LINCOLN BENEFIT LIFE COMPANY
A Member of Allstate Financial Group
P.O. Box 80469, Lincoln, Nebraska 68501
PART I - APPLICATION FOR LIFE INSURANCE

Section A – PRIMARY PROPOSED INSURED

1. Name (First, Middle, Last) | Birthdate (M/D/Y) | Height and Weight Ft. In. Lbs.

Age | Sex | Birth State | Marital Status | Driver's License #/State | Social Security No.

Home Address | City | State | Zip | How Long?

2. Employer Name | Home Phone ( ) - | Work Phone ( ) -

Employer Address | City | State | Zip | How Long?

Occupation and Job Duties | Annual Income $

3. Tobacco or nicotine products currently used: ☐ None ☐ Cigarettes Packs/day___ ☐ Other_____

Used in past 3 years other than above? ☐ No ☐ Yes-Type? _____ When Quit?_____

4. (a) Primary Beneficiary(ies)** | Address

Relationship | Age | SSN/Tax ID # | City | State | Zip

(b) Contingent Beneficiary(ies)** | Address

Relationship | Age | SSN/Tax ID # | City | State | Zip

***Surviving beneficiaries in the same class (primary or contingent) share equally unless otherwise stated.*

Section B – ADDITIONAL OR JOINT INSURED *(If more than one, submit additional copies of Section B.)*

1. Name (First, Middle, Last) | Birthdate (M/D/Y) | Height and Weight Ft. In. Lbs.

Age | Sex | Birth State | Marital Status | Driver's License #/State | Social Security No.

Home Address | City | State | Zip | How Long?

2. Employer Name | Home Phone ( ) - | Work Phone ( ) -

Employer Address | City | State | Zip | How Long?

Occupation and Job Duties | Annual Income $

3. Tobacco or nicotine products currently used: ☐ None ☐ Cigarettes Packs/day___ ☐ Other_____

Used in past 3 years other than above? ☐ No ☐ Yes-Type? _____ When Quit?_____

4. (a) Primary Beneficiary(ies)** | Address

Relationship | Age | SSN/Tax ID # | City | State | Zip

(b) Contingent Beneficiary(ies)** | Address

Relationship | Age | SSN/Tax ID # | City | State | Zip

***Surviving beneficiaries in the same class (primary or contingent) share equally unless otherwise stated.*

Section C – CHILDREN PROPOSED FOR COVERAGE UNDER CPR

(Must be Insured's children, adopted children, or stepchildren age 17 or less)

1. Name (First, Middle, Last) | Birthdate (M/D/Y) | Age | Sex

/ /

/ /

/ /

/ /

Section D – OWNER IF OTHER THAN THE FIRST NAMED INSURED

1. Owner Name (if other than Primary Insured) | Relationship | Home Phone ( ) -

Address | City | State | Zip | SSN/Tax ID #

2. ☐ Joint Owner** ☐ Contingent Owner** | Relationship | Home Phone ( ) -

Address | City | State | Zip | SSN/Tax ID #

***Check only one. Joint owners have right of survivorship. Contingent owner succeeds to ownership if Primary Owner dies.*

Section E – THE POLICY

1. Plan of Insurance _____
2. Face Amount $_____
3. Planned Premium $_____
4. Death Benefit Option: ☐ 1 ☐ 2
5. Premium Mode: ☐ Single ☐ Annual ☐ Semiannual ☐ Quarterly Direct ☐ Quarterly BOM ☐ Monthly BOM
6. Optional Coverage:

☐ Accidental Death Benefit on (Name)_____ ☐ WP or COP $_____

☐ CPR - ☐ 1 Unit ($5,000) ☐ 2 Units ($10,000) ☐ Other:_____

☐ PTR $_____ ☐ AIR $_____ on (Name)_____

Section F – OTHER INSURANCE / REPLACEMENT INFORMATION

1. Does anyone proposed for this insurance now have any life insurance or annuity:	Yes	No
a. in force or application(s) pending in any company?	☐	☐
b. which will be replaced, changed or borrowed against because of this application? *(Circle applicable policy numbers.)*	☐	☐
c. which will be part of a 1035 exchange because of this application? *(Do not 1035 exchange an annuity to life insurance.)*	☐	☐

If a, b, or c is answered "Yes," give details below and submit appropriate replacement and/or 1035 exchange form(s) and policy illustrations.

Person Covered	Person Covered
Company Name	Company Name
Face Amt. ADB Amt. Date Applied (M/D/Y) / /	Face Amt. ADB Amt. Date Applied (M/D/Y) / /
Policy Number Plan Type	Policy Number Plan Type
Person Covered	Person Covered
Company Name	Company Name
Face Amt. ADB Amt. Date Applied (M/D/Y) / /	Face Amt. ADB Amt. Date Applied (M/D/Y) / /
Policy Number Plan Type	Policy Number Plan Type

Section G – NONPHYSICAL DATA AND TEMPORARY INSURANCE QUALIFIERS

1. In the past 3 years has anyone proposed for insurance: **Explain any "yes" answers in Details section on Page 4.**

		Yes	No
a.	had 3 or more traffic tickets, been arrested for driving under the influence of drugs or alcohol, or had their driver's license suspended or revoked?	☐	☐
b.	flown as pilot or crew member of any aircraft?	☐	☐
c.	engaged in sky or scuba diving, vehicle racing or mountain climbing?	☐	☐
2.	Has anyone proposed for insurance EVER had an application for life insurance declined, postponed, rated or modified?	☐	☐
3.	Are there any proposed insureds who have lived in the U.S. less than 3 years, plan to travel outside the U.S. in the next 2 years or are not U.S. citizens?	☐	☐
4.	In the past 10 years, has anyone proposed for insurance:		
a.	been charged with a felony?	☐	☐
b.	used, or been arrested for possession, sale or delivery of, illegal drugs?	☐	☐
c.	sought or received treatment or advice for use of cocaine, heroin, narcotics, hallucinogens or other mind altering substances not prescribed by a physician?	☐	☐
d.	sought or received treatment or advice for coronary artery disease, stroke, AIDS (Acquired Immune Deficiency Syndrome), or been told they have had any of these disorders?	☐	☐
e.	been treated for or diagnosed with cancer other than basal cell skin cancer?	☐	☐

Do not submit payment with application if any of questions 4(a) through 4(e) are answered "yes" or not answered.

Section H – HEALTH AND MEDICAL HISTORY

All questions apply to all proposed insureds including children proposed for coverage under CPR. Circle applicable conditions.

Explain any "yes" answers in Details section on Page 4.

1. Has anyone proposed for insurance EVER been treated for, had any sign or symptom of, or been told that he/she had:

		Yes	No
a.	high blood pressure or any disorder of heart or blood vessels?	☐	☐
b.	cancer or tumor?	☐	☐
c.	dependency on or addiction to alcohol or any drug?	☐	☐

2. In the past 10 years, has anyone proposed for insurance been treated for, had any sign or symptom of, or been told that he/she had:

		Yes	No
a.	epilepsy or seizures, disorder of brain or nervous system, mental or nervous disorder?	☐	☐
b.	diabetes, thyroid or glandular disorder?	☐	☐
c.	asthma, emphysema or other lung disorder?	☐	☐
d.	any disorder of digestive tract, liver or pancreas?	☐	☐
e.	anemia or other disorder of blood or blood cells except HIV status?	☐	☐

2. Continued

		Yes	No
f.	disorder of kidneys, bladder or reproductive organs?	☐	☐
g.	arthritis or disorder of bones, skin or muscle?	☐	☐

3. Other than above, in the past 5 years, has anyone proposed for insurance:

a.	had a checkup, consultation, hospitalization, illness, surgery, or medical or diagnostic test?	☐	☐
b.	been advised to have a medical consultation, diagnostic test, or surgery which has not been done?	☐	☐
4.	Other than above, is anyone proposed for insurance currently taking any prescription medication?	☐	☐
5.	Does anyone proposed for insurance have a family history of heart disorder or cancer beginning before age 60 in any natural parent or sibling? *(If "Yes," complete table below).*	☐	☐

Relative	Disorder	Age at Onset	Age at Death	Age if Living

6. Primary Physician (Name, First and Last) Date last seen / / Reason Result

Address City State Zip Phone Number ( ) -

DETAILS of "Yes" answers in Sections G and H.

Ques. #	Date	Proposed Insured	Symptoms, Diagnosis, Treatment	Physician/Facility Name, Address and Phone

REMARKS

AGENT REMARKS / ADDITIONAL INFORMATION

FOR HOME OFFICE ENDORSEMENTS ONLY

If office corrections have been made, they may be found on the page immediately following the application.

SUPPLEMENTAL OTHER INSURANCE / REPLACEMENT INFORMATION

Person Covered	Person Covered
Company Name	Company Name
Face Amt. ADB Amt. Date Applied (M/D/Y) / /	Face Amt. ADB Amt. Date Applied (M/D/Y) / /
Policy Number Plan Type	Policy Number Plan Type

SUPPLEMENTAL BENEFICIARY INFORMATION

(a) Primary Beneficiary(ies)** Address

Relationship Age SSN/Tax ID # City State Zip

(a) Primary Beneficiary(ies)** Address

Relationship Age SSN/Tax ID # City State Zip

(b) Contingent Beneficiary(ies)** Address

Relationship Age SSN/Tax ID # City State Zip

(b) Contingent Beneficiary(ies)** Address

Relationship Age SSN/Tax ID # City State Zip

SUPPLEMENTAL MEDICAL DETAILS

PERMIT TO OBTAIN AND DISCLOSE CERTAIN DATA

A. Lincoln Benefit Life Company, its reinsurers, and consumer reporting agencies may get data about my (our) health, occupations, mode of living (except as may be related directly or indirectly to sexual orientation), avocations and any other non-medical information. I understand that the information obtained by use of this authorization will be used to determine eligibility for insurance and/or benefits, or for Lincoln Benefit Life Company to determine its obligations under the policy issued in connection with this application.

B. Any doctor, practitioner, medical or medically related facility, the Veterans Administration, the Medical Information Bureau, Inc. (MIB, Inc.), viatical settlement company, employer, consumer reporting agency, insurance company or insurance-support organization which has such data about me or my children may give such data to Lincoln Benefit Life Company when this permit or a copy of it is shown. All sources but the MIB, Inc., may give such data to agencies Lincoln Benefit Life Company has hired to retrieve the information.

C. Any request by Lincoln Benefit Life Company for medical records is on my behalf; the information must be provided within any requirements imposed by applicable state statutes governing patient access to medical records.

D. Data about mental illness, alcoholism, sexually transmitted diseases, and the use of drugs are to be included.

E. Lincoln Benefit Life Company or its reinsurers may make a brief report about me or my children to the MIB, Inc.

F. This permit is good for 30 months after it is signed.

G. Lincoln Benefit Life Company may obtain an investigative consumer report ("inspection report") on me.

☐ I want to be interviewed if such a report is obtained.

H. I have read this permit and know I may request a copy of it. I also have received the NOTICE REGARDING MIB, INC., NOTICE UNDER THE FAIR CREDIT REPORTING ACT and INSURANCE INFORMATION PRACTICES.

DECLARATIONS

A. I (each undersigned) declare that all answers written on this application are full and correct to the best of my knowledge and belief. Except in Maine, Missouri, Oregon, and South Carolina, Lincoln Benefit Life Company is not presumed to know any information not in this application.

B. Lincoln Benefit Life Company may add to or correct the Application in the space "For Home Office Endorsements Only" on an addendum page immediately following the application. Any changes are agreed to if the policy issued is accepted by me (us), but written agreement will be obtained from me for any change in insurance amount, plan, benefits, payment class or age at issue. (In West Virginia and Pennsylvania, written consent will be obtained for any changes.)

C. Insurance will start only as provided in the Receipt and Temporary Insurance Agreement issued in connection with this application. If no receipt is issued, or if insurance under it has stopped and not started again, no insurance will start by reason of the application until the policy is delivered and the first payment is accepted by Lincoln Benefit Life Company. In this case, the insurance will start when the policy is delivered and the first premium paid in full. No insurance will start if at that time the health of all proposed insureds is not as described in the application.

D. I acknowledge that I have read and understand this application, including the notices regarding the Fair Credit Reporting Act, MIB, and Insurance Information Practices. I acknowledge receipt of these notices.

E. Only an officer of Lincoln Benefit Life Company may change this application or waive a right or requirement. No agent may do this.

ALL QUESTIONS WERE ASKED OF ME AND, IF APPLICABLE, THE ADDITIONAL/JOINT INSURED AND PARENT(S) OF ANY CHILDREN LISTED ON THIS APPLICATION. I (WE) HAVE READ ALL INFORMATION BEFORE SIGNING.

SIGNED AT (City, State)	**DATE (M/D/Y)** / /	**X** **SIGNATURE OF PRIMARY PROPOSED INSURED**
X **SIGNATURE OF AGENT**		**X** **SIGNATURE OF ADDITIONAL/JOINT INSURED**
X **SIGNATURE OF OWNER**		**X** **SIGNATURE OF PARENT (*If ANY insured under age 15)***
X **TITLE IF OWNER IS A BUSINESS OR OTHER ORGANIZATION.**		

FINANCIAL INFORMATION

1. *Complete if face amount > $250,000 or primary proposed insured is age 65 or older.* Data pertains to primary proposed insured, if insurance need based on his/her finances, otherwise to: ☐ spouse ☐ primary and spouse jointly ☐ other_____

   a) Net Worth Calculation

   Assets $ _____

   Liabilities $ _____

   Net Worth $ _____

   b) Total Income Calculation

   Earned Income $ _____

   Unearned Income $ _____

   Total Income $ _____

   c) Source of this information?

   ☐ Client

   ☐ Client's CPA

   ☐ My best estimate

   d) If face amount > $4,999,999, CPA-prepared personal financial statement is: ☐ provided ☐ available on request

2. *Complete for all business insurance cases (buy-sell, key person, etc).*

   a) Product/service sold _____ b) Year started _____ c) PI's ownership % _____

	Yes	No
d) Any pending reorganization, acquisition, merger or expansion of this business?	☐	☐
e) Has this business ever been subject to bankruptcy proceedings?	☐	☐
f) Are there any comparable owners/officers who are not being similarly insured?	☐	☐

   g) Business Equity (book value)

   Assets $ _____

   Liabilities $ _____

   Equity $ _____

   h) Last Year's Net Income (loss)

   Gross Revenue $ _____

   Expenses $ _____

   Net Income (loss) $ _____

   i) Source of this information?

   ☐ Client

   ☐ Financial Statement

   ☐ My best estimate

   j) Fair Market Value and how determined $_____

   k) Does the business have a web site? ☐ No ☐ Yes - give address: _____

   l) *If face amount $3,000,000 or more, please submit most recent financial statement for the business.*

Explanations, Special Instructions

AGENT REPORT

	Yes	No
1. Is the proposed insured related to you?	☐	☐
2. Are there any proposed insureds whom you did not see when you took the application?	☐	☐
3. To your knowledge, will the policy applied for replace any existing insurance or annuity?	☐	☐

4. What is the purpose of the insurance? _____

5. How long and how well have you known the primary proposed insured? _____

6. Have LBL's age/amount medical requirements been ordered? ☐ Yes ☐ No ☐ N/A 7. Rate class quoted?_____

8. To the best of your knowledge, do all proposed insureds meet LBL's published requirements for the rate class(es) quoted? ☐ Yes ☐ No

9. If primary proposed insured under age 18, how much life insurance is in force on:

Father $_____ Mother $_____ Siblings $_____

10. If the primary proposed insured is a nonemployed spouse, how much life insurance does the employed spouse have? $_____

Explanations, Special Instructions

Printed Name(s) of Agent(s)	Comm. %	Agent No(s).	Phone	Fax and E-mail
			( ) -	( ) -
			( ) -	( ) -

Date / /

Agent Signature _____

Joint Agent Signature _____

LINCOLN BENEFIT LIFE COMPANY

P.O. Box 80469, Lincoln, Nebraska 68501

RECEIPT AND TEMPORARY INSURANCE AGREEMENT ***(Referred to as "Agreement")***

- **All checks must be made payable to the company. Do not make checks payable to the agent or leave the payee blank.**
- **Do not submit money or give receipt if any of questions 4(a) through 4(e) in Section G are answered "Yes" or not answered.**

$ _____ has been received from _____

as a payment for the life insurance on (Insured/Additional/Joint Insured) _____

applied for on this date, except as limited in the Amount of Insurance section below.

NO INSURANCE WILL TAKE EFFECT EXCEPT AS DESCRIBED BELOW.

When Temporary Insurance Starts

If the payment has been accepted by us and Part I of the application has been completed on or before the date of this Agreement, temporary insurance under this Agreement will start on the later of: (1) the date of the Agreement; or (2) the date the last medical exam is completed.

When Temporary Insurance Will Stop

Temporary insurance under this Agreement will stop on the first of the dates below:

1. The date we write to the Owner that we have stopped considering the application. We have the absolute right to so stop.
2. The date we advise the Owner that a medical exam is required, in which event insurance will stop with respect only to the person(s) required to have a medical exam. Insurance under this Agreement will start again for the person(s) when the last of the required medical exams is done. We have the absolute right to require such medical exams.
3. The date we agree to issue the coverage as applied for in the application. The insurance will then be provided by the policy.
4. The date we offer to issue insurance other than as applied for in the application.

We will refund all payments for which this Agreement was given if we stop considering the application. If payment was made by credit card, we will refund through the credit card, except in Alabama, California, New Hampshire, and South Carolina.

Continued on reverse side.

AGENT: This special notice MUST be detached and given to the Proposed Insured.

NOTICE REGARDING MIB

Information regarding insurability will be treated as confidential. We or our reinsurer(s) may make a brief report to the Medical Information Bureau, Inc. (M.I.B.). M.I.B. is a non-profit membership organization of life insurance companies. M.I.B. operates an information exchange on behalf of its members. If you apply to another M.I.B. member for life or health insurance, or a claim for benefits is submitted to such a company, the M.I.B. may supply such company with the information in its file. Upon receipt of a request from you, the M.I.B. will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the M.I.B.'s file, you may contact M.I.B. and seek a correction in accordance with the Federal Fair Credit Reporting Act. The address of the M.I.B.'s information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112. Its telephone number is (617) 426-3660.

We or our reinsurer(s) may also release information in our file to other life companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted.

INSURANCE INFORMATION PRACTICES

We will rely primarily on the information you give us. We may also get information from other sources, such as doctors and other medical professionals who have treated you. In some cases, we may ask a consumer reporting agency to gather information and send us an investigative consumer report as explained in the Notice Under the Fair Credit Reporting Act below. You may ask to be interviewed as part of the preparation of any such report.

In certain limited circumstances, we are allowed by law to disclose necessary items of personal information to third parties without your specific authorization.

You have the right to be told about, and to see and copy, items of personal information about you that appear in our files, including information contained in investigative consumer reports. You also have the right to seek correction of information you believe to be inaccurate.

We will send you a more detailed explanation of our information practices if you send us a written request. You may send your request to Underwriting Department, Lincoln Benefit Life Company, P.O. Box 80469, Lincoln, Nebraska 68501.

Continued on reverse side.

Amount of Insurance

If temporary insurance under this Agreement is in effect, it will have the same benefits, provisions, and limitations and be for the same amount as the plan applied for. But we will provide no more than a combined total of $1,000,000 of temporary life insurance and accidental death benefit on any one life under this and any other Temporary Insurance Agreements.

Conditions Under Which There Is No Coverage

1. If any of questions 4(a) through 4(e) in Section G are answered "Yes" or not answered, no insurance is provided by this Agreement.
2. If in the answers in the application, there is any fraud or misrepresentation material to our acceptance of the risk, then no insurance starts under this Agreement. We will pay only a refund of all payments made.
3. If a person proposed for this insurance dies by suicide while sane or self-destruction while insane, we will pay only a refund of all payments made for that person's insurance. Temporary insurance will continue on all other proposed insureds whose coverage is not contingent on the insurance of the person who died. We may offer to issue insurance other than as applied for in the application on any person(s) proposed for this insurance.
4. No insurance starts under this Agreement if no payment is received, if a check or draft given as payment is not honored by the bank, or, in the case of a credit card payment, if the charge is refused by the credit card issuer.

No one can waive or change any of the terms of this Agreement.

Date / / Agent Name: _____

Agent Number: ⌊ ⌋

NOTICE UNDER THE FAIR CREDIT REPORTING ACT

In compliance with the Fair Credit Reporting Act, you are hereby notified that an investigative consumer report may be made. This would be by personal interviews with neighbors, friends, associates, or other persons. This will concern the character, general reputation, personal characteristics and mode of living (except as may be related to sexual orientation) of any person proposed for insurance. You may obtain additional information concerning the nature and scope of this investigation, and a written summary of your rights under the Fair Credit Reporting Act, by contacting our Home Office. Our address is Lincoln Benefit Life Company, P.O. Box 80469, Lincoln, Nebraska 68501. Upon your written request, you will be informed whether or not an investigation was made by us. If so, you will receive the name and address of the consumer reporting agency involved. You may inspect and review a copy of the Investigative Consumer Report by contacting the consumer reporting agency.

AGREEMENT FOR PRE-AUTHORIZED METHOD (NOT TRANSFERABLE OR NEGOTIABLE)

LINCOLN BENEFIT LIFE COMPANY ID NUMBER 47-0221457 AGENT: Provide Voided Blank Check

I (We) hereby authorize (a) LINCOLN BENEFIT LIFE COMPANY to initiate debit entries to my (our) account indicated below to pay the premiums, and other charges, such as non-sufficient funds, due on any insurance policy issued pursuant to the application which accompanies this statement, and (b) the Financial Institution named below (INSTITUTION) to debit my (our) account for such amount.

INSTITUTION

ADDRESS CITY STATE

ACCOUNT HOLDER NAME: _____ Policy Number: _____

TRANSIT/ABA # _____

ACCOUNT # _____

The term "debit entry" shall include charges to my (our) account by orders initiated by electronic means, checks, drafts or any other order. I agree that a photographic copy of this agreement shall be as valid as the original.

I (we) have the right to stop payment of a debit entry by giving notice to INSTITUTION in such time as to afford INSTITUTION a reasonable opportunity to act prior to charging my (our) account. After my (our) account has been charged. I (we) have the right to have the amount of an erroneous debit immediately credited to such account by INSTITUTION up to 15 days following issuance of statement or 45 days after posting, whichever comes first.

INSTITUTION'S treatment of each account debit, check draft or other order initiated by LINCOLN BENEFIT LIFE COMPANY, and its rights with respect to it will be the same as if it were signed personally by me (us). If any such debit entry is dishonored for any reason, INSTITUTION will not be under any liability even though dishonor results in the forfeiture of insurance.

In addition, I (we) have read, fully understand and also agree to the provisions on the reverse side of this form.

_____ _____
(Depositor) (Joint Depositor, if any)

_____ _____
(Date) (Owner, if other than Depositor or Joint Depositor)

IT IS UNDERSTOOD THAT ALL DEBIT ENTRIES INITIATED BY LINCOLN BENEFIT LIFE COMPANY PURSUANT TO THE AGREEMENT BELOW SHALL BE SUBJECT TO THE FOLLOWING PROVISIONS:

This Agreement shall not be effective until accepted by LINCOLN BENEFIT LIFE COMPANY.

LINCOLN BENEFIT LIFE COMPANY may initiate an entry that is larger than the next previous entry, or may change the date of the billing cycle, providing LINCOLN BENEFIT LIFE COMPANY tells me (either or us) in writing about the increase or the new date at least ten (10) days before charging the larger amount to my (our) account or making the first entry to be affected by the new date.

LINCOLN BENEFIT LIFE COMPANY will not send premium notices. Periodic statements, cancelled checks or other orders received by me (either of us) from INSTITUTION will be my (our) receipt.

This Agreement will end when (a) LINCOLN BENEFIT LIFE COMPANY or INSTITUTION receives a written request from me (either of us) to end it, or (b) when LINCOLN BENEFIT LIFE COMPANY or INSTITUTION sends me (either of us) written notice ten (10) days prior to LINCOLN BENEFIT LIFE COMPANY'S or INSTITUTION'S termination of the Agreement.

This Agreement may be ended automatically by LINCOLN BENEFIT LIFE COMPANY if any debit entry has been refused by INSTITUTION because of insufficient funds in my (our) account.

If the Agreement ends for any reason, all premiums due will become directly payable to LINCOLN BENEFIT LIFE COMPANY by me (us) until another payment plan is agreed to in writing.

LINCOLN BENEFIT LIFE
C O M P A N Y
A MEMBER OF THE ALLSTATE LIFE GROUP

Lincoln Benefit Life Company
PO Box 80469
Lincoln, NE 68501-0469

SURETY LIFE
A MEMBER OF THE ALLSTATE LIFE GROUP

Surety Life Insurance Company
PO Box 82599
Lincoln, NE 68501-2599

COMPUTER SCREEN CERTIFICATION

I certify that I displayed a computer screen illustration for _____
(print applicant name)
that complies with state requirements and for which no hard copy was furnished. The illustration was based on the following personal and policy information:

1. Gender Male ☐ Female ☐
2. Age _____
3. Underwriting or Rating Class _____
4. Type of Policy Illustrated _____

◊5. Type of Rider(s) Illustrated _____

◊6. Company Product Name and Form Number _____

*7. Initial Death Benefit $_____

*8. Premium Illustrated $_____ Number of Years_____

◊*9. Interest Rates Illustrated _____% (guaranteed) _____% (non-guaranteed)

*10. Number of Years Policy Illustrated _____

◊Required for South Dakota applicants only.
***Required for Pennsylvania applicants only.**

_____ _____
Signature of Agent Date

I acknowledge that I viewed a computer screen illustration based on the information as stated above. NO hard copy of the illustration was furnished. I understand that an illustration conforming to the policy as issued will be prepared and personally delivered by my agent to me no later than at the time the policy is delivered.

_____ _____
Signature of Applicant Date

INSTRUCTIONS TO AGENT
Submit white copy to Home Office with application. Yellow copy is for applicant.

LINCOLN BENEFIT LIFE
COMPANY

A Member of Allstate Financial Group

Lincoln Benefit Life Company
PO Box 80469
Lincoln, NE 68501-0469

ILLUSTRATION DISCLOSURE

(This form is to be used when an illustration was not given to the applicant/owner at the time of application for life insurance or the applicant applied for coverage other than as illustrated.)

Applicant's Name _____ Policy Number _____

Applicant's D.O.B. _____ Applicant's Social Security Number _____

Please Initial One:

_____ I acknowledge that no illustration of the policy was provided and I understand that an illustration conforming to the policy as issued will be provided no later than at the time of policy delivery.

_____ I acknowledge that the illustration provided to me did not conform to the policy for which I applied. I understand that an illustration conforming to the policy as issued will be provided no later than at the time of policy delivery.

_____ _____
Signature of Owner Month/Day/Year

I hereby certify to the information above regarding the use of no illustration or an illustration that does not conform to the policy for which the applicant applied.

_____
Signature of Agent

INSTRUCTIONS TO AGENT
Submit original to Home Office with application. Copy to applicant.

LINCOLN BENEFIT LIFE
COMPANY
A Member of Allstate Financial Group
P.O. BOX 80469
LINCOLN, NE 68501-0469

Name _____ Policy # _____

Date of Birth _____ Social Security # _____

NOTICE AND CONSENT FORM FOR AIDS-RELATED TESTING

To evaluate your insurability, the insured named above (the Insurer) has requested that you provide a sample of your blood, urine, or oral fluid for testing and analysis to determine the presence of human immunodeficiency virus (HIV) antibodies. By signing and dating this form you agree that this test may be done and that underwriting decisions will be based on the test result. A series of three tests will be performed by a licensed laboratory through a medically accepted procedure.

Pre-Testing Considerations

Many public health organizations have recommended that before taking an AIDS-related test a person seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, prior to being tested. A list of counseling services is located on the reverse side of this form.

Meaning of Positive Test Result

The test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus. Antibodies are blood cells produced by the body in response to infection. A positive test result does not mean that you have AIDS but that you are at significantly increased risk of developing problems with your immune system. The test for HIV antibodies is very sensitive. Errors are rare, but they do occur. Your private physician, a public health clinic, or an AIDS information organization in your city might provide you with further information on the medical implications of a positive test.

Positive HIV antibody test results will adversely affect your application for insurance. This means that your application will probably be declined, or an increased premium charged, or other policy changes may be necessary.

Confidentiality of Test Results

All test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed as required by law or may be disclosed to employees of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer or to outside legal counsel who need such information to effectively represent the Insurer in regard to your application. If your test result is positive, it may be released to an insurance medical information exchange or another insurer only if a non-specific blood test result code is used which does not indicate that you were subject to testing related to the human immunodeficiency virus.

Notification of Test Result

If your test results are negative, no routine notification will be sent to you. If your test results are reported by the laboratory to the Insurer as being positive, you will receive that information. Because a trained person should deliver that information so that you can understand clearly what the test result means, you are asked to list your private physician so that the insurer can have him or her tell you the test result and explain its meaning.

Name and address of physician for reporting a positive test result: _____

_____

_____

In the event the result is positive, you will be urged to contact a private physician, County Health Department, State Department of Health Services, local medical societies, or alternative test sites for appropriate counseling. If no physician is named above, the result will be sent to you at the address provided by registered mail with delivery restricted to you only.

Consent

I have read and understand this Notice and Consent for AIDS-Related Blood Testing. I voluntarily consent to the collection of blood, urine, or oral fluid from me, the testing of blood, urine, or oral fluid, and the disclosure of the test results as described above. I have read the information on this form about what a test result means and understand that I should contact a local AIDS service group or my private physician for further information and counseling if the test is positive. I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

_____ _____
Signature of Proposed Insured or Parent Guardian Name of Proposed Insured (PRINT)

Date Signed: _____ _____
(This Consent is not valid 6 months after this date!) Address

AIDS COUNSELING ORGANIZATIONS

The following organizations can assist you in understanding the meaning of the HIV antibody test and its results, as well as provide or help you secure counseling:

San Francisco AIDS Foundation
25 Van Ness Avenue
Suite 660
San Francisco, CA 94102
415/864-5855

AIDS Project -East Bay
400 40th Street
Suite 20
Oakland, CA 94609
415/420-8181

Sacramento AIDS Foundation
1900 K Street
Suite 201
Sacramento, CA 95814
916/448-2437

ARIS Project
595 Millich Drive
Suite 104
Campbell, CA 95008
408/370-3272

Central Valley AIDS Team
P.O. Box 4640
Fresno, CA 93744
209/264-2436

AIDS Project Los Angeles
3670 Wilshire Blvd.
Suite 300
Los Angeles, CA 90010
213/380-2000

AIDS Services Foundation of Orange County
1685-A Babcock Street
Costa Mesa, CA 92627
714/646-0411

San Diego AIDS Project
3777 Fourth Avenue
San Diego, CA 92103
619/543-0300

LINCOLN BENEFIT LIFE COMPANY

Term Insurance Disclosure

This policy does not provide any nonforfeiture benefits (such as surrender values). This means that if you fail to pay a premium within a specified time of its due date, this policy will lapse without any value.

You should compare this policy to other level-premium term policies. Such policies would provide identical insurance coverage, but may also be required to provide nonforfeiture benefits at certain durations where this policy does not. However, the premiums for such term policies might be higher than the premiums for this policy.

When considering the purchase of this policy, you should compare the value of having nonforfeiture benefits (such as cash values) versus the level of the premiums that you will pay.

LINCOLN BENEFIT LIFE COMPANY
INDETERMINATE PREMIUM RIDER
SUMMARY OF PREMIUM PROVISIONS
LR 9861 - ADDITIONAL INSURED TERM INSURANCE RIDER

The rider you have applied for is of a type called an Indeterminate Premium Rider. This means that the schedule of premiums we are currently charging is not guaranteed for all future years.

Current premium rates are guaranteed for the first **ten** years. Starting on the **tenth** anniversary, and on any anniversary after the **tenth**, we may increase premium rates up to the guaranteed maximum premium. Any premium which we charge that is less than the guaranteed maximum premium is guaranteed for only one year. One of the purposes of this type of plan is to provide you with insurance coverage at a lower premium than we would be willing to offer if the premium were required to be unchangeable by us for the life of the rider.

This is not a rider form. We will send you a rider if we approve your application. Read it carefully. If you are not satisfied you may return it within 20 days for a full refund.

_____ _____
Signature of Applicant Date

Authorization for Release of Health-Related Information to
___Allstate Life Insurance Company
___Lincoln Benefit Life
___Allstate Life Insurance Company of New York

_____ ____ / _____/ _____
Name of proposed insured/patient (please print) Date of birth

_____ ____ / _____/ _____
Name of proposed insured/patient (please print) Date of birth

"I", "me", "my" means each Applicant signing this Authorization.

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, Pharmacy Benefit Manager or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record and any other information that may be considered protected health information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") concerning me to the Allstate Life Insurance Company, Lincoln Benefit Life or Allstate Life Insurance Company of New York ("The Insurance Company") and its agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I terminate any agreements I have made with My Providers to restrict my medical records and any associated HIPAA protected health information and I instruct My Providers to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that The Insurance Company may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with The Insurance Company.

This authorization shall remain in force for 30 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to The Insurance Company. I understand that a revocation is not effective if any of My Providers has relied on this authorization or to the extent that The Insurance Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by certain federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I also understand that if I refuse to sign this authorization, The Insurance Company may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I acknowledge that I have received a copy of this authorization.

_____ _____
Applicant's Name (Please Print) Date of Birth

_____ _____
Applicant's Signature Date

_____ _____
Joint Applicant's Name (Please Print) Date of Birth

_____ _____
Joint Applicant's Signature Date

RETURN ONE COPY TO HOME OFFICE, LEAVE ONE COPY WITH APPLICANT(S) **LG938**

Authorization for Release of Health-Related Information to
___Allstate Life Insurance Company
___Lincoln Benefit Life
___Allstate Life Insurance Company of New York

_____ ____ / _____/ _____
Name of proposed insured/patient (please print) Date of birth

_____ ____ / _____/ _____
Name of proposed insured/patient (please print) Date of birth

"I", "me", "my" means each Applicant signing this Authorization.

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, Pharmacy Benefit Manager or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record and any other information that may be considered protected health information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") concerning me to the Allstate Life Insurance Company, Lincoln Benefit Life or Allstate Life Insurance Company of New York ("The Insurance Company") and its agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

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This protected health information is to be disclosed under this Authorization so that The Insurance Company may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with The Insurance Company.

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_____ _____
Applicant's Name (Please Print) Date of Birth

_____ _____
Applicant's Signature Date

_____ _____
Joint Applicant's Name (Please Print) Date of Birth

_____ _____
Joint Applicant's Signature Date

RETURN ONE COPY TO HOME OFFICE, LEAVE ONE COPY WITH APPLICANT(S) **LG938**