulting insurance policy, and/or any other delivery requirement, issued pursuant to this application.

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) State in which Owner Signs the Application

_____ _____ _____
Print Name of Owner Owner/Officer Title Date

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