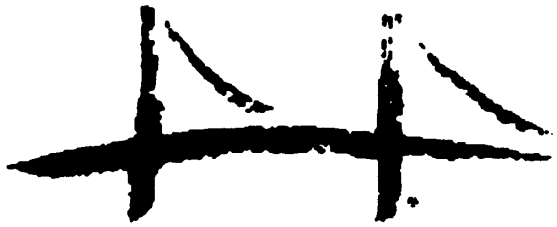

West Coast Life
Insurance Company

A PROTECTIVE COMPANY

CALIFORNIA LIFE APPLICATION PACKET

CONTENTS AND WEBSITE INSTRUCTIONS

CONTENTS

WEBSITE INSTRUCTIONS

1. Log onto **www.westcoastlife.com**
2. Click on **Agent Center**
3. Enter your *agent number* as your **user ID**, then hit the tab key (note: if your agent number consists of more than one letter and four numbers, drop the final number)
4. Enter your *zipcode* as your **password** (note: your zipcode of record may be your BGA's zipcode or your home zipcode – wherever your commissions are mailed.)
5. Click on **Download Forms and Software**
6. Select **Application Packets**
7. Highlight your state and product of choice
8. Click **Execute**
9. To print, click on packet in number column to open document. Print.
10. To save to your desktop, right click on packet in number column and select "save target as" from drop-down menu. Rename and save file as desired.

West Coast Life
Insurance Company
A PROTECTIVE COMPANY

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

Part I

SECTION I : INSUREDS [State of Domicile - Nebraska] **LIFE INSURANCE APPLICATION**

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	Prop. Ins. No	Spouse Yes	Spouse No	Children Yes	Children 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	Prop. Ins. No	Spouse Yes	Spouse No	Children Yes	Children 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. Height			_____		_____	
(If more than one child proposed for insurance, list in Section VI below.) 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 **Part I**

(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 Temporary Life 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.

Any person who knowingly with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties according to state law.

Signed At _____ Date _____
(City and State)

(X) _____ (X) _____
Signature of Proposed Insured Signature of Spouse, If Proposed for Insurance

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

West Coast Life Insurance Company
A PROTECTIVE COMPANY

Application Supplement - Part I

Supplement to Life Insurance Application

The statements and answers to the questions listed below shall become a part of the attached application; shall be subject to the terms of the attached application; and shall become a part of any policy based on this application.

Print Name of Proposed Insured(s): _____

(1) **For any policy to be issued as a result of this application, will any portion of the initial or future premiums be borrowed, loaned or otherwise financed?** ☐ Yes ☐ No

If yes, complete the "Statement of Owner Intent" (Application Supplement - Part II) and the "Premium Financing Disclosure and Acknowledgement" form.

(2) **Is there any intention that any party other than the Owner(s) will obtain any right, title or interest in any policy issued on the life of the Proposed Insured(s) as a result of this application?** ☐ Yes ☐ No

If yes, complete the "Statement of Owner Intent" (Application Supplement - Part II).

(3) **Is a trust to be an Owner of any policy issued as a result of this application?** ☐ Yes ☐ No

If yes, complete the "Trust Certification" (Application Supplement - Part III).

(4) If the issue age of any Proposed Insured is 65 or older **AND** the total coverage currently applied for across all Protective companies is $1,000,000 or more, complete the "Statement of Owner Intent" (Application Supplement - Part II).

Is any Proposed Insured 65 or older AND is total coverage $1,000,000 or more? ☐ Yes ☐ No

West Coast Life Insurance Company
A PROTECTIVE COMPANY

Application Supplement - Part II

Statement of Owner Intent

This supplement will be attached to and become part of the application with which it is used.

It is the policy of West Coast Life Insurance Company ("the Company") that life insurance should only be purchased to provide protection to those with an insurable interest in the life of the insured. The Company will not knowingly participate in life insurance sales motivated by the possible sale of policies in a secondary market or participation of investors in policy death benefits. Accordingly, we ask the Proposed Insured(s) and Owner(s) (if different) to answer the following questions.

This supplement must be completed and signed by the Proposed Insured(s) and the Owner(s) applying for a life insurance policy to be issued by the Company whenever:

1) There is any intention that any party other than the Owner(s) will obtain any right, title or interest in any policy issued on the life of the Proposed Insured(s) as a result of the life application; or
2) If the issue age of any Proposed Insured is 65 or older **AND** the total coverage currently applied for across all Protective companies is $1,000,000 or more; or
3) Any Proposed Insured or Owner has indicated that any portion of the initial or future premiums will be borrowed, loaned or otherwise financed; or
4) Upon the request of the underwriter.

PROPOSED INSURED 1: *Name* _____

PROPOSED INSURED 2: *Name* _____

Owner(s) / Trustee(s) 1: *Name* _____

Owner(s) / Trustee(s) 2: *Name* _____

REGARDING ALL PERSONS PROPOSED FOR INSURANCE: **Give full details in "Remarks" for any YES answers.**	Prop Ins 1 Yes No	Prop Ins 2 Yes No
1. Will any portion of the initial or future premiums for this policy be borrowed, loaned or otherwise financed by any individual(s) or entity(ies) other than the Proposed Insured(s) or immediate family members of the Proposed Insured(s)? …… *If **YES**, please identify all parties involved (in Remarks); and please **attach** copies of any trust documents, all financing agreements or promissory notes and all related side agreements and schedules.*	☐ ☐	☐ ☐
2. Answer this question ONLY if the answer to Question 1 is **YES**. a.) Is there any collateral for the loan other than the life insurance policy?..... *If **YES**, please describe the additional collateral in "Remarks".* b.) Is there an explicit exit strategy for repayment of the loan? …… *If **YES**, please **attach** all supporting documentation; and (in Remarks) please describe the exit strategy, the gift, income and estate tax implications of all transactions, and the financial implications of any mechanism used to execute the strategy.*	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐
3. Will any premiums for this policy be paid by any individual(s) or entity(ies) - other than the Proposed Insured(s), employer(s) of the Proposed Insured(s), or immediate family member(s) of the Proposed Insured(s) - in exchange for any portion of the policy's death benefit? …… *If **YES**, please specify (in Remarks) how death benefits will be distributed upon the death(s) of the Proposed Insured(s), including each recipient's name and percentage or amount to be received.*	☐ ☐	☐ ☐

Continued……

REGARDING ALL PERSONS PROPOSED FOR INSURANCE:
Give full details in "Remarks" for any YES answers.

	Prop Ins 1 Yes	Prop Ins 1 No	Prop Ins 2 Yes	Prop Ins 2 No
4. Has a life insurance policy insuring the life of any Proposed Insured ever been sold or transferred to a third party? …… *If **YES**, please identify below:*	☐	☐	☐	☐

All Parties Involved	Reason Sold or Transferred	Policy Number	Issuing Carrier	Face Amount	Date Issued	Date Sold or Transferred

	Prop Ins 1 Yes	Prop Ins 1 No	Prop Ins 2 Yes	Prop Ins 2 No
5. Does any Proposed Insured or Owner intend to sell or transfer any interest in this policy (being applied for) or in any other life insurance policy (currently in force or applied for with any company) to a life settlement company or other third party? …… *If **YES**, please provide details in Remarks.*	☐	☐	☐	☐
6. Has any Proposed Insured or Owner been solicited to sell or transfer this or any other life insurance policy to a life settlement company or other third party? …… *If **YES**, please provide details in Remarks.*	☐	☐	☐	☐
7. Has any Proposed Insured or Owner been involved in any discussion about the possible sale or transfer of this policy or the possible sale or transfer of a beneficial interest in a trust, Limited Liability Company ("LLC"), Limited Liability Partnership ("LLP") or other entity created or to be created to own this policy? …… *If **YES**, please provide details in Remarks.*	☐	☐	☐	☐
8. Will any Proposed Insured or Owner receive a fee, cash payment, free trip, or any other consideration from any individual, group of individuals, or entity in connection with the issuance of this policy; or has a third party offered any Proposed Insured or Owner "free" life insurance? *If **YES**, please provide details in Remarks.*	☐	☐	☐	☐
9. Has any Proposed Insured or Owner discussed or been assured in writing or by other means regardless of the loan balance or the cash surrender value of this policy, the Proposed Insured(s) or Owner(s) can fully satisfy the outstanding loan by simply transferring all or a portion of the rights in this policy to the lender or another party?..... *If **YES**, please provide details in Remarks.*	☐	☐	☐	☐
10. In the last two years has any Proposed Insured or Owner authorized a life expectancy valuation to be performed or has any Proposed Insured or Owner been asked to authorize a life expenctancy valuation in the future?..... *If **YES**, please **attach** a copy of each valuation that has been performed.*	☐	☐	☐	☐

REMARKS:

ADDITIONAL REMARKS:

I (We) have read or have had read to me (us) the completed Supplement before signing below. All statements and answers in this Supplement are correctly recorded and are full, complete and true. I (We) understand that the information being provided in this Supplement is being relied upon in considering the application for life insurance and is subject to the applicable Fraud Statement as provided in the Application for Life Insurance.

Signed in _____, this _____ day of _____, _____.
(State) *(Month)* *(Year)*

Signature(s) of Proposed Insured(s): _____

_____

Signature(s) of Owner(s)/Trustee(s): _____
(provide officer's title if policy is owned by a corporation)

_____
(provide officer's title if policy is owned by a corporation)

Signature of Witness: _____

PRODUCER CERTIFICATION:

By signing below, I hereby certify that to the best of my knowledge and belief, the information provided herein is complete, accurate, and correct and that the life insurance being applied for conforms to the Company's guidelines.

_____
Producer Name (PRINT)

_____ _____ _____
Signature of Producer Date Signed at (City, State)

F-WCL-409 (6/08)

West Coast Life Insurance Company
A PROTECTIVE COMPANY

Disclosure and Acknowledgement

If any portion of the initial or future premiums will be borrowed, loaned or otherwise financed, this Disclosure and Acknowledgement form must be signed by the Proposed Insured(s) and the Owner(s), if different.

The Proposed Insured(s) or the Owner(s), if different, also called "the applicant(s)" herein, has (have) applied for a life insurance policy from West Coast Life Insurance Company ("the Company"). The applicant(s) is (are) considering borrowing from a third-party lender to pay for some or all of the premiums for the proposed policy. To clarify the roles of the parties involved, the Company is providing this Disclosure and Acknowledgement form but notes that all the statements may not pertain to all premium financing arrangements and that it is the responsibility of the applicant(s) to discuss the particular risks and benefits of any premium financing arrangement with his or her (their) advisors.

I (We) understand and agree as follows:

1. The Company does not authorize any of its representatives to endorse or recommend premium financing; the Company does not provide lending, tax, or legal advice; and the applicant(s) has (have) not relied on the Company or any of its representatives in deciding whether to enter into any premium financing arrangement.
2. The applicant(s) is (are) solely responsible for the selection of the lender and the negotiation of the terms of any loan/financing agreement.
3. Notwithstanding its acceptance of any particular program, neither the Company nor any of its representatives express any opinion or endorse any specific financing arrangement or lender.
4. Premium financing involves certain lending risks, including but not limited to: change in interest rates, increased premium costs, market volatility, change in collateral valuation, margin calls, and termination, modification, or non-renewal of the loan. These risks include the risk that the policy will not be in force at the time of the death of the Proposed Insured(s) because either the lender has foreclosed on the policy or the amount owed to the lender exceeds the insurance proceeds, in which case additional funds may be needed to repay the loan. If the policy is surrendered, the Owner(s) will be taxed on any policy gain even though the policy proceeds are paid to the collateral assignee.
5. The applicant(s) is (are) relying solely on the advice and recommendation of his or her (their) own tax and legal advisors about whether to enter into a premium financing arrangement, including but not limited to any advice regarding: the Federal and state income, gift, and estate tax implications of premium financing; and premium financing involving policies classified as Modified Endowment Contracts ("MEC").
6. The Company is not a party to and is not bound by any of the provisions or representations relating to any premium financing arrangement related to the proposed policy, except as may be required under any properly executed collateral assignment(s).
7. Illustrated premium payments, policy values and death benefits are hypothetical and are not guaranteed. These hypothetical values are based on the age, sex and risk class of the Proposed Insured(s), the death benefit option, and any riders shown. Actual credited interest rates, actual cost of insurance rates, any policy loans or partial surrenders, and any policy or rider changes will affect actual results and may impact the financing arrangement and duration of the policy.
8. Issuance of any life insurance policy by the Company to the applicant(s) is in no way contingent upon his or her (their) receipt of financing for any or all of the premiums related to the proposed policy.
9. In general, interest on a loan to finance the purchase of insurance is not tax deductible.

Acknowledging the above, I (we) hereby release and hold the Company, and it directors, officers, employees, and representatives, harmless from any and all claims, demands, expenses, actions, causes of action, or suits of any kind or nature, both known and unknown, arising out of, related to, or in any manner connected with any premium financing entered into in connection with the proposed policy.

Proposed Insured (PRINT) _____ Signature _____ Date _____

Proposed Insured (PRINT) _____ Signature _____ Date _____

Owner/Trustee (if different) _____ Signature _____ Date _____

Owner/Trustee (if different) _____ Signature _____ Date _____

Producer Certification:

By signing below, I hereby certify that I have presented copies of this form to the Proposed Insured(s) and Owner(s), that I have made no statements and provided no information to the Proposed Insured(s) and Owner(s) inconsistent with the information provided in this form, and that the life insurance being applied for conforms to the Company's guidelines.

Producer Name (PRINT) _____ Signature _____

Date: _____ Signed at (City, State): _____

West Coast Life Insurance Company
A PROTECTIVE COMPANY

Application Supplement - Part III

Trust Certification

This supplement will be attached to and become part of the application with which it is used.

It is the policy of West Coast Life Insurance Company ("the Company") that life insurance should only be purchased to provide protection to those with an insurable interest in the life of the insured. The Company will not knowingly participate in life insurance sales motivated by the possible sale of policies in a secondary market or participation of investors in policy death benefits. Accordingly, we ask the Owner(s)/Trustee(s) and Grantor(s) to complete the following information.

This supplement must be completed and signed whenever a trust is to be an Owner of any policy issued as a result of the life application. Upon the request of the Company or when any portion of the initial or future premiums will be borrowed, loaned or otherwise financed, copies of all trust documents must also be submitted.

Proposed Insured 1: _____
First Name Middle Name Last Name

Proposed Insured 2: _____
First Name Middle Name Last Name

Name(s) of Owner(s)/Trustee(s): _____
_____

Name(s) of Grantor(s): _____
_____

Name of the Trust: _____ ("the Trust")

Current Beneficiary(ies) of the Trust: _____
_____
_____

Date of the Trust: _____ (mm/dd/yyyy) **Date the Trust was Signed:** _____ (mm/dd/yyyy)

Address of the Trust: _____
_____
_____

Situs of the Trust (the Trust is subject to the laws of the State of): _____

Describe the relationship between the Grantor(s) and the Trustee(s): _____
_____
_____
_____

I (We) have read or have had read to me (us) the completed Supplement before signing below. All statements and answers in this Supplement are correctly recorded and are full, complete and true. I (We) understand that the information being provided in this Supplement is being relied upon in considering the application for life insurance and is subject to the applicable Fraud Statement as provided in the Application for Life Insurance.

I (We) certify that:

a) The Trustee(s) is (are) allowed by the terms of the Trust to purchase life insurance and securities;
b) The Trust permits the Trustee(s) to exercise all ownership rights provided by the policy that is issued by the Company to the Trust, including but not limited to the right to surrender, pledge or encumber the policy or make withdrawals;
c) The Trustee(s) is (are) permitted to distribute the policy to any beneficiary of the Trust or to sell and transfer ownership of the policy pursuant to the sale;
d) Beneficial interests under the Trust can and will only be established for persons who: (i) are related to the Proposed Insured(s) by blood or by law; (ii) have a substantial interest in the life of the Proposed Insured(s) engendered by love and affection; or (iii) hold a lawful and substantial economic interest in the continued life of the Proposed Insured(s);
e) Neither the Company nor anyone acting as its agent is responsible to determine the authority of the Trustee(s) or the validity of the trust or to inquire into or review the provisions of the Trust;
f) Neither the Company nor anyone acting as its agent shall be charged with knowledge of the terms of the Trust; and
g) The Company may rely on the evidence submitted for any change of the Trustee(s) and/or the appointment of any successor Trustee(s) and is not responsible to determine that the change or the appointment of any additional or successor Trustee(s) conforms to the provisions of the Trust.

Signed in _____, this _____ day of _____, _____.
(State) (Month) (Year)

Signature(s) of Owner(s)/Trustee(s): _____

_____

Signature(s) of Grantor(s): _____

_____

Signature of Witness: _____

Producer Certification:

By signing below, I hereby certify that to the best of my knowledge and belief, the information provided herein is complete, accurate, and correct and that the life insurance being applied for conforms to the Company's guidelines.

Producer Name (PRINT): _____

Producer Signature: _____

Date: _____ Signed at (City, State): _____

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

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 <u>MUST</u> BE SIGNED <u>WITHOUT MODIFICATION</u> 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

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

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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 <u>MUST</u> BE SIGNED <u>WITHOUT MODIFICATION</u> 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

P.O. Box 193892, San Francisco, CA 94119-3892
Home Office: San Francisco, California
1-800-366-9378

California Elder Notice to All Purchasers of Life Insurance or Long Term Care Age 65 or Over

You should be aware that the sale or liquidation of any stock, bond, IRA, certificate of deposit, mutual fund, annuity, or other asset to fund the purchase of this life or long term care product may have tax consequences, early withdrawal penalties, or other costs or penalties as a result of the sale or liquidation.

You or your representative may wish to consult independent legal or financial advice before selling or liquidating any assets and prior to the purchase of any life or long term care products being solicited, offered for sale, or sold.

West Coast Life
Insurance Company
A PROTECTIVE COMPANY
P.O. Box 193892, San Francisco, CA 94119-3892
1-800-366-9378 / (415) 591-8200

NOTICE AND CONSENT FOR AIDS-RELATED BLOOD TESTING

To evaluate your insurability, the insurer named above has requested that you provide a sample of your blood for testing and analysis to determine the presence of human immunodeficiency virus (HIV) antibodies and other tests which may include tests for cholesterol and related blood lipids, diabetes, liver or kidney disorders, immune disorders or the presence of medications, drugs, nicotine and their metabolites. By signing and dating this form you agree that these tests may be done and that underwriting decisions will be based on the test results. Regarding the HIV test, 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 blood 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.

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. 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 may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

Confidentiality of Test Results

All of the 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 responsibility to make underwriting decisions on behalf of the Insurer or to outside legal counsel who needs such information to effectively represent the Insurer in regard to your application. The results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover results of tests for other disease or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular person.

Notification of Test Result

If your HIV test result is negative, no routine notification will be sent to you. Because a trained person should deliver information regarding a positive test result 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 its meaning.

Name of physician for reporting a possible positive test result: _____

Address: _____

If you do not wish to know the results of the test, initial here: _____ In the event the test is positive and you are denied coverage because of that fact and you request the reason for the denial, the insurer may require you to name a physician at that time in order to receive the information.

If you want to know the results of the test but do not at present have a private physician, initial here:_____ The results will be sent to you at the address provided by registered mail with delivery restricted to you only. If you desire the results to be mailed to some Person other than yourself who is not a physician, print that person's name and address here:

_____.

The results will be sent to that person by registered mail with restricted delivery.

Consent

I have read and I understand this Notice and Consent for AIDS-related Blood Testing. I voluntarily consent to the withdrawal of blood from me, the testing of that blood, 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 result 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. This authorization is valid for six (6) months from the date signed.

Signature of Proposed Insured	Social Security No. and/or Drivers License No. and State	Date
Witness		Date

P.O. Box 193892, San Francisco, CA 94119-3892
1-800-366-9378 / (415) 591-8200

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Address: _____

If you do not wish to know the results of the test, initial here: _____ In the event the test is positive and you are denied coverage because of that fact and you request the reason for the denial, the insurer may require you to name a physician at that time in order to receive the information.

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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. This authorization is valid for six (6) months from the date signed.

Signature of Proposed Insured	Social Security No. and/or Drivers License No. and State	Date
Witness		Date

TEMPORARY LIFE INSURANCE RECEIPT

THIS RECEIPT PROVIDES A LIMITED AMOUNT OF LIFE INSURANCE COVERAGE, FOR A LIMITED PERIOD OF TIME, SUBJECT TO THE TERMS OF THIS RECEIPT. Premium payment in the amount of $_____ is made for Life Insurance on each person proposed for insurance. **ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE INSURANCE COMPANY - DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.**

QUALIFYING SCREENING QUESTIONS

		Yes	No
1	Has any person proposed for insurance in this application:		
	a. within the past 90 days been admitted to a hospital or other medical facility, been advised to be admitted, or had surgery performed or recommended?	☐	☐
	b. within the past 2 years, been treated for heart trouble, stroke, or cancer, or had such treatment recommended by a physician or other practitioner?	☐	☐
2	Is any person proposed for insurance in this application under 15 days of age or over the age of 80 years (nearest birthday)?	☐	☐

If any of the above questions, including any subpart thereof, is answered YES or LEFT BLANK, no representative of West Coast Life Insurance Company is authorized to accept a premium and NO COVERAGE will take effect under this Receipt. No one is authorized to accept a premium on Proposed Insureds under 15 days of age or over age 80 and NO Coverage will take effect under this Receipt.

TERMS AND CONDITIONS

AMOUNT OF COVERAGE - $1,000,000 OVERALL MAXIMUM FOR ALL POLICIES, APPLICATIONS, AND RECEIPTS
If a premium has been accepted by West Coast Life Insurance Company for an application for Life Insurance and any person proposed for Insurance in such application dies while this temporary life receipt is in effect, West Coast Life will pay, subject to the conditions and limitations contained herein, to the beneficiary designated in such application a death benefit equal to the lesser of:

a. the amount of life insurance applied for under such application, or
b. the greater of (i) $1,000,000 less the amount of death benefits due to and payable by virtue of the insured's death under any other West Coast Life policy, application, temporary receipt or the like, or (ii) $50,000.

In no event shall West Coast Life's liability under this Receipt exceed $1,000,000. Any money received will be refunded.

DATE COVERAGE BEGINS: Temporary Life Insurance under this Receipt will begin on the date this Receipt is executed and the application has been completed.

DATE COVERAGE TERMINATES: Temporary Life Insurance under this Receipt will terminate automatically on the earlier of:

a. the date that West Coast Life mails notice of termination of coverage and refund of the advance premium payment to the Applicant at the address designated in this application, or
b. the date that West Coast Life approves for issue the policy applied for at the rate class and for the amount indicated in this application. In no event shall coverage be provided under this Receipt if the policy applied for has been issued.

LIMITATIONS: This receipt does not provide benefits for disability. If Temporary Life Insurance is terminated in accordance with (a) above, West Coast Life's liability under this Receipt is limited to a refund of the premium payment made. If any person proposed for insurance dies by suicide, West Coast Life's liability under this Receipt is limited to a refund of the payment made. There is no coverage under this Receipt if the check submitted as payment is not honored by the bank on first presentation. No one is authorized to waive or modify any of the provisions of this Receipt. **COVERAGE UNDER THIS RECEIPT SHALL BE VOID IF THERE IS FRAUD OR A MATERIAL MISREPRESENTATION IN THE APPLICATION FOR LIFE INSURANCE OR IN ANY ANSWER TO THE QUALIFYING SCREENING QUESTIONS OF THIS RECEIPT. I (WE) HAVE RECEIVED A COPY OF AND HAVE READ THIS TEMPORARY INSURANCE RECEIPT AND DECLARE THAT THE ANSWERS ARE TRUE TO THE BEST OF MY (OUR) KNOWLEDGE AND BELIEF. I (WE) UNDERSTAND AND AGREE TO ALL ITS TERMS.**

Signed At _____ (X) _____
Proposed Insured 1 (Sign Name in Full)

Date _____ (X) _____
Proposed Insured 2 (Sign Name in Full)

(X) _____ (X) _____
Witnessed by Agent — Signature of Parent or Guardian, if Minor

_____ (X) _____
Agent Name (Printed) — *Applicant/Owner, if Other than Proposed Insured

_____
Street Address

*If owner is Corporation, Partnership or Trust, a Corporate Officer, Partner of the Trustee must sign and state title.

_____
City, State and Zip

NOTICE TO APPLICANT: You should retain the copy of this Receipt. The original will be retained by West Coast Life. If you do not hear from us regarding the insurance applied for within 100 days from the date of this Receipt, notify us at West Coast Life Insurance Company, P.O. Box 193892, San Francisco, CA 94119-3892, 1-800-366-9378, Attn: Underwriting Services.

TEMPORARY LIFE INSURANCE RECEIPT

THIS RECEIPT PROVIDES A LIMITED AMOUNT OF LIFE INSURANCE COVERAGE, FOR A LIMITED PERIOD OF TIME, SUBJECT TO THE TERMS OF THIS RECEIPT. Premium payment in the amount of $_____ is made for Life Insurance on each person proposed for insurance. **ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE INSURANCE COMPANY - DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.**

QUALIFYING SCREENING QUESTIONS

		Yes	No
1	Has any person proposed for insurance in this application:		
	a. within the past 90 days been admitted to a hospital or other medical facility, been advised to be admitted, or had surgery performed or recommended?	☐	☐
	b. within the past 2 years, been treated for heart trouble, stroke, or cancer, or had such treatment recommended by a physician or other practitioner?	☐	☐
2	Is any person proposed for insurance in this application under 15 days of age or over the age of 80 years (nearest birthday)?	☐	☐

If any of the above questions, including any subpart thereof, is answered YES or LEFT BLANK, no representative of West Coast Life Insurance Company is authorized to accept a premium and NO COVERAGE will take effect under this Receipt. No one is authorized to accept a premium on Proposed Insureds under 15 days of age or over age 80 and NO Coverage will take effect under this Receipt.

TERMS AND CONDITIONS

AMOUNT OF COVERAGE - $1,000,000 OVERALL MAXIMUM FOR ALL POLICIES, APPLICATIONS, AND RECEIPTS
If a premium has been accepted by West Coast Life Insurance Company for an application for Life Insurance and any person proposed for Insurance in such application dies while this temporary life receipt is in effect, West Coast Life will pay, subject to the conditions and limitations contained herein, to the beneficiary designated in such application a death benefit equal to the lesser of:

a. the amount of life insurance applied for under such application, or
b. the greater of (i) $1,000,000 less the amount of death benefits due to and payable by virtue of the insured's death under any other West Coast Life policy, application, temporary receipt or the like, or (ii) $50,000.

In no event shall West Coast Life's liability under this Receipt exceed $1,000,000. Any money received will be refunded.

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DATE COVERAGE TERMINATES: Temporary Life Insurance under this Receipt will terminate automatically on the earlier of:

a. the date that West Coast Life mails notice of termination of coverage and refund of the advance premium payment to the Applicant at the address designated in this application, or
b. the date that West Coast Life approves for issue the policy applied for at the rate class and for the amount indicated in this application. In no event shall coverage be provided under this Receipt if the policy applied for has been issued.

LIMITATIONS: This receipt does not provide benefits for disability. If Temporary Life Insurance is terminated in accordance with (a) above, West Coast Life's liability under this Receipt is limited to a refund of the premium payment made. If any person proposed for insurance dies by suicide, West Coast Life's liability under this Receipt is limited to a refund of the payment made. There is no coverage under this Receipt if the check submitted as payment is not honored by the bank on first presentation. No one is authorized to waive or modify any of the provisions of this Receipt. **COVERAGE UNDER THIS RECEIPT SHALL BE VOID IF THERE IS FRAUD OR A MATERIAL MISREPRESENTATION IN THE APPLICATION FOR LIFE INSURANCE OR IN ANY ANSWER TO THE QUALIFYING SCREENING QUESTIONS OF THIS RECEIPT. I (WE) HAVE RECEIVED A COPY OF AND HAVE READ THIS TEMPORARY INSURANCE RECEIPT AND DECLARE THAT THE ANSWERS ARE TRUE TO THE BEST OF MY (OUR) KNOWLEDGE AND BELIEF. I (WE) UNDERSTAND AND AGREE TO ALL ITS TERMS.**

Signed At _____ (X) _____
Proposed Insured 1 (Sign Name in Full)

Date _____ (X) _____
Proposed Insured 2 (Sign Name in Full)

(X) _____ (X) _____
Witnessed by Agent — Signature of Parent or Guardian, if Minor

_____ (X) _____
Agent Name (Printed) — *Applicant/Owner, if Other than Proposed Insured

_____
Street Address

*If owner is Corporation, Partnership or Trust, a Corporate Officer, Partner of the Trustee must sign and state title.

_____
City, State and Zip

NOTICE TO APPLICANT: You should retain the copy of this Receipt. The original will be retained by West Coast Life. If you do not hear from us regarding the insurance applied for within 100 days from the date of this Receipt, notify us at West Coast Life Insurance Company, P.O. Box 193892, San Francisco, CA 94119-3892, 1-800-366-9378, Attn: Underwriting Services.

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)

Electronic Policy Delivery Election Form

West Coast Life now offers you the option of receiving your policy in an electronic PDF format instead of paper. The PDF of your policy will be stored on our secure Online Customer Service website which is available 24 hours a day. The Policy Summary Sheet includes an outline of your policy benefits. We recommend that you print and store the Policy Summary Sheet with your financial records.

How Electronic Policy Delivery works:

- You decide how you want your policy to be delivered - paper or electronic PDF via e-mail.
- Once your policy is approved and issued, your agent will have the opportunity to preview your policy in advance to ensure that it meets your needs.
- You will receive an email with a link to a secure West Coast Life website.
- Click on the link and be directed to our Online Customer Service website where you will create your secure, personal User ID and Password.
- Once in the system, you will be able to review the electronic PDF of your policy contract and will electronically sign all delivery requirements and make any necessary premium payments.
- You may make your initial premium payment or pay any balance of the initial premium due on our secure website by either bank draft or credit card.
- Next you will print the Policy Summary Sheet and save it in a secure location. *(We recommend keeping it with other financial planning documents such as your Last Will and Testament.)*
- You can save the electronic PDF of your policy to a secure location on your computer, print it, or refer to the West Coast Life Online Customer Service website at any time to review your stored policy.

To select Electronic Policy Delivery:

Check the box below. Provide your email address, signature and date signed in the fields provided.

❑ **Yes – I would like my policy delivered electronically.**

Email Address for Customer *(Proposed insured, owner and payor must be the same person)*

Customer Signature **Date Signed**

West Coast Life
Insurance Company
A PROTECTIVE COMPANY

West Coast Life
Insurance Company
A PROTECTIVE COMPANY

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

NOTICE REGARDING REPLACEMENT
REPLACING YOUR LIFE INSURANCE POLICY OR ANNUITY

Are you thinking about buying a new life insurance policy or annuity and discontinuing or changing an existing one? If you are, your decision could be a good one — or a mistake. You will not know for sure unless you make a careful comparison of your existing benefits and the proposed benefits.

Make sure you understand the facts. You should ask the company or agent that sold you your existing policy to give you information about it.

Hear both sides before you decide. This way you can be sure you are making a decision that is in your best interest.

We are required by law to notify your existing company that you may be replacing their policy.

Policy # Being Replaced	Company	Policy Type

Date	Print Agent's Name

Applicant's Signature	Agent's Signature

ATTENTION CONSUMER. THIS NOTICE IS REQUIRED BY THE INSURANCE COMMISSIONER.
PLEASE READ IT CAREFULLY BEFORE SIGNING.

West Coast Life
Insurance Company
A PROTECTIVE COMPANY

P.O. Box 193892, San Francisco, CA 94119-3892
343 Sansome Street, San Francisco, CA 94104
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PLEASE READ IT CAREFULLY BEFORE SIGNING.

P.O. Box 193892, San Francisco, CA 94119-3892
Home Office: San Francisco, California
1-800-366-9378

STATEMENT REGARDING ILLUSTRATIONS

(This form must be submitted with the application in lieu of a signed illustration)

Sales illustrations are required for any product sold by West Coast Life Insurance Company which sets out non-guaranteed elements. An illustration conforming in all respects to the policy applied for by the applicant may not always be immediately available to the agent when an application is solicited.

I did not sign an illustration conforming to the policy as applied for. If a policy contract is issued as a result of this application, I understand that at the time of delivery I will be provided with an illustration which conforms to the policy being delivered. My signature on that illustration will be required by West Coast Life as an acceptance requirement.

_____ _____
Applicant Signature Date

I certify that the applicant whose signature appears above did not sign an illustration conforming to the policy as applied for. I have informed the applicant that an illustration conforming to the policy as issued will be provided at the time of policy delivery and that West Coast Life will require the applicant to sign that illustration if the applicant wishes to accept the policy as delivered.

_____ _____
West Coast Life Agent Signature Date

A completed copy of this form must be provided to the Applicant and the Home Office.

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)

When we process your application for life insurance, we need the personal information you give us on your application. We may also need to obtain it from others. That's why we ask you to sign an authorization. With your authorization, we may get information from others. For example, we will get the results of any physical examination you take as a part of the application process. We may also get medical information about you from your doctors or from any hospital or clinic that has provided you services. We may also request a consumer reporting agency (a "CRA") to prepare an investigative consumer report. An investigative consumer report provides information about a person's character, general reputation, personal characteristics and mode of living, except as may be related directly or indirectly to his or her sexual orientation. To obtain the information, the CRA may interview neighbors, friends or other persons acquainted with the person who is the subject of the report. If we request such a report about you, you have the right to be interviewed and to know the nature and scope of the investigation. Upon request, you also have the right to get a copy of the report. To exercise any of these rights, please write to the address at the end of this notice.

Protecting personal and privileged information about our customers is important. We disclose information in only three situations:

First, we may disclose information if you have authorized us to disclose it. For example, with your authorization, we or our reinsurers may disclose information to other insurance companies to which you apply for life or health insurance, or to whom a claim for benefits may be submitted. We may disclose it to the Medical Information Bureau (the "MIB"). The MIB, formerly known as the Medical Information Bureau, is a not-for-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. When a person applies for life or health insurance with or submits a claim for benefits to an MIB member company, the company may request information from MIB. MIB provides the company making the request with any relevant information in its files. You may request MIB to disclose to you any information MIB may have about you. If you question the accuracy of information MIB has disclosed to you, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address and telephone number of MIB's information office are 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8374; 866-692-6901 (TTY 866-346-3642). Information for consumers about MIB may be obtained on its website at www.mib.com.

Second, we may disclose information if the law permits us to disclose it. For example, the law permits us to disclose information to others who provide services to help us process or administer our business. Medical examiners who assist us during underwriting and claims administrators who help us with our claims are the kinds of service providers to whom we may disclose information.

Third, sometimes we have a legal duty to disclose information. For example, we are required and committed to combating insurance fraud. We disclose information to law enforcement authorities investigating or prosecuting an insurance fraud scheme.

You have the right 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 THE 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.