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  - Faster cycle times
  - Potential for instant decisions
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# Banner Life Insurance Company

## Individual Life Insurance Application

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### Information and Underwriting Practices (Including MIB, Inc. Notice and Fair Credit Reporting Act Notice)

As used in this application for life insurance, references to “you” mean the proposed insured.

#### Underwriting

Once we receive your application, we will begin an evaluation process called underwriting to determine whether you are eligible for insurance and, if so, the rate you should pay for that insurance. We may find that we are unable to give you the insurance you have applied for or that we are able to give it to you only on a modified basis or at a rate greater than our lowest rate.

Your application will be our primary source of information; therefore, it must be true, complete, and accurate. You must inform us of a change to any answer in any part of your application before accepting delivery of a policy; in fact, you agree to do so when you sign your application. We will seek information from other sources to help us evaluate the information you give us on your application.

#### Contestability

We strongly urge you to review the completed application closely for accuracy. A claim may be denied, the policy may be void or your coverage may be lost if the application is incomplete or if it contains false statements or material misrepresentations. Any policy that may be issued will indicate when and under what circumstances it may be contested. Please be aware that if the application contains material misrepresentations or conceals material facts, and you submitted it with the intent to defraud or to facilitate fraud against us, you may also be guilty of insurance fraud, which is a crime. You must inform us of a change to any answer in any part of your application before accepting delivery of a policy; in fact, you agree to do so when you sign your application.

#### Replacement of Existing Coverage

If you intend to replace existing coverage, please inform us and answer “yes” to the replacement question in the application; state law may require that additional forms be completed and information obtained that may help you compare policies. If you are undecided about keeping existing coverage, indicating an intention to replace existing coverage may help you get the information you need to make a decision. If you do replace existing coverage, the new policy may contain new suicide and contestable periods. The following would be considered replacement: you stop paying premiums on an existing policy or surrender an existing policy before or shortly after applying to us or you borrow from an existing policy to pay premiums for the insurance for which you are applying. State law may define replacement to include other situations.

#### Insurance Information Practices

We will rely primarily on information provided by you. We may supplement that information with information from other sources such as medical professionals who have treated you. In some cases, we may ask a consumer reporting agency to collect information and submit an investigative consumer report to us as explained in this Notice under Federal Fair Credit Reporting Notice. You may request to be interviewed in connection with the preparation of this report.

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

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

We will send you a more detailed explanation of our information practices if you send us a written request. You may send your request to the Underwriting Manager, Banner Life Insurance Company, 3275 Bennett Creek Avenue, Frederick, MD 21704.



## **Information and Underwriting Practices (Including MIB, Inc. Notice and Fair Credit Reporting Act Notice) (cont'd)**

### **Federal Fair Credit Reporting Notice**

As part of our underwriting, we may ask that an investigative consumer report be prepared. An independent source known as a consumer reporting agency will prepare the report. The report will typically include information as to your character, general reputation, mode of living, and personal characteristics. The agency may conduct personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted in order to get this information. If you write to us within a reasonable time after you receive this Notice, we will tell you whether or not a report was requested. If a report was requested, we will tell you the name, address, and telephone number of the agency to whom the request was made. Upon request, the agency will furnish information as to the nature and scope of its investigation. If you would like to inspect and to receive a copy of the report, you may do so by contacting the agency.

### **MIB, Inc. (Medical Information Bureau) Pre-Notice Disclosure**

Information regarding your insurability will be treated as confidential. Banner Life Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB, Inc. member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, Inc., upon request, will supply each company with the information about you in its file.

Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information in your file. Please contact MIB, Inc. at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB, Inc.'s file, you may contact MIB, Inc. and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB, Inc.'s information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734.

Banner Life Insurance Company, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB, Inc. may be obtained on its website at [www.mib.com](http://www.mib.com).

# Banner Life Insurance Company

## Individual Life Insurance Application

### Part 1

#### Section A: Proposed Insured (You)

1. Full Name

\_\_\_\_\_  
First Middle Last

\_\_\_\_\_  
Maiden Suffix

2. Sex  Male  Female

3. Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ 4. Social Security Number \_\_\_\_\_

5. Email Address \_\_\_\_\_

6. Primary Residence (If mailing address is different, please include in Section K details)

\_\_\_\_\_  
Address

\_\_\_\_\_  
Apt. Number City State Zip

7. Phone numbers Please check box for contact preference

8. Are you Please check one

Cell (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Home (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Work (\_\_\_\_) \_\_\_\_ - \_\_\_\_

U.S. Citizen

U.S. Permanent Resident (green card)

U.S. H1B Visa Holder

Other (provide details): \_\_\_\_\_

9. State of Birth \_\_\_\_\_ (Country if not born in U.S.) \_\_\_\_\_

10. Driver's License or State ID No. \_\_\_\_\_ State of Issue \_\_\_\_\_

11. Please check one box below that best describes your employment status

Paid Employee or self-employed  Student  Retired

Homemaker or stay-at-home parent  Unemployed

12a. Do you work in any of the following occupations (please check all that apply)?

The military (full-time or reserves)  Full-time bartender or nightclub worker  Fire-fighter

A pilot or member of a flight crew  Stuntperson or circus performer  SWAT team member

Corrections officer in prison team  Professional sportsperson  None

12b. Do the duties of your occupation require you to be (please check all that apply)?

Outside at heights over 50 ft.  Near explosive or nuclear materials

Underground (e.g. mining)  On site at an oil or gas production facility

Underwater (e.g. diving)  Near corrosive or toxic materials

At sea (e.g. on a fishing boat or cargo ship)  In a meat processing facility

Using heavy machinery or equipment at high temperatures or high pressure  None



## Section B: Insurance Applied For

1. Amount of Insurance \$ \_\_\_\_\_
2. Plan of Insurance \_\_\_\_\_
3. Death Benefit Option (if available with Plan)  
 Level Death Benefit  Increasing Death Benefit
4. Additional Benefits (if available) complete supplemental applications as necessary  
 Waiver of Premium  Child Insurance Rider  Accidental Death  
 Term Insurance Rider: \$ \_\_\_\_\_ amount \_\_\_\_\_ term. \_\_\_\_\_ # in years  
 Term Insurance Rider: \$ \_\_\_\_\_ amount \_\_\_\_\_ term. \_\_\_\_\_ # in years  
 Other: (description and amount): \_\_\_\_\_
5. Why is this insurance being purchased (check one)?  
 Personal Insurance  Business Insurance (check all that apply)  
 Keyperson  Buy-Sell  Loan Collateral  Stock Redemption

## Section C: Beneficiary *Share percentage totals must equal 100%. If necessary, use Remarks Section K.*

1. Primary Beneficiary Type:  Trust (skip to Section D, complete Section E)  Estate of the insured (skip to D)  
 All lawful children equally  Individual  Business  Other Type \_\_\_\_\_

Unless Beneficiary is a trust or estate of the Insured, complete the rest of this section.

### 1a. Primary Beneficiary (Beneficiaries)

\_\_\_\_\_  
 First Middle Last

Or Business Name \_\_\_\_\_

\_\_\_\_\_  
 Relationship to Proposed Insured % Share (\_\_\_\_\_) - \_\_\_\_\_  
 SSN or Tax ID# \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_  
 Telephone \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_  
 Apt. Number City State Zip

### 1b.

\_\_\_\_\_  
 First Middle Last

Or Business Name \_\_\_\_\_

\_\_\_\_\_  
 Relationship to Proposed Insured % Share (\_\_\_\_\_) - \_\_\_\_\_  
 SSN or Tax ID# \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_  
 Telephone \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_  
 Apt. Number City State Zip

## Section C: Beneficiary (cont'd)

### 2a. Contingent Beneficiary (Beneficiaries)

\_\_\_\_\_  
 First Middle Last

Or Business Name \_\_\_\_\_

\_\_\_\_\_  
 Relationship to Proposed Insured % Share ( ) -  
 SSN or Tax ID# \_\_\_\_\_ Date of Birth / / Telephone

Address \_\_\_\_\_

\_\_\_\_\_  
 Apt. Number City State Zip

### 2b.

\_\_\_\_\_  
 First Middle Last

Or Business Name \_\_\_\_\_

\_\_\_\_\_  
 Relationship to Proposed Insured % Share ( ) -  
 SSN or Tax ID# \_\_\_\_\_ Date of Birth / / Telephone

Address \_\_\_\_\_

\_\_\_\_\_  
 Apt. Number City State Zip

## Section D: Owner

1. Owner is  Proposed Insured (Skip to Section E)  Trust (Skip to Section E)  Other than Proposed Insured or Trust

\_\_\_\_\_  
 First Middle Last

Or Business Name \_\_\_\_\_

\_\_\_\_\_  
 Relationship to Proposed Insured % Share ( ) -  
 SSN or Tax ID# \_\_\_\_\_ Date of Birth / / Telephone

Address \_\_\_\_\_ City

\_\_\_\_\_  
 State Zip Email Address

If Owner is a business, also provide website address \_\_\_\_\_

### Section E: Trust Information (Complete if trust is owner or beneficiary)

- 1. Type of Trust?  Irrevocable  Revocable  
 Testamentary (Trustee as listed in my last will and testament - skip to Section F)
- 2. Exact name of trust

Trust Name

Current Trustee

First

Middle

Last

Trust Tax ID#

Date of Trust

\_\_\_\_ / \_\_\_\_ / \_\_\_\_

Address

City

State

Zip

Email Address

Telephone

(\_\_\_\_) \_\_\_\_ - \_\_\_\_

For multiple Trustees, check one of the following boxes (if no box is checked, the Company will require all signatures)

- A majority may act for all
- Anyone may act alone
- All must act unanimously
- Certain Trustees must act jointly (provide names in Remarks Section K)

### Section F: Premium and Payor

- 1. Payment Method:  Electronic Funds Transfer (EFT)  Direct Bill
- 2. Frequency of Premium Payment  Annual  Semi-Annual  Quarterly  Monthly (EFT only)
- 3. Planned periodic premium for universal life product: (Provide details in Remarks Section K.)  
a.  1st Year Only \$ \_\_\_\_\_ 2nd Year and Thereafter \$ \_\_\_\_\_ or  
b. Premium For All Years \$ \_\_\_\_\_
- 4. a. Date to Save Age?  Yes  No b. Specific Policy Date  Yes  No Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_
- 5. Who will pay the premium? (the individual or legal entity making premium payments and receiving premium notifications, notice of pending lapses, and termination for nonpayment)  
 Proposed Insured  Owner  Other - If Other, complete the information below.

Or Business Name

Address

City

State

Zip

Email Address

Telephone

(\_\_\_\_) \_\_\_\_ - \_\_\_\_

Relationship to Proposed Insured

## Section F: Premium and Payor (cont'd)

6. Designate Secondary Addressee (Optional - In addition to the Payor, an additional individual or legal entity can be elected to receive premium notifications, notice of pending lapses, and termination for nonpayment)

\_\_\_\_\_  
 First Middle Last

\_\_\_\_\_  
 Or Business Name

\_\_\_\_\_  
 Address

\_\_\_\_\_  
 Apt. Number City State Zip

Telephone ( ) -

## Section G: Other Insurance

- 1a. Do you have existing life insurance or annuity contracts (except for group insurance through our employer)?.....  Yes  No
- 1b. If yes, provide information for each policy currently in force (except group insurance). Indicate which will be replaced, end, or changed by the insurance currently being applied for.

Company	Face Amount	Issue Year	Business Insurance?		Replacing?	
			Yes	No	Yes	No
	\$					
	\$					
	\$					
	\$					

2. Including this application, but excluding group insurance, what will be the total amount of life insurance coverage on your life? \$ \_\_\_\_\_

## Section H: General Questions

1. Have you ever had an application for life, disability income or long term care insurance declined, postponed, modified, rated or offered with a reduced face amount? (If Yes, provide details in Section K).....  Yes  No
- 2a. In the past 10 years have you used any form of tobacco or nicotine product, including cigarettes, chewing tobacco, smokeless tobacco, cigars, nicotine gum, patch, vaping or electronic cigarettes?(Please ignore cigar use if fewer than 13 per year).....  Yes  No
- 2b. If yes, what was the date you last used tobacco or nicotine product? Month \_\_\_\_\_ Year \_\_\_\_\_
- 3a. In the last 5 years, have you used marijuana (cannabis) in any form?.....  Yes  No
- 3b. If yes, do you use:  more than once a week  once a week  less than once a week
- Date of last use: Month \_\_\_\_\_ Year \_\_\_\_\_
4. 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 yourself or your immediate family members? (If Yes, provide details in Section K).....  Yes  No

## Section H: General Questions (cont'd)

5. Have you ever been convicted of, or currently charged with, a felony, or are you currently on parole or probation?.....  Yes  No

6a. In the last 5 years, have you filed for bankruptcy?.....  Yes  No

6b. If yes, check Chapter Type:  7  11  13  15

6c. And, discharge date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

7. In the last 8 years, how many times have you been convicted of, or pled guilty or no contest to Driving While Intoxicated (DWI) or Driving Under the Influence (DUI)? \_\_\_\_\_

Date of last offense: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

8a. In the past 5 years, have you had your driver's license suspended or revoked, or been convicted of, or pled guilty or no contest to a moving violation?.....  Yes  No

8b. (If yes, complete grid below)

Offense	How many during the last:		
	2 years	3 years	5 years
Driver's license suspension or revocation			
Moving Violations			

9. Which, if any, do you engage in or plan to engage in the next 6 months? (check all that apply or None)

- |  |   |
|--|---|
| <input type="checkbox"/> Motor Sports Racing                               | <input type="checkbox"/> Skydiving  |
| <input type="checkbox"/> BASE jumping                                      | <input type="checkbox"/> Scuba diving deeper than 100ft   |
| <input type="checkbox"/> Hang gliding                                      | <input type="checkbox"/> Ultralight flying  |
| <input type="checkbox"/> Ice, rock or mountain climbing (excluding indoor) | <input type="checkbox"/> Any activity involving flying (other than as a passenger or crew member of a commercial airline) |
| <input type="checkbox"/> Heli-skiing                                       | <input type="checkbox"/> None   |

10. Do you have a valid pilot's license?.....  Yes  No

11a. Do you intend to travel outside the U.S. or Canada, or change country of residence in the next 12 months? (check all that apply)

- Travel outside the U.S. or Canada (if checked, answer b. and c.)
- Change country of residence  No travel or change of residence

11b. How many weeks does the Proposed Insured expect to be outside of the U.S. and Canada in the next 12 months?  
 \_\_\_\_\_ weeks

11c. What countries do you intend to travel to?

Country	For how long? (in days)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

## Section H: Other Insurance (cont'd)

- 11d. If Mexico, what city will you be traveling to? \_\_\_\_\_
- 11e. And, what mode of transportation will be used to get there?  Commercial Airline  Cruise Ship  
 Other \_\_\_\_\_

## Section I: Proposed Insured Financial Information

1. What is your annual earned income (include salary, bonus, commissions, etc)? \$ \_\_\_\_\_
2. What is the total household earned income? \$ \_\_\_\_\_  
 Complete only if your annual earned income is less than \$20,000 (otherwise skip to next section).
- 3a. Do you have a spouse or life partner?.....  Yes  No
- 3b. If yes, do they have at least the same amount of life insurance (either in force or applied for) with you as the beneficiary?.....  Yes  No

## Section J: Business Financial Information

Complete this section if the purpose of the insurance is business insurance.

1a. Name of Business \_\_\_\_\_

1b. Address \_\_\_\_\_

\_\_\_\_\_ Apt. Number \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

1c. Website \_\_\_\_\_

If you prefer your financial professional (accountant, CPA, attorney, etc.) to provide business valuation information, provide contact information.

\_\_\_\_\_ ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_  
 Name of Financial Professional Telephone

Address \_\_\_\_\_

\_\_\_\_\_ Apt. Number \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Website \_\_\_\_\_

2. What is the business net income after taxes for the prior tax reporting year? \$ \_\_\_\_\_
3. What is the date the business was established? \_\_\_\_\_ / \_\_\_\_\_
4. In the last 5 years, has the business or its principals filed for bankruptcy or had any charge off of bad debts?.....  Yes  No

## Section J: Business Financial Information (cont'd)

5. What type of business?  Sole Prop  LLC  S-Corp  Other \_\_\_\_\_
- 6a. What percentage of the business do you own? \_\_\_\_\_ % (if 100%, skip to Section K)
- 6b. Are other partner/owners/executives being proportionally insured? (Use Remarks Section K to indicate names, percentage of ownership and amount of coverage for each).....  Yes  No
- 

## Section K: Remarks - Use Supplement to Applications if necessary

## Declarations

I/we have read the application and all statements and answers contained within this application including Part 1 or Part 2, and any statements or supplements thereto, copies of which shall be attached to and made a part of any policy to be issued, are true and complete to the best of my/our knowledge and belief and made to induce Banner Life Insurance Company (the Company) to issue an insurance policy. The statements and answers in the application are the basis for any policy issued by the Company, and no information about me will be considered to have been given to the Company unless it is stated in the application.

I agree to notify the Company of any changes to the statements and answers given in any part of the application before accepting delivery of any policy. No agent, sales representative, or other person has power to:

- (a) accept risk;
- (b) make or modify contracts;
- (c) make, void, waive or change any conditions or provisions of the application, policy or receipt, as applicable;
- (d) waive any Company rights or requirements;
- (e) waive any information the Company requests;
- (f) discharge any contract of insurance; or
- (g) bind the Company by making promises respecting benefits upon any policy to be issued.

**I/we understand and agree that no insurance will be in effect unless and until: (i) the policy has been delivered and accepted; (ii) the full first modal premium for the issued policy has been paid while the insured is alive; and (iii) there has been no change in either the health or habits of the proposed insured or any answers to any of the questions in the application.**

Changes or corrections made by the Company and noted in the Remarks section above are ratified by the Owner upon acceptance of a contract containing this application with the noted changes or corrections. Any change in plan of insurance, amount, age at issue, gender if applicable, class, or benefits shall require the written consent of the Owner and the Proposed Insured.

**NOTICE:** State insurance law may prohibit the owner of a life insurance policy from entering into any agreement to sell, transfer or assign a life insurance policy prior to the date the policy was issued, or within a period of time specified by state law after the date the policy was issued. You should consult with legal advisors if you have any questions about these matters.

**I/We Acknowledge that:** federal law requires sufficient information to identify the parties to the purchase of a policy, and that failure to provide such information could result in the policy not being issued, being delayed, unprocessed transaction requests or policy termination.

**I/We agree that:** by providing an email address authorizes the Company to communicate by email as well as to deliver our policy and related documents by email subject to eligibility, and that I/We have access to the internet and a valid email address to receive electronic policy delivery.

## Authorization to Obtain and Disclose Information and Information Practices

I/We acknowledge we received a copy of and completed an Authorization to Obtain and Disclose Information along with the Company's Information and Underwriting Practices, including the MIB, Inc Notice and Fair Credit Reporting Notice.

I/We would like to be interviewed if an investigative consumer report will be made (please refer to the Company's Information and Underwriting Practices, for more information on an investigative consumer report).

**Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.**

\_\_\_\_\_  
 Proposed Insured

Signed at \_\_\_\_\_ on \_\_\_\_\_  
 City/State Date(mm/dd/yy)

\_\_\_\_\_  
 Signature of Owner (if other than Proposed Insured). If Owner is a firm, trust, or corporation, include signer's title with signature.

Signed at \_\_\_\_\_ on \_\_\_\_\_  
 City/State Date(mm/dd/yy)

\_\_\_\_\_  
 Print Owner/Officer Name (if applicable)

\_\_\_\_\_  
 Signature of Agent/Broker/Producer

Owner Title \_\_\_\_\_  
 Signed at \_\_\_\_\_ on \_\_\_\_\_  
 City/State Date(mm/dd/yy)

# Banner Life Insurance Company

## Individual Life Insurance Application

### Section A: Medical History

1. Name of Proposed Insured

Policy Number (if known)

First

Middle

Last

2. Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_

3. Height \_\_\_\_ ft. \_\_\_\_ in.

4. Weight \_\_\_\_ lbs.

4a. Has your weight changed by more than 10 lbs. in the past year?  Yes  No

4b. If yes, amount gained \_\_\_\_ lbs. or amount lost \_\_\_\_ lbs. and reason:

Diet and/or exercise

Pregnancy/Childbirth

Weight loss surgery

Illness/disease/injury

Other \_\_\_\_\_

5. Primary Physician

Name of Physician or Facility

Address

Apt. Number

City

State

Zip

Telephone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

\_\_\_\_ / \_\_\_\_ / \_\_\_\_

\_\_\_\_ / \_\_\_\_ / \_\_\_\_

Date last seen

Date of last full physical  
including blood tests

6. Physician Last Consulted (if same as Primary Physician, skip to Question 7)

Name of Physician or Facility

Address

Apt. Number

City

State

Zip

Telephone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

\_\_\_\_ / \_\_\_\_ / \_\_\_\_

Date last seen

Specialty

7. Health Insurer Company Name

Name

Plan Number

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Date coverage started



8a. How many alcoholic drinks do you consume per week? \_\_\_\_\_

8b. When you consume alcohol, what is the average number of drinks you have? \_\_\_\_\_

## Section B: Family History

1a. Have both of your biological parents lived to age 75 or older?.....  Yes  No  Unknown1b. Has a biological parent ever been diagnosed or treated by a licensed health care professional for coronary artery disease, angina, heart attack or cancer before age 60?.....  Yes  No  Unknown1c. Has a biological parent ever been diagnosed or treated by a licensed health care professional for polycystic kidney disease, Huntington's disease, sickle cell anemia or FAP (familial adenomatous polyposis)?.....  Yes  No  Unknown

2. If yes to 1b, complete the table in question 2 below (otherwise skip to question 3.)

	Age at Onset of Condition		If death caused from listed condition, age of death	
	Mother	Father	Mother	Father
Coronary Artery Disease, Angina, Heart Attack				
Cancer of the Breast or Ovary				
Cancer of the Bowel (Colon)				
Cancer of another site				

3a. Has a biological sibling ever been diagnosed or treated by a licensed health care professional for coronary artery disease, angina, heart attack or cancer before age 60?.....  Yes  No  Unknown3b. Has a biological sibling ever been diagnosed or treated by a licensed health care professional for polycystic kidney disease, Huntington's disease, sickle cell anemia or FAP (familial adenomatous polyposis)?.....  Yes  No  Unknown

4. If yes to 3a, complete the table in question 4 below (otherwise skip to Section C.)

	Number of siblings with condition	Youngest age of onset	Second youngest age of onset	If death from condition, youngest age of death
Coronary Artery Disease, Angina, Heart Attack				
Cancer of the Breast or Ovary				
Cancer of the Bowel (Colon)				
Cancer of another site				

## Section C: Health History

For each question 1-7, check all the boxes that apply, or the box labeled none. Where the answer is other than none, please provide details in Section F.

Have you EVER seen a licensed health care professional regarding, or have you EVER been diagnosed or treated for:

1. Any of the following, check all that apply or none:

- |   |  |
|---|--|
| <input type="checkbox"/> Stroke           | <input type="checkbox"/> TIA (Transient Ischemic Attack)     |
| <input type="checkbox"/> Mini Stroke      | <input type="checkbox"/> Carotid Artery Disease              |
| <input type="checkbox"/> Brain Hemorrhage | <input type="checkbox"/> Diabetes                            |
| <input type="checkbox"/> High Blood Sugar | <input type="checkbox"/> Disease or Disorder of the Pancreas |
|   | <input type="checkbox"/> None                                |

## Section C: Health History (cont'd)

## 2. Heart Disease or Disorder:

- |  |  |
|--|--|
| <input type="checkbox"/> Angina        | <input type="checkbox"/> Heart Murmur or Valve Problem |
| <input type="checkbox"/> Heart Attack  | <input type="checkbox"/> Coronary Artery Disease       |
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Other                         |
|  | <input type="checkbox"/> None                          |

## 3. Cancer or Cancerous condition:

- |   |   |
|---|---|
| <input type="checkbox"/> Hodgkin's Lymphoma | <input type="checkbox"/> Non-Hodgkin's Lymphoma |
| <input type="checkbox"/> Leukemia           | <input type="checkbox"/> Basal Cell Carcinoma   |
| <input type="checkbox"/> Melanoma           | <input type="checkbox"/> Other                  |
| <input type="checkbox"/> Tumor              | <input type="checkbox"/> None                   |

## 4. Disorder of your blood or blood vessels:

- |  |   |
|--|---|
| <input type="checkbox"/> Anemia  | <input type="checkbox"/> DVT (Deep Vein Thrombosis) |
| <input type="checkbox"/> Clotting Disorder   | <input type="checkbox"/> Blood Clot                 |
| <input type="checkbox"/> Surgery to your blood vessels (please ignore non-ulcerative varicose veins) | <input type="checkbox"/> Other                      |
|  | <input type="checkbox"/> None                       |

## 5. Neurological conditions:

- |  |  |
|--|--|
| <input type="checkbox"/> MS (Multiple Sclerosis) | <input type="checkbox"/> ALS (Amyotrophic Lateral Sclerosis) |
| <input type="checkbox"/> Parkinson's Disease     | <input type="checkbox"/> Convulsions or Seizures             |
| <input type="checkbox"/> Optic Neuritis          | <input type="checkbox"/> Other                               |
|  | <input type="checkbox"/> None                                |

## 6. Disease or disorder of your intestine, colon or rectum:

- |  |   |
|--|---|
| <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Ulcerative Colitis |
| <input type="checkbox"/> Colitis         | <input type="checkbox"/> Duodenitis         |
| <input type="checkbox"/> Spastic Colon   | <input type="checkbox"/> Other              |
|  | <input type="checkbox"/> None               |

## 7. Disease or disorder of your liver:

- |                                    |                                      |
|------------------------------------|--------------------------------------|
| <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Fatty Liver |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Other       |
|                                    | <input type="checkbox"/> None        |

For questions 8-13, have you EVER been: **(if yes, provide details in Section F)**

8. Admitted to a hospital for suicidal thoughts or attempts of suicide or any other mental health condition?.....  Yes  No
9. Diagnosed by a member of the medical profession or tested positive for the Human Immunodeficiency (AIDS virus) or acquired immune deficiency syndrome (AIDS)?.....  Yes  No
10. Addicted to alcohol or been advised by a medical professional to reduce the amount of alcohol you drink due to how much you use?.....  Yes  No

## Section C: Health History (cont'd)

11. Advised by a physician or member of the medical profession to attend or attended an alcohol support group?.....  Yes  No
12. A user of narcotics, barbiturates, anabolic steroids, amphetamines, hallucinogens, heroin, crack, cocaine, or habit forming drugs except as prescribed by a licensed health care professional?.....  Yes  No
13. Addicted to or misused prescription medication?.....  Yes  No

## Section D: Health History 5 Years

For each question 1-8, check all the boxes that apply, or the box labeled none. Where the answer is other than none, please provide details in Section F.

Apart from anything you've already told us about in this application, during the last 5 years have you consulted a licensed health care professional regarding or have you been diagnosed or treated for:

1. Any of the following, check all that apply or none:

- |   |  |
|---|--|
| <input type="checkbox"/> High Cholesterol   | <input type="checkbox"/> High or Borderline High Blood Pressure  |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Palpitations                            |
| <input type="checkbox"/> Chest Pain         | <input type="checkbox"/> Irregular Heart Beat                    |
| <input type="checkbox"/> Paralysis          | <input type="checkbox"/> Persistent Tingling or Pins and Needles |
| <input type="checkbox"/> Numbness           | <input type="checkbox"/> None                                    |

2. Any of the following, check all that apply or none:

- |  |   |
|--|---|
| <input type="checkbox"/> Growth or Lump              | <input type="checkbox"/> Polyp              |
| <input type="checkbox"/> HPV (Human Papilloma Virus) | <input type="checkbox"/> Pre-Cancerous Mole |
|  | <input type="checkbox"/> None               |

3. Any disease or disorder of your kidneys, bladder or prostate:

- |  |  |
|--|--|
| <input type="checkbox"/> Cystitis            | <input type="checkbox"/> Sugar in your Urine   |
| <input type="checkbox"/> Blood in your Urine | <input type="checkbox"/> Protein in your Urine |
| <input type="checkbox"/> Kidney Stones       | <input type="checkbox"/> Other                 |
|  | <input type="checkbox"/> None                  |

4. Any disease or disorder of your esophagus, stomach, gallbladder or bowel: (please ignore diarrhea, food poisoning, sickness or vomiting, stomach bug or upset provided no hospital investigations were advised or completed)

- |   |  |
|---|--|
| <input type="checkbox"/> Barrett's Esophagus  | <input type="checkbox"/> GERD (Gastroesophageal Reflux Disorder) |
| <input type="checkbox"/> Celiac Disease       | <input type="checkbox"/> IBS (Irritable Bowel Syndrome)          |
| <input type="checkbox"/> Diverticular Disease | <input type="checkbox"/> Other                                   |
| <input type="checkbox"/> Ulcers               | <input type="checkbox"/> None                                    |

5. Any disease or disorder of your lungs or breathing:

- |                                      |   |
|--------------------------------------|---|
| <input type="checkbox"/> Asthma      | <input type="checkbox"/> Sleep Apnea                                  |
| <input type="checkbox"/> Emphysema   | <input type="checkbox"/> COPD (Chronic Obstructive Pulmonary Disease) |
| <input type="checkbox"/> Bronchitis  | <input type="checkbox"/> Pulmonary Fibrosis                           |
| <input type="checkbox"/> Sarcoidosis | <input type="checkbox"/> Other  |
|                                      | <input type="checkbox"/> None   |

## Section D: Health History 5 Years (cont'd)

### 6. Any Arthritis or Auto-Immune condition:

- |   |   |
|---|---|
| <input type="checkbox"/> Lupus                | <input type="checkbox"/> Ankylosing Spondylitis |
| <input type="checkbox"/> Osteomyelitis        | <input type="checkbox"/> Gout                   |
| <input type="checkbox"/> Fibromyalgia         | <input type="checkbox"/> Other                  |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> None                   |

### 7. Any Mental Illness:

- |  |  |
|--|--|
| <input type="checkbox"/> Anxiety             | <input type="checkbox"/> PTSD (Post-Traumatic Stress Disorder)           |
| <input type="checkbox"/> Schizophrenia       | <input type="checkbox"/> Suicidal Thoughts or Actions                    |
| <input type="checkbox"/> Anorexia or Bulimia | <input type="checkbox"/> ADHD (Attention Deficit Hyperactivity Disorder) |
| <input type="checkbox"/> Bipolar Disorder    | <input type="checkbox"/> Other   |
| <input type="checkbox"/> Depression          | <input type="checkbox"/> None  |

### 8. Any Dementia or Memory Loss:

- |  |                                |
|--|--------------------------------|
| <input type="checkbox"/> Memory Loss         | <input type="checkbox"/> Other |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> None  |

## Section E: Health History Other

**Apart from** anything you've already told us about in this application: (if yes, provide details in Section F)

1. Are you currently waiting to be evaluated or tested at a hospital or by a licensed health care professional?.....  Yes  No
2. Have you been referred to any licensed health care professional or medical facility within the last six months?.....  Yes  No
3. Have you been advised by a licensed health care professional to see them within the next six months? (Please ignore consultation for repeat prescriptions).....  Yes  No
4. During the last 3 months, have you been diagnosed or treated by a member of the medical profession for any of the following: (if yes, provide details in Section F)
 

<input type="checkbox"/> Unexplained Bleeding	<input type="checkbox"/> A cough that's lasted for 3 weeks or more
<input type="checkbox"/> Lump or Growth	<input type="checkbox"/> A mole or freckle that has bled or changed in appearance
<input type="checkbox"/> Fainting	<input type="checkbox"/> Vertigo
<input type="checkbox"/> Any other symptom that you intend to see a licensed health care professional about for the first time	<input type="checkbox"/> None

## Section F: Details

## Section F: Details (cont'd) - Use Supplement to Applications if necessary

## Declarations

I have read the application and all statements and answers contained within this application, including any Part 1 or Part 2, and any statement or supplements thereto, copies of which shall be attached to and made a part of any policy to be issued, are true and complete to the best of my/our knowledge and belief and made to induce Banner Life Insurance Company (the Company) to issue an insurance policy. The statements and answers in the application are the basis for any policy issued by the Company, and no information about me will be considered to have been given to the Company unless it is stated in the application.

I agree to notify the Company of any changes to the statements and answers given in any part of the application before accepting delivery of any policy. No agent, sales representative, or other person has power to:

- (a) accept risk
- (b) make or modify contact;
- (c) make, void, waive or change any conditions or provisions of the application, policy or receipt, as applicable;
- (d) waive any Company rights or requirements;
- (e) waive any information the Company requests;
- (f) discharge any contract of insurance; or
- (g) bind the Company by making promises respecting benefits upon any policy to be issued.

**I understand and agree that no insurance will be in effect unless and until: (i) the policy has been delivered and accepted; (ii) the full first modal premium for the issued policy has been paid while the insured is alive; and (iii) there has been no change in either the health or habits of the proposed insured or any answers to any of the questions in the application.**

Changes or corrections made by the Company, such as amendments, corrections, or additions, are ratified by the Owner upon acceptance of a contract containing this application with the noted changes or corrections. Any change in plan of insurance, amount, age at issue, gender if applicable, class, or benefits shall require the written consent of the Owner and the Proposed Insured.

**Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.**

\_\_\_\_\_  
Proposed Insured

Signed at \_\_\_\_\_  
City/State

\_\_\_\_\_  
Date (mm/dd/yy)

**AGENT'S REPORT**

1. Name of Proposed Insured \_\_\_\_\_ Date of Birth \_\_\_\_\_
2. Number of years you have known the primary Proposed Insured \_\_\_\_\_
3. Who first suggested the purchase of this insurance?  Agent  Owner/Applicant  Proposed Insured  Other \_\_\_\_\_
4. Was the application signed after all questions were answered?.....  Yes  No
5. Did you personally see the Proposed Insured?.....  Yes  No
6. Did anyone sign or assist in the completion of Part 1 or Part 2 of the Application for or on behalf of the Proposed Insured? .....  Yes  No
7. Are you aware of any information that would adversely affect any Proposed Insured's eligibility, acceptability, or insurability?...  
If Yes, please provide details in the Remarks section below, and do not provide limited temporary life insurance.  Yes  No
8. Did you provide the client with the Temporary Life Insurance Application and Agreement (TIAA) form?.....  Yes  No
9. Premium Class Quoted \_\_\_\_\_
10. Are there any personal or business companion applications?.....  Yes  No  
If Yes, please provide name and date of birth in the Remarks section below.
11. a. To the best of your knowledge, does the policy applied for involve the replacement of existing insurance? .....  Yes  No  
b. If Yes, has the Proposed Insured replaced other life insurance policies in the past 2 years?.....  Yes  No
12. Are there any plans to sell or assign this policy to another person or entity, life settlement provider or investor, or will it replace a policy that has already been sold to a life settlement company or investor? .....  Yes  No
13. Will the premium for this policy be loaned or otherwise financed by an individual(s) or entity other than the Proposed Insured or immediate family members of the Proposed Insured? .....  Yes  No  
If Yes, please identify all parties involved and provide copies of all financing agreements or promissory notes and all related side agreements and schedules.

**Remarks** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**STATEMENTS BY AGENT**

**I certify that:**

- I asked and carefully explained each question to the Proposed Insured and Owner/applicant before recording each answer prior to the application being signed;
- The answers given in this application and Agent's Report are complete and accurate to the best of my knowledge and belief;
- The Proposed Insured and applicant know that any fraudulent statement or material misrepresentation in the application may result in loss of coverage under the policy;
- I have given the Notice to Proposed Insured attached to this application to the Proposed Insured;
- If the insurance applied for will or may replace any existing life insurance policy or annuity contract, I have completed any and all proper state required replacement form(s);
- I have explained to the Proposed Insured that if money is submitted with this application, conditions of the Temporary Insurance Application and Agreement must be met.
- If I become aware of a change in the health or habits of the Proposed Insured occurring after the date of the application but before the policy is delivered, I promise to inform the Company of the change and agree to withhold delivery of the policy until instructed by the Company to do so.

Signature of Licensed Insurance Agent	Date	Phone No. (        ) _____
Print Name of Above Signature		Agent # _____ SSN _____
Print Name of Agency, if different from above		Share of commission _____
Signature of Additional Licensed Insurance Agent	Date	Phone No. (        ) _____
Print Name for Above Additional Signature		Agent # _____ SSN _____
Print Name of Additional Agency, if different from above		Share of commission _____

**GENERAL AGENT INFORMATION**

GA name \_\_\_\_\_ GA # \_\_\_\_\_ Case Manager \_\_\_\_\_



**Banner Life Insurance Company**  
3275 Bennett Creek Avenue  
Frederick, Maryland 21704  
800-638-8428  
[www.LGAmerica.com](http://www.LGAmerica.com)

## Privacy Notice

### LEGAL & GENERAL AMERICA PRIVACY NOTICE

#### Your privacy is important to us.

Your privacy is important to us. At Legal & General America (Banner Life Insurance Company and William Penn Life Insurance Company of New York), we understand that the information you provide to us or we collect about you is private. This privacy notice is provided to you so that you will understand what Legal & General America does with the personal information we collect about you and the measures we take to protect your privacy.

#### Who has access to INSURANCE policy customer information?

The information that we collect about you is used for company purposes only. Our employees, service providers, and independent agents of Legal & General America have access to your information, and are authorized to review it, only for the purposes of carrying out their official duties and responsibilities. Our employees and independent agents are required to keep customer information confidential.

#### Who has access to ANNUITY customer information?

The information that is provided to us is used for company purposes only. Our employees and service providers have access to your information, and are authorized to review it, only for the purposes of carrying out their official duties and responsibilities. Our employees and service providers are required to keep customer information confidential.

#### Why does Legal & General America collect and maintain information?

As regulated insurance carriers, the Legal & General America companies are required by state laws and regulations to collect and maintain certain information about our 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 Legal & General America.

#### What type of information does Legal & General America collect and maintain?

We collect and maintain various types of information about our customers. The types of personal information we collect and share depend on the product or service you have with us. This information can include:

- Information that you submit to us, such as your name, address, telephone number, biometric information, and Social Security number.
- Information about your transactions and experiences with us, such as payment history, underwriting, claims, and account balance.
- Information from non-affiliated third parties about your medical, employment and income history; your banking relationships; your assets and liabilities and your driving record.
- Information from consumer reporting agencies such as information about your medical, income, and credit history.
- Information about you that may be derived from your visits to Legal & General America's websites ([www.LGAmerica.com](http://www.LGAmerica.com) and [www.LGRA.com](http://www.LGRA.com)) and interactions with our online advertisements, including cookies and IP addresses.

## **Does Legal & General America disclose customer information to, or share customer information with, outsiders?**

We may share customer non-public financial information within our Legal & General family of companies. We do not share customer non-public medical information within our Legal & General family of companies unless you expressly consent or as permitted or required by law.

As allowed by law, we may from time to time share non-public personal financial information with a non-affiliated third party that performs services or functions on our behalf. These services or functions may include underwriting, claims processing, billing, policy administration, and marketing of our own products and services; or financial products or services offered pursuant to a joint agreement between us and one or more financial institutions. We do not allow third parties performing services or functions on our behalf to use our customer information for their own marketing purposes.

We do not share information about your creditworthiness or insurability for marketing purposes within the Legal & General family of companies. We may share information about you with consumer reporting agencies, for instance, during the underwriting process.

We handle information about former and prospective customers the same as existing customers. If our privacy policy changes in any material respect, we will notify you of such change as required by law.

## **How can you contact Legal & General America if you have privacy questions?**

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

### **If you have a Banner insurance policy, contact:**

Banner Customer Service  
Call toll-free: 800-638-8428  
Fax: 301-294-6960  
Hours: 8:00 a.m. - 5:00 p.m. (ET), Monday - Friday  
3275 Bennett Creek Avenue  
Frederick, Maryland 21704

### **If you have a Banner retirement annuity, contact:**

Retirement Services  
Call toll-free: 800-664-6129  
Fax: 301-810-4889  
Hours: 8:00 a.m. - 6:00 p.m. (ET), Monday - Friday  
3275 Bennett Creek Avenue  
Frederick, Maryland 21704

### **If you have a William Penn insurance policy, contact:**

William Penn Customer Service  
Call toll-free: 800-346-4773  
Fax: 516-229-3081  
Hours: 8:30 a.m. - 4:45 p.m. (ET), Monday - Friday  
3275 Bennett Creek Avenue  
Frederick, Maryland 21704

### **If you have a William Penn retirement annuity, contact:**

Retirement Services  
Call toll-free: 855-914-9123  
Fax: 301-810-4889  
Hours: 8:00 a.m. - 6:00 p.m. (ET), Monday - Friday  
3275 Bennett Creek Avenue  
Frederick, Maryland 21704

We are in the business of maintaining long-term relationships and we know there is no quicker way to lose trust than to misuse information. We maintain physical, electronic, and procedural safeguards to protect customer information and to comply with federal and state laws. In addition, we review our policies and procedures, monitor our computer networks and test the effectiveness of our security.

## **Legal & General America Companies**

This notice is provided by: Legal & General America, Banner Life Insurance Company, and William Penn Life Insurance Company of New York.