Life Insurance Application

Banner Life Insurance Company
1701 Research Boulevard
Rockville, Maryland 20850-3191

Banner Life Insurance Company
100 Quentin Roosevelt Boulevard
Garden City, New York 11530-9641

HOME OFFICE USE ONLY | Policy No. | Cash Received: $ | HOME OFFICE USE ONLY

PART I

(Please answer all questions completely and legibly.)

1. a. Proposed Insured's Name _____ (FIRST M.I. LAST)
   Maiden and/or Prior Name _____
   b. ☐ Male ☐ Female c. Date of Birth _____/_____/_____ (MO. DAY YR.)
   d. State/Country of Birth _____
   e. U.S. Citizen ☐ Yes ☐ No
   If NO, give immigration status/type of visa
   _____
   f. ☐ Single ☐ Married g. Ht. ____ft. ____in. h. Wt. _____ lbs.
   i. Social Security #/Tax I.D. # _____
   j. Driver's License Number _____
   k. License State _____
   l. Current Residence Address:
   Street _____
   City/State/Zip _____
   Telephone Number _____
   Previous address within last 3 years if other than above:
   Check if "None"
   Street _____
   City/State/Zip _____
   m. Current Business Address:
   Employer Name _____
   Street _____
   City/State/Zip _____
   Telephone Number _____
   Years of employment with this employer _____
   n. Occupation _____
   Duties _____
   o. Annual Income - Employment $_____ Other $_____

2. Owner (if other than Proposed Insured):
   a. Name _____
   b. Current Address: ☐ Residence ☐ Business
   Street _____
   City/State/Zip _____
   Telephone Number _____
   c. Relationship to Proposed Insured _____
   d. Social Security #/Tax I.D. # _____

3. Send Premium Notices to:
   ☐ Proposed Insured ☐ Owner ☐ Other
   (Give name, address and telephone number if Other)
   Name _____
   Street _____
   City/State/Zip _____
   Telephone Number _____

4. a. Primary Beneficiary
   Name _____ Age _____
   Relationship to Proposed Insured _____
   b. Contingent Beneficiary
   Name _____ Age _____
   Relationship to Proposed Insured _____

5. Other Proposed Insured(s)

Name	Sex	Relationship to Proposed Insured	Date of Birth (Mo-Day-Yr)	Height (Ft./In.)	Weight	State/Country of Birth	Social Security # or Tax I.D. #

6. For other proposed insured(s) age 18 or older listed in #5 above provide: Name, address and telephone number of employer, occupation & duties, years employed there and current annual income.

7. List any existing life insurance on all persons proposed for insurance. Include health and disability insurance if these types of coverages are applied for. If none, state none. If additional space is needed, complete Additional Details Supplement to Application.

Name of Proposed Insured	Company	Face Amount	Type	Year Issued	ADB	Dis. Inc.

8. Plan of Insurance _____

☐ Preferred Non-Tobacco ☐ Non-Smoker
☐ Non-Tobacco ☐ Tobacco/Smoker

9. Amount of Insurance $ _____

10. Premium Payment

☐ Annually ☐ Quarterly ☐ Other_____
☐ Semi-Annually ☐ PAC

a. Do you want Automatic Premium Loan? (If applicable)
☐ Yes ☐ No

b. Planned Modal Premium $_____

c. Additional (amount in excess of 10b) $_____

d. Total Initial Premium (10b + 10c) $_____

11. Payment submitted with application $_____
☐ Check if "None"

12. Death Benefit Option - If applicable
☐ Option A - Specified amount plus cash value
☐ Option B - Specified amount including cash value

13. Riders and Benefits on Proposed Insured:

☐ Primary Insured Rider $_____
☐ Basic Insured Rider $_____
☐ Accidental Death Benefit $_____
☐ Waiver of Monthly Deduction Benefit
☐ Waiver of Premium Benefit
☐ Disability Benefit Rider
☐ Disability Income Rider $_____ per month
☐ Long Term Care Rider
☐ Catastrophic Illness and Injury Rider
☐ Cost of Living Rider
☐ Guaranteed Insurability Benefit
☐ Guaranteed Death Benefit Rider
☐ Survivor Conversion Option Rider
☐ Beneficiary Purchase Option Rider $ _____
☐ Other_____

14. Riders and Benefits on Other Proposed Insureds:

	Amount	Non-Tobacco	Non-Smoker	Tobacco/Smoker
☐ Spouse Rider				
☐ Other Insured Rider				
☐ Child Rider				
☐ Other_____				
☐ Other_____				

15. Remarks

Items 16 through 23 apply to and are to be completed for all persons proposed for insurance. For YES answers, give full details in section 24 below and complete any special form(s) required.

16. Is any insurance or annuity in this or any other company being replaced as a result of this application? (If YES, give full details below and complete any required replacement forms.) ..... ☐ Yes ☐ No

17. Have you made any flights, other than as a fare-paying passenger on a regularly scheduled airline, within the past 2 years; or do you intend to fly, other than as a fare paying passenger on a regularly scheduled airline? (If YES, give full details below and complete Special Activities Supplement to Application.) ..... ☐ Yes ☐ No

18. Have you participated in skin or scuba diving, hang gliding, parachuting, ballooning or motor racing of any kind within the past 3 years, or do you intend to participate in these activities? (If YES, give full details below and complete Special Activities Supplement to Application.) ..... ☐ Yes ☐ No

19. Have you had any involvement as an operator in a motor vehicle accident, or citation for a moving violation, or the suspension or revocation of driver's license within the past two years? (If YES, give full details below) If so provide your driver's license number and state of issue:_____ ..... ☐ Yes ☐ No

20. Do you intend to travel or reside outside of the United States in the next two years? (If YES, give full details below and complete Special Activities Supplement to Application.) ..... ☐ Yes ☐ No

21. Have you had any life, health or disability insurance declined, postponed, rated, modified, refused reinstatement or renewal, or a disability claim submitted to this or any other company within the past 5 years? (If YES, give full details below.) ..... ☐ Yes ☐ No

22. Is any other application(s) or negotiations for life, health, disability or accidental death insurance pending or contemplated? (If YES, give full details below including companies applied to, amounts and dates applied for.) .. ☐ Yes ☐ No

23. a. Have you ever used any kind of tobacco or any other product containing nicotine? ..... ☐ Yes ☐ No
    b. If "Yes", has such use been discontinued? ..... ☐ Yes ☐ No
    c. If use has been discontinued, give date it was discontinued: _____

24. Give full details to questions 16 through 23 above which have been answered YES:

25. Special Requests:

26. Home Office Corrections (Not for use with policies issued for delivery in MD, KY, PA, WV):

PART II

All **YES** answers require full details. (All questions pertain to each proposed insured.)

1. Does any proposed insured in Part I have a personal physician? (If YES, complete the following.) ☐ Yes ☐ No

Name of Proposed Insured	Name, Address and Phone Number of Personal Physician	Date Last Visited, Reason, Results

2. Has any proposed insured in Part I had any weight gain or loss in the last year? (If YES, complete the following.) ☐ Yes ☐ No

Name of Proposed Insured	Weight Gain (lbs.)	Weight Loss (lbs.)	Reason

3. Within the past 10 years, has any proposed insured in Part I been treated for or diagnosed by a member of the medical profession as having: (If YES, circle applicable condition.)
   a. Nervous or mental disorder, paralysis, epilepsy, loss of consciousness, stroke, recurring dizziness or chronic headaches? ☐ Yes ☐ No
   b. Asthma, pleurisy, bronchitis, emphysema, tuberculosis, spitting blood or chronic cough? ☐ Yes ☐ No
   c. Heart attack, heart disease, palpitations, angina or pain in the chest, heart murmur, rheumatic fever or high blood pressure? ☐ Yes ☐ No
   d. Ulcer of stomach or duodenum, colitis, disease of liver or gall bladder or gallstones? ☐ Yes ☐ No
   e. Kidney disease, kidney stones or renal colic? ☐ Yes ☐ No
   f. Blood, albumin, sugar or pus in the urine? ☐ Yes ☐ No
   g. Diabetes, venereal disease, goiter or a hernia? ☐ Yes ☐ No
   h. Anemia, or any disease of the blood or lymph glands? ☐ Yes ☐ No
   i. Eye or ear disease, loss of sight or hearing? ☐ Yes ☐ No
   j. Any disease of the breasts or pelvic organs? ☐ Yes ☐ No
   k. Any bone or joint disease, arthritis, gout, backache, sciatica, loss of extremity or deformity? ☐ Yes ☐ No
   l. Any thyroid or other endocrine disorder? ☐ Yes ☐ No
   m. Any cyst, cancer or tumor? ☐ Yes ☐ No
   n. An immune deficiency disorder, AIDS, or AIDS Related Complex (ARC) or positive text results indicating the presence of the AIDS virus? ☐ Yes ☐ No
   o. Any other illness, disease or injury? ☐ Yes ☐ No

4. Within the past 10 years, has any proposed insured in Part I:
   a. Had any treatment for, or been advised to have treatment for, or to refrain from, the use of alcohol or any drug, amphetamines, barbiturates, sedatives, cocaine or heroin? ☐ Yes ☐ No
   b. Used amphetamines, barbiturates, cocaine, heroin, sedatives or any controlled substance not prescribed by a physician? ☐ Yes ☐ No
   c. Had or been advised to have any surgery? ☐ Yes ☐ No
   d. Been treated, or been advised to have treatment, in or at any hospital, clinic or similar institution? ☐ Yes ☐ No

5. Within the past 5 years, has any proposed insured in Part I:
   a. Had a physical examination? ☐ Yes ☐ No
   b. Had any X-rays, electrocardiograms, blood tests or any other medical tests? ☐ Yes ☐ No
   c. Taken any medication? ☐ Yes ☐ No
   d. Been disabled? ☐ Yes ☐ No

6. Is any proposed insured in Part I:
   a. Now being treated by a physician or other licensed medical practitioner? ..... ☐ Yes ☐ No
   b. Now pregnant? (If YES, expected date of delivery_____.) ..... ☐ Yes ☐ No

7. Has any immediate family member of any proposed insured in Part I had any history of cancer, high blood pressure, heart or kidney disease, tuberculosis, epilepsy, diabetes, mental illness or attempted suicide? ..... ☐ Yes ☐ No

Give full details below for questions 3-7.

Question Number	Name of Proposed Insured	Give full details for each question answered YES, including date, nature of illness or injury, number of attacks, duration, severity, treatment, results, names, addresses and telephone numbers of doctors, hospitals or clinics involved. (If additional space required, use Additional Details Supplement to Application.)

8. Family History of Proposed Insured:

Family Member	Age if Living	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

9. Family History of Proposed Insured Spouse or Other Proposed Insured(s): (Provide name and information for each proposed insured. Attach Additional Details Supplement to Application if necessary.)

Proposed Insured: _____

Family Member	Age if Living	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Proposed Insured: _____

Family Member	Age if Living	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

AGREEMENT

GENERAL. To the best of the knowledge and belief of those who sign below, all answers to the questions in this application are complete and true. This application includes any supplements or amendments to it. It is agreed that all answers to such questions, including this agreement, will form the basis of any policy issued. Any information regarding any proposed insured will only be considered to have been given to Banner Life Insurance Company if it is stated in this application.

Acceptance of the policy by the owner shall constitute ratification of any changes made by Banner Life Insurance Company under "Home Office Corrections." However, in Maryland and all other states where the law requires written consent for any change in the application, no such change will become effective unless agreed to in writing. The notices for the Federal Fair Credit Reporting Act, Medical Information Bureau, Inc. Pre-Notice and Notice of Information Practice, have been received by the undersigned applicants.

WHEN INSURANCE TAKES EFFECT. Except as provided in the Conditional Receipt bearing the same number as this application, no insurance applied for will take effect until the full first premium is paid and such policy is delivered to the owner while all proposed insureds are living and their health remains as described in this application. If all of these take place, insurance will take effect on the policy date.

LIMITATION ON AUTHORITY OF AGENTS AND EXAMINERS. No sales representative or other person except the company's elected officers may waive or change the terms or provisions of this contract.

AUTHORIZATION. I authorize any physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, employer, consumer reporting agency, the Medical Information Bureau, and any other organization, institution or person having any information (including diagnosis, treatment or prognosis) about my physical or mental condition or any other information about me or my health, to give to Banner Life Insurance Company, its authorized representatives, and its reinsurers, any such information. I understand that this information will be used by Banner Life Insurance Company or its reinsurers to determine my eligibility for insurance or my eligibility for benefits under an insurance policy.

1. This authorization shall be valid for 30 months from the date below. A photostatic copy of this authorization shall be as valid as the original.

2. I understand that I am entitled to receive a copy of this authorization.

3. If an investigative consumer report is prepared in connection with my application, I request to be interviewed. ☐ Yes ☐ No

(Please DO NOT use felt tip pen for signatures.)

Signed at _____ on _____
City State Zip Date (month/day/year)

Agent X _____ X _____
Proposed Insured, or parent or legal guardian if Proposed Insured is a minor

Agent Number X _____

_____ _____
Owner, if other than the Proposed Insured Spouse or Other Insured

_____ _____
Contingent Owner Other Insured

Application No.: _____ _____
Other Insured

AUTHORIZATION TO DRAW CHECKS IN PAYMENT OF LIFE INSURANCE PREMIUMS

(Please type or print all items except signatures.)

AUTHORIZATION is hereby provided to Banner Life Insurance Company to draw a check each month upon my account at the:

ATTACH SAMPLE PERSONAL CHECK

_____

Full Name of Bank

_____

(Street Address (Not P.O. Box)) (City) (State) (Zip)

for the purpose of paying premiums for insurance on the following named persons:

Name of Insured(s) (Please Print)	Policy Number or Date of Application for Insurance if Policy has not Been Issued

(Please DO NOT use felt tip pen for signatures.)

This authorization is revocable only upon receipt by Banner Life Insurance Company of a written revocation signed by me. I hereby agree that the mailing of checks to the designated bank shall constitute due notice of premiums being due upon the policy.

Signed at _____ this _____ of _____ 20 _____

(city / state) (day) (month) (year)

X _____ X _____

Bank signature of Premium Payor(s) - Give Both signatures if Joint Account

ACKNOWLEDGEMENT OF RECEIPT OF APPLICATION IN HOME OFFICE

To be completed by Agent:

Agent's Account No.: _____ Proposed Insured: _____

To be completed in Home Office:

File No._____ Date Application Received: _____ Cash Received: $ _____

Remarks (Home Office use only):

AUTHORIZATION TO HONOR CHECKS

To _____ Bank

Bank Address _____
(Street Address (Not P.O. Box)) (City) (State) (Zip)

As a convenience to me, I hereby request and authorize you to pay and charge to my account checks drawn on my account by and payable to the order of Banner Life Insurance Company of Rockville, MD, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such check.

I further agree that if any such check be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

Banner Life Insurance Company is instructed to forward this authorization to you. (Please DO NOT use felt tip pen for signatures.)

X _____ X _____
Bank signature of Premium Payor(s) - Give Both signatures if Joint Account

_____ _____
Date Depositor's Bank Account No.

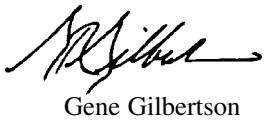
To: The Bank named above:

So that you may comply with your depositor's request, Banner Life Insurance Company agrees:

(1) To indemnify you and hold you harmless from any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any check, draft or order, whether or not genuine, purporting to be executed or issued by or on behalf of the undersigned, and received by you in the regular course of business for the purpose of payment, including any costs or expenses reasonably incurred in connection therewith.

(2) To indemnify you for any loss in the event that any such check, draft or order shall be dishonored whether with or without cause, and whether intentionally or inadvertently, even though such dishonor results in a forfeiture of the insurance.

(3) To defend at our own cost and expense any action which might be brought by any depositor or any other persons because of your actions taken pursuant to the foregoing requests, or in any manner arising by reason of your participation in the foregoing plan of premium collection.



Gene Gilbertson
Senior Vice President and Chief Financial Officer

Authorized in a resolution adopted by the Board of Directors at Banner Life Insurance Company on December 3, 1986.

Receipt No._____

CONDITIONAL RECEIPT

All premium checks must be made payable to **BANNER LIFE INSURANCE COMPANY** ("Company"); do not make check payable to the agent or leave the payee blank.

Banner Life Insurance Company has received from _____ the sum of $_____ in payment of the first premium on a proposed insurance policy for which an application corresponding in date and name with this receipt has been made to the Company.

No insurance shall take effect under this conditional receipt unless all of the following conditions are met:

1. The payment shown above must be at least equal to the minimum initial monthly premium for the plan and amount of insurance applied for;
2. All information which the Company shall require in order to determine the insurability of each person proposed for insurance must be received by the Company within sixty (60) days from the date of this Conditional Receipt;
3. Each person proposed for insurance must, as of the Effective Date, be determined to have been insurable under the Company's rules and standards for the plan and amount of insurance applied for on a standard premium basis;
4. The statements and answers in all parts of the application are, without material change, true and complete as of the Effective Date.

If all of the above conditions are met, then the insurance shall become effective as of the Effective Date. The insurance shall be as provided by the terms and conditions of the policy applied for and in use by the Company on the Effective Date.

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

Maximum Amount: The amount of insurance becoming effective under this Conditional Receipt is limited to the extent that the total liability of the Company for the death of each person proposed for insurance in the application shall not exceed $500,000 to issue age 75 and $200,000 between issue age(s) 76 and 80. There is no coverage beyond issue age 80. Such amount includes: (a) life insurance then in force with the Company and (b) any benefits payable by the Company as a result of accidental death.

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

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

The above referenced payment will also be returned if the Company: (a) declines to issue a policy as applied for or (b) issues a different policy not accepted by the Applicant. A delay in refund of the above payment shall not be construed to create a contract of insurance. Such delay will also not create any liability on behalf of the Company other than for return of the above payment.

This receipt shall be void if altered or modified. (Please DO NOT use felt tip pen for signatures.)

Dated at _____ this _____ day of _____, 20 _____.

X_____ Agent #_____

Agent

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

X_____ _____

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

NOTICE TO PROPOSED INSURED REGARDING INSURANCE WITH
BANNER LIFE INSURANCE COMPANY
1701 RESEARCH BOULEVARD, ROCKVILLE, MD 20850

NOTIFICATION UNDER FEDERAL FAIR CREDIT REPORTING ACT

This is to inform you that as part of our procedure for processing your insurance application, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics and mode of living. Upon receipt of a written request, the Company will provide you with further information about the nature and scope of any such investigation or the name and address of any agency from which a consumer report was requested.

NOTICE OF INFORMATION PRACTICES

In order to properly evaluate your insurability, we have to collect a certain amount of personal information about you. You are our most important source of information. However, we may also collect information from others who have information about you. This information, as well as other personal or privileged information, may be disclosed to others in certain circumstances. You have a right to obtain access to and to correct personal information collected by us. You also have a right to obtain a copy of any investigative consumer report on you in our files. We hope that you find this Notice of Information Practices informative. We want you to know that we take your privacy very seriously. If you would like a more detailed description of our information practices or if you have any questions about the material in this notice, please contact us.

MEDICAL INFORMATION BUREAU, INC. PRE-NOTICE

Information regarding your insurability will be treated as confidential. Banner Life Insurance Company, or its reinsurers, may make a brief report thereon to the Medical Information Bureau, Inc. ("Bureau"), a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information it may have in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure to you of any information it may have in its file on you. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, and the telephone number is (617) 426-3660.

Banner Life Insurance Company, or its reinsurers, may also release information in its file to other life or health insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted.

AGENT'S REPORT

(Must be completed in all instances)

1. How long have you known each proposed insured and/or owner? _____
   Are you related to any proposed insured and/or owner? ☐ Yes ☐ No
   (If related to any proposed insured, arrange for medical examination.)
   Relationship to Proposed Insured and/or Owner _____
   Relationship to Other Proposed Insured(s) _____

2. To the best of your knowledge, is any insurance or annuity in this or any other company being replaced as a result of this application? ☐ Yes ☐ No (If YES, attach completed replacement forms, if required.)

3. Purpose of Insurance
   ☐ Individual Protection ☐ Sole Proprietor Insurance ☐ Corporate Insurance: ☐ Split Dollar
   ☐ Family Insurance ☐ Partnership Insurance ☐ Reverse Split Dollar
   ☐ Estate Planning ☐ Deferred Compensation
   ☐ Other _____

   a. If business insurance, are other officers insured or applying for insurance at this time? ☐ Yes ☐ No
   (If YES, give names, amounts of insurance and percentage of interest in the business; if NO, explain.)
   _____

   b. If business insurance, the net worth of the business is $ _____

4. Do you have information not given in this application which might affect the insurability of any proposed insured? ☐ Yes ☐ No
   (If YES, give full details.)
   _____
   _____

5. a. Did you personally see the proposed insured(s)? ☐ Yes ☐ No
   b. Was the application signed by the proposed insured after all questions were answered? ☐ Yes ☐ No
   (If 5a or 5b is NO, give full details.) _____
   _____

6. If the proposed insured is married and coverage on the spouse is not requested, please give:
   a. Name of spouse _____ b. Amount of insurance on spouse _____

7. If the proposed insured is a minor child:
   a. Amount of insurance on father $ _____ on mother $ _____
   b. Any brothers or sisters? ☐ Yes ☐ No
   (If YES, give names and amount of life insurance on each. If YES, and there is no life insurance, please explain.)
   _____
   c. Are there any children on whom coverage is not being requested? ☐ Yes ☐ No
   (If YES, give full details.) _____
   d. Who will pay the premiums? _____

8. The following requirements have been ordered on the following proposed insured(s). (Indicate names next to requirements.):
   a. ☐ Paramedical Exam HOS _____
   b. ☐ Blood Profile _____
   c. ☐ EKG _____
   d. ☐ Chest X-Ray _____
   e. ☐ Inspection Report _____
   f. ☐ Other _____

9. Source of Business:
   a. ☐ Referred Lead b. ☐ Direct Mail Lead c. ☐ Home Office Lead d. ☐ Other Lead _____

10. Remarks: _____

Signature of Agent _____

Agent's Name(s) _____ #(s) _____

Date _____

If this is a split commission case provide agent names, numbers and percentage split _____
_____
_____

AGENT/AGENCY CHECK LIST

By completing the following check list, you will avoid underwriting delays, expedite policy issue and reduce application amendments.

1. Does this application qualify for Jet Issue?
   (If YES, attach Jet sticker to the front of the application.) ..... ☐ Yes ☐ No

2. Have all the questions on Part I, Part II, the Agent's Report and all supplemental forms been completed fully and correctly? ..... ☐ Yes ☐ No

3. Have all the changes been initialed by the applicant (owner)? ..... ☐ Yes ☐ No

4. Has the correct plan of insurance been indicated? (See Question #8.) ..... ☐ Yes ☐ No

5. For universal life, has Benefit Option A or B been checked? (See Question #12.)
   If VUL, complete VUL Supplement to Part I of application. ..... ☐ Yes ☐ No

6. Has the replacement question been answered and if applicable, proper forms enclosed? (See Question #16 and Agent's Report question #2.) ..... ☐ Yes ☐ No

7. Have all required signatures been obtained? ..... ☐ Yes ☐ No

8. Has the correct amount of premium been submitted with this application? (See Question #11.) ..... ☐ Yes ☐ No

9. Have the PAC form(s) and any other necessary questionnaires been properly completed and attached? ..... ☐ Yes ☐ No

10. Have the Medical Information Bureau and Consumer Report notices been given to the proposed insured(s)? ..... ☐ Yes ☐ No

11. Include an explanation for each question above answered "NO" and write any special message(s) to underwriting regarding this application in the space below.

Remarks:

Agent Name	Agent Number	Date
Agency Name	Agency Number	Date

1701 Research Boulevard
Rockville, Maryland 20850
(301) 279-4800

Privacy Policy

Our corporate policy.

Your privacy is important to us. At Banner Life Insurance Company, we understand that the information you provide to us or we collect about you is private.

This privacy policy is provided to you so that you will understand what Banner Life does with the personal information you provide to us and the measures we take to protect your privacy.

Who has access to customer information?

The information that you provide to us is used for Banner Life purposes only. Banner Life employees and independent agents have access to your information, and are authorized to review it, only for the purposes of carrying out their official duties and responsibilities. Banner Life employees and independent agents are required to keep customer information confidential.

Why does Banner Life collect and maintain information?

As a regulated insurance carrier, Banner Life is required by state laws and regulations to collect and maintain certain information about its customers. The information we collect also enables us to provide you with services and products that meet your individual needs and to provide you with the high level of customer care that you have come to expect from Banner Life.

What type of information does Banner Life collect and maintain?

Banner Life collects and maintains various types of information about its customers. The types of information we collect and maintain about you may include:

- Information that you submit to us, such as your name, address, telephone number, and Social Security Number.
- Information about your transactions with Banner Life, such as payment history and account balance.
- Information from non-affiliated third parties about your medical, employment and income history; your assets and liabilities; and your driving record.
- Information from consumer reporting agencies about your credit history.
- Information about you that may be derived from your visits to Banner Life's website.

Does Banner Life disclose customer information to, or share customer information with, outsiders?

Banner Life does not disclose any non-public personal financial or any non-public personal medical information about our customers or former customers to anyone, except as permitted or required by law.

It is Banner Life's current policy not to disclose customer information to, or share customer information with, other businesses for marketing purposes.

If this policy should change, Banner Life will notify you by mail, and you will be given an opportunity to request that your information not be disclosed to, or shared with, other businesses for marketing purposes.

How can I contact Banner Life if I have privacy questions?

If you have any questions about the privacy of your information, you can contact the Customer Service Department by:

Mail: Customer Service Department
Banner Life Insurance Department
1701 Research Boulevard
Rockville, MD 20850

or

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