New application and submission process

In a continued effort to simplify the application process, Legal & General America will be replacing our traditional paper application (ICC08-LIA and state variations) with a new Life Insurance Application (LIA) (ICC17-LIA and state variations for CA, DE, FL, ND, SD). This new LIA combines the ease of using a fillable PDF form with all the benefits of digital processing and accelerated underwriting.

Effective August 1, the traditional paper application will no longer be accepted. All submissions must utilize either our new LIA or apply digitally through the Horizon Platform.

New LIA process

1. Fully complete the Part 1, Part 2 of the new LIA and the Agent Report. There are no additional forms needed. You would send the application to your General Agency as usual.
2. The GA will review the application and send to LGA.
3. Once the application is received, LGA will process the application in the digital platform.
4. An email will be sent to your client containing a link to access their application. The client will log in using their last name, date of birth and zip code. LGA will also email the client a one-time security code to log in.
5. The client will be asked to review their application for accuracy and provide any additional information needed.
6. Once the review is completed, the client will sign and submit the application electronically.
7. The application will be reviewed to determine if any requirements are needed
8. Once the policy is approved, policy delivery will take place online through the Offer, Pay, Issue process.
9. Notices will be sent directly to your client via email and SMS based on your GA preferences.

Pro Tips

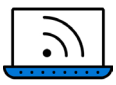
- **Make sure to include a valid email address for your client on the application.**
- **Let your client know they will receive an email from Banner Life | Legal & General America. The subject line will be: "[Client name] additional information needed to process your application".**
- **LGA may need to reach out to your client during the underwriting process via email, please tell them to open and respond when needed.**
- **Make sure you are licensed in the Owner's resident state. Please note select states will require full hierarchies to be licensed.**
- **Do not order any requirements (exams, APS's, etc.). LGA will order all 3rd party requirements.**
- **Do not collect money or send a check with the new LIA. We will determine TIAA eligibility and collect payment details electronically, if applicable, during the digital client journey. Physical checks will not be accepted.**

Less invasive

Over 55% of cases are approved exam free and 22% of cases are instant decisions

Faster decisions

Cycle times in Horizon are 50% faster than traditional methods



Offer, pay, issue

Digital offers, real-time policy delivery, Get More, Get Less

To get started, contact your General Agency

Legal & General
BANNER LIFE

Banner Life Insurance Company
Individual Life Insurance Application

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.

Legal & General AMERICA

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 (TTY866-346-3642). 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.

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

☐ Cell ( ) -

☐ Home ( ) -

☐ Work ( ) -

8. Are you Please check one

☐ 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

Legal & General AMERICA

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 _____% Telephone (_____) _____ - _____

SSN or Tax ID# _____ Date of Birth _____ / _____ / _____

Address _____

Apt. Number _____ City _____ State _____ Zip _____

1b.

First _____ Middle _____ Last _____

Or Business Name _____

Relationship to Proposed Insured _____ % Share _____% Telephone (_____) _____ - _____

SSN or Tax ID# _____ Date of Birth _____ / _____ / _____

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 | Telephone

SSN or Tax ID# | Date of Birth

Address

Apt. Number | City | State | Zip

2b.

First | Middle | Last

Or Business Name

Relationship to Proposed Insured | % Share | Telephone

SSN or Tax ID# | Date of Birth

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 | Telephone

SSN or Tax ID# | Date of Birth

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 your 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)

☐ Motor Sports Racing
☐ BASE jumping
☐ Hang gliding
☐ Ice, rock or mountain climbing (excluding indoor)
☐ Heli-skiing
☐ Skydiving
☐ Scuba diving deeper than 100ft
☐ Ultralight flying
☐ Any activity involving flying (other than as a passenger or crew member of a commercial airline)
☐ 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.

	Signed at		on	
Proposed Insured		City/State		Date(mm/dd/yy)
	Signed at		on	
Signature of Owner (if other than Proposed Insured). If Owner is a firm, trust, or corporation, include signer's title with signature.		City/State		Date(mm/dd/yy)
Print Owner/Officer Name (if applicable)		Owner Title		
	Signed at		on	
Signature of Agent/Broker/Producer		City/State		Date(mm/dd/yy)

Banner Life Insurance Company
Individual Life Insurance Application

Part 2

Section A: Medical History

1. Name of Proposed Insured _____ First _____ Middle _____ Last

Policy Number (if known) _____

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 ☐ Unknown

1b. 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 ☐ Unknown

1c. 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 ☐ Unknown

3b. 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:

☐ Stroke
☐ Mini Stroke
☐ Brain Hemorrhage
☐ High Blood Sugar
☐ TIA (Transient Ischemic Attack)
☐ Carotid Artery Disease
☐ Diabetes
☐ Disease or Disorder of the Pancreas
☐ None

Section C: Health History (cont'd)

2. Heart Disease or Disorder:

- ☐ Angina
- ☐ Heart Attack
- ☐ Heart Surgery
- ☐ Heart Murmur or Valve Problem
- ☐ Coronary Artery Disease
- ☐ Other
- ☐ None

3. Cancer or Cancerous condition:

- ☐ Hodgkin's Lymphoma
- ☐ Leukemia
- ☐ Melanoma
- ☐ Tumor
- ☐ Non-Hodgkin's Lymphoma
- ☐ Basal Cell Carcinoma
- ☐ Other
- ☐ None

4. Disorder of your blood or blood vessels:

- ☐ Anemia
- ☐ Clotting Disorder
- ☐ Surgery to your blood vessels (please ignore non-ulcerative varicose veins)
- ☐ DVT (Deep Vein Thrombosis)
- ☐ Blood Clot
- ☐ Other
- ☐ None

5. Neurological conditions:

- ☐ MS (Multiple Sclerosis)
- ☐ Parkinson's Disease
- ☐ Optic Neuritis
- ☐ ALS (Amyotrophic Lateral Sclerosis)
- ☐ Convulsions or Seizures
- ☐ Other
- ☐ None

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

- ☐ Crohn's Disease
- ☐ Colitis
- ☐ Spastic Colon
- ☐ Ulcerative Colitis
- ☐ Duodenitis
- ☐ Other
- ☐ None

7. Disease or disorder of your liver:

- ☐ Cirrhosis
- ☐ Hepatitis
- ☐ Fatty Liver
- ☐ Other
- ☐ 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:

- ☐ High Cholesterol
- ☐ High or Borderline High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Palpitations
- ☐ Chest Pain
- ☐ Irregular Heart Beat
- ☐ Paralysis
- ☐ Persistent Tingling or Pins and Needles
- ☐ Numbness
- ☐ None

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

- ☐ Growth or Lump
- ☐ Polyp
- ☐ HPV (Human Papilloma Virus)
- ☐ Pre-Cancerous Mole
- ☐ None

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

- ☐ Cystitis
- ☐ Sugar in your Urine
- ☐ Blood in your Urine
- ☐ Protein in your Urine
- ☐ Kidney Stones
- ☐ Other
- ☐ 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)

- ☐ Barrett's Esophagus
- ☐ GERD (Gastroesophageal Reflux Disorder)
- ☐ Celiac Disease
- ☐ IBS (Irritable Bowel Syndrome)
- ☐ Diverticular Disease
- ☐ Other
- ☐ Ulcers
- ☐ None

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

- ☐ Asthma
- ☐ Sleep Apnea
- ☐ Emphysema
- ☐ COPD (Chronic Obstructive Pulmonary Disease)
- ☐ Bronchitis
- ☐ Pulmonary Fibrosis
- ☐ Sarcoidosis
- ☐ Other
- ☐ None

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

6. Any Arthritis or Auto-Immune condition:

- ☐ Lupus
- ☐ Osteomyelitis
- ☐ Fibromyalgia
- ☐ Rheumatoid Arthritis
- ☐ Ankylosing Spondylitis
- ☐ Gout
- ☐ Other
- ☐ None

7. Any Mental Illness:

- ☐ Anxiety
- ☐ Schizophrenia
- ☐ Anorexia or Bulimia
- ☐ Bipolar Disorder
- ☐ Depression
- ☐ PTSD (Post-Traumatic Stress Disorder)
- ☐ Suicidal Thoughts or Actions
- ☐ ADHD (Attention Deficit Hyperactivity Disorder)
- ☐ Other
- ☐ None

8. Any Dementia or Memory Loss:

- ☐ Memory Loss
- ☐ Alzheimer's Disease
- ☐ Other
- ☐ 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)

- ☐ Unexplained Bleeding
- ☐ Lump or Growth
- ☐ Fainting
- ☐ Any other symptom that you intend to see a licensed health care professional about for the first time
- ☐ A cough that's lasted for 3 weeks or more
- ☐ A mole or freckle that has bled or changed in appearance
- ☐ Vertigo
- ☐ 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.

	Signed at		
Proposed Insured		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 _____

	Yes	No
4. Was the application signed after all questions were answered?	☐	☐
5. Did you personally see the Proposed Insured?	☐	☐
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?	☐	☐
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.	☐	☐
8. Did you provide the client with the Temporary Life Insurance Application and Agreement (TIAA) form?	☐	☐
9. Premium Class Quoted _____		
10. Are there any personal or business companion applications? 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?	☐	☐
b. If Yes, has the Proposed Insured replaced other life insurance policies in the past 2 years?	☐	☐
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?	☐	☐
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? 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.

_____ Phone No. ( ) _____
Signature of Licensed Insurance Agent Date

_____ Agent # _____ SSN _____
Print Name of Above Signature

_____ Share of commission _____
Print Name of Agency, if different from above

_____ Phone No. ( ) _____
Signature of Additional Licensed Insurance Agent Date

_____ Agent # _____ SSN _____
Print Name for Above Additional Signature

_____ Share of commission _____
Print Name of Additional Agency, if different from above

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

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 and 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 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 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 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.

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

INDIVIDUAL LIFE TEMPORARY INSURANCE APPLICATION AND AGREEMENT (TIAA)

Name of Proposed Insured _____ Date of Birth _____

Notice to Proposed Insured and Owner. Payment of the Amount Remitted may only be made at the same time that both the Application - Part 1 and this TIAA are completed. If the Insurer does not respond to you within 90 days, notify the Insurer at the above address. **Make the Amount Remitted payable to Banner Life Insurance Company. Do not make it payable to the licensed insurance agent or leave the payee blank. We do not accept cash or cash equivalents (money orders, cashiers checks) or "starter" checks.**

TEMPORARY INSURANCE APPLICATION (Answer all questions.)

Insurer The Insurer is Banner Life Insurance Company.

Temporary insurance cannot begin and you should make no payment if any question below is answered "Yes" or left blank.

		Yes	No
1.	Is the Proposed Insured more than 70 years old (age nearest birthday) on the date of this TIAA?.....	☐	☐
2.	Does the total amount of insurance on the Proposed Insured's life inforce and/or pending with Banner Life Insurance Company exceed $1,000,000?.....	☐	☐
3.	In the past 90 days, has the Proposed Insured been admitted, or medically advised by a member of the medical profession to be admitted, to a hospital or other licensed health care facility, or had surgery performed or recommended by a member of the medical profession, or been medically advised to have any medical test (excluding an HIV-related test) that was not completed?.....	☐	☐
4.	In the past 5 years, has the Proposed Insured been investigated, diagnosed, treated for, or been advised to be investigated or treated by a member of the medical profession for: heart disease; any disorder of the nervous system and brain including stroke or cognitive impairment; cancer; lung, kidney or liver disease; suicide attempt or ideation; alcohol or drug dependence or abuse; or diabetes?.....	☐	☐
5.	In the last 30 days, have you been diagnosed with, been treated for, or sought testing or consultation, or do you intend to seek testing or consultation with a member of the medical profession for Coronavirus including COVID-19, or for fever, or cough, or shortness of breath?.....	☐	☐

THIS AGREEMENT PROVIDES A LIMITED AMOUNT OF LIFE INSURANCE COVERAGE FOR A LIMITED AMOUNT OF TIME, SUBJECT TO THE TERMS AND CONDITIONS SET FORTH BELOW.

TEMPORARY INSURANCE AGREEMENT

Agreement. Subject to the terms of the policy applied for and this TIAA, the Insurer agrees to pay the Limited Amount to the beneficiaries listed in the Application - Part 1 upon receipt of due proof that the Proposed Insured died, except due to suicide, and provided all eligibility requirements and conditions for coverage under this Agreement have been met. The consideration for temporary insurance is the Temporary Insurance Application and payment of an amount equal to the first modal premium for the plan applied for or completion of the payment options form.

Limited Amount. The Limited Amount is the lesser of: (1) the amount of insurance applied for in the Application or (2) $1,000,000 minus the amount of insurance on the Proposed Insured's life with the Insurer under any other inforce policies or applications for insurance now pending or other temporary insurance agreements.

Start Date. Temporary insurance equal to the Limited Amount will begin on the Start Date subject to the terms of this TIAA. The Start Date is the Date of this TIAA.

Name of Proposed Insured _____ Date of Birth _____

INDIVIDUAL LIFE TEMPORARY INSURANCE APPLICATION AND AGREEMENT (TIAA) (Continued)

Stop Date - 90 Day Maximum. Temporary insurance automatically ends on the Stop Date and the entire amount remitted will be returned without interest to or for the benefit of the Owner. The Stop Date is the **earliest** of the following: (1) the date the Owner withdraws the application for insurance or refuses to accept any policy issued or offered; (2) 45 days after the Start Date if the Insurer has not received a properly completed Application - Part 2, associated underwriting questions and all medical examinations, tests, x-rays and electrocardiograms required by the Insurer as set forth in its published guidelines; (3) the date the Insurer mails or otherwise provides notice to the Owner or their agent that it was unable to approve the requested coverage at a Standard or better underwriting classification which does not include a Table Rating, Flat Extra charge; (4) the date the Insurer mails or otherwise provides notice to the Owner or their representative that it has declined or canceled the application; (5) the date the Insurer mails or otherwise provides a premium refund to the Owner or their representative; (6) 90 days after the Start Date, or (7) the date the policy is delivered to the Owner and delivery requirements have been completed.

Policy Date. The Policy Date of any policy issued will be the Issue Date unless the policy is backdated at the Owner's request. The Amount Remitted will be applied to the first modal premium(s) for the policy. Upon policy delivery, and the completion of any delivery requirements, the policy will replace this TIAA.

Other Limitations. The Insurer's liability will be limited to a return of the Amount Remitted if: (1) any part of the life insurance application (Part 1, Part 2 or any supplements thereto) or this TIAA contains a misrepresentation material to the Insurer; or (2) the Proposed Insured dies by suicide.

I represent that: (1) I have read and received a copy of this TIAA and agree to all of its terms and conditions; (2) I understand and agree that temporary insurance will not begin if any question in this TIAA is answered Yes or left blank and any collection of premium will not activate coverage under this agreement; (3) I understand and agree that submission of an NSF check or a credit card, debit card, or Electronic Funds Transfer account number on which the Insurer is unable to draft sufficient funds will not constitute remittance of premium and will not activate or maintain coverage under this agreement; (4) the answers given in this TIAA are true and correct, and I understand that, if they are false, temporary insurance may be denied or declined; (5) I understand that completing this TIAA does not guarantee that the Insurer will issue a policy on the Proposed Insured's life; and (6) I understand that the licensed insurance agent is not authorized to change or waive the terms of this TIAA or to collect premium if the Proposed Insured is ineligible for coverage under this Agreement.

Signature of Proposed Insured	Date of this TIAA	Signature of Owner (if other than Proposed Insured)

LICENSED INSURANCE AGENT'S STATEMENT

Amount Remitted/Authorized $ _____ Person Authorizing _____

On the Date of this TIAA, I received the Amount Remitted/Authorized in exchange for this TIAA. The TIAA bears the same date as the Application - Part 1. I agree that I am not authorized to change or waive the terms of this TIAA and represent that I have not attempted to do so. I have read and explained the terms of this TIAA to the Proposed Insured and Owner. I have left a copy with the Owner.

Signature of Licensed Insurance Agent	Licensed Insurance Agent Number

Legal & General AMERICA

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

NOTICE AND CONSENT FOR BLOOD TESTING WHICH MAY INCLUDE AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING

Examiner Address _____

_____

_____

To determine your insurability, the Insurer named above (the Insurer) has requested that you provide a sample of your blood for testing and analysis. All tests will be performed by a licensed laboratory.

Unless precluded by law, tests may be performed to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. The HIV antibody test that we perform is actually a series of tests done by a medically accepted procedure. The HIV antigen test directly identifies AIDS viral particles. These tests are extremely reliable. Other tests which may be performed include determinations of blood cholesterol and related lipids (fats) and screening for liver or kidney disorders, diabetes, and immune disorders.

All tests results will be treated confidentially. They will be reported by the laboratory to the Insurer. When necessary for business reasons in connection with insurance you have or have applied for with the Insurer, the Insurer may disclose test results to others involved solely in the underwriting process such as its affiliates, reinsurers, employees, or contractors. If the Insurer is a member of the Medical Information Bureau (MIB, Inc.), and if the test results for HIV antibodies/antigens are other than normal, the Insurer will report to the MIB, Inc. a generic code which signifies only a non-specific blood test abnormality. If your HIV test is normal, no report will be made about it to the MIB, Inc. Other test results may be reported to the MIB, Inc. in a more specific manner. The organizations described in this paragraph may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or as authorized by you.

If your HIV test results are normal, no routine notification will be sent to you. If the HIV test results are other than normal, the Insurer will contact you. The Insurer may also contact you if there are other abnormal test results which, in the Insurer's opinion, are significant. The Insurer will ask you for the name of a physician or other health care provider to whom you may authorize disclosure and with whom you may wish to discuss the results.

Positive HIV antibody/antigen test results do not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others.

Positive HIV antibody or antigen test results or other significant blood abnormalities 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.

I have read and I understand this Notice of Consent For Blood Testing Which May Include HIV Antibody/Antigen Testing. I voluntarily consent to the withdrawal of blood from me by needle, the testing of that blood, and the disclosure of the test results as described above.

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.

Name and Address of designated Physician: _____

_____

_____ _____

Proposed Insured Date of Birth

_____ _____ _____

Signature of Proposed Insured or Parent/Guardian Date State of Residence

Please make copies for relevant parties as appropriate.

Legal & General AMERICA

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

Accelerated Death Benefit Disclosure

Name of Proposed Insured _____ Policy Number _____

Receipt of accelerated death benefits may affect eligibility for Public Assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children and Supplemental Security Income (SSI). Receipt of accelerated death benefits may be taxable. Prior to applying for accelerated death benefits, policy owners should consult with a personal tax advisor and the appropriate social services agency. There is no additional premium or cost of insurance required for the Accelerated Death Benefit Rider; instead a lien is associated with the acceleration and an administrative charge, not to exceed $250, is required upon the exercise of the benefit. Review your Policy and the Accelerated Death Benefit Rider for complete limitations, terms, and conditions. The accelerated death benefit feature is subject to state variations; it may not be available in all states.

- We will pay an accelerated death benefit, at the Policy Owner's request, if the Policy Owner provides to us evidence acceptable to us that the Insured is living and has a medical condition that is reasonably expected to result in a life expectancy of twelve months or less.
- The maximum accelerated death benefit is the lesser of: (i) $500,000.00, or (ii) 75% of the policy's primary death benefit as of the date the company approves payment of the accelerated death benefit, less any outstanding loan balance. The accelerated death benefit will be paid in a lump sum.
- The requested accelerated death benefit amount, plus an administrative fee not to exceed $250, will create a lien against the policy. Interest on the amount of the Policy lien accrues daily and is added to the amount of the Policy lien. **The amount payable at the Insured's death is reduced by the amount of the Policy lien.**
- **Receipt of an accelerated death benefit will: 1) limit availability of partial and full cash surrender values and additional loans, 2) not affect future required premium payments or future cost of insurance rates and values, and 3) not affect the accumulation values, loan balance, or future loan interest charges.**
- **Continued premium payment is required to keep the Policy in force. Unpaid premiums will be added to the Policy lien. Prior to maturity, the Policy will not terminate unless the lien equals or exceeds the Policy's death benefit proceeds. Upon termination or maturity of the Policy, no further death benefits will be paid and available cash surrender values will be limited.**

The sample illustration assumes: (1) $500,000 death benefit; (2) $5,000 loan value. Owner requests maximum accelerated death benefit. The maximum accelerated death benefit equals .75 x $500,000, less outstanding policy loan ($5,000) = $370,000. Lien amount = $370,000 + $250 administrative fee = $370,250. This example is illustrative only and not intended to show actual values. Net Death Benefit = Death Benefit less Lien amount less any policy loan (if applicable). The Available Cash Surrender Value is the maximum available for full surrenders, partial surrenders, or loans.

	Immediately Before Acceleration	**Immediately After Acceleration Death Benefit Payment of $370,000**
Death Benefit (Gross)	$500,000	$500,000
Premium	$200 per month	$200 per month
Lien Amount	$0	$370,250
Policy Loan	$5,000	$5,000
Account Value	$32,000	$32,000
Cash Surrender Value	$30,000	$30,000
Available Cash Surrender Value	$25,000	$0
Net Death Benefit	$495,000	$124,750

Note: your policy may not provide for Cash Surrender Values and/or Loans. In such case, the maximum accelerated death benefit is the lesser of: i) 75% of the policy death benefit or ii) $500,000.

I acknowledge that I have received and read this Disclosure Statement and I understand that only the actual provisions of the Accelerated Death Benefit Rider will control payment of an accelerated death benefit.

_____ _____ _____ _____

Owner Signature Date Agent Signature Date

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

Important Notice: Replacement of Life Insurance or Annuities

This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant.

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy or an annuity contract involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, or an existing policy to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interests. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? _____ Yes _____ No

2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? _____ Yes _____ No

If you answered "yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

	INSURER NAME	CONTRACT OR POLICY #	INSURED OR ANNUITANT	REPLACED (R) OR FINANCING (F)
1.				
2.				
3.				

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because_____ .

I certify that the responses herein are, to the best of my knowledge, accurate:

_____ _____
Applicant's Signature and Printed Name Date

_____ _____
Producer's Signature and Printed Name Date

I do not want this notice read aloud to me. _____ (Applicants must initial only if they do not want the notice read aloud.)

A completed copy of this form must be provided to the applicant and administrative office.

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase make sense.

PREMIUMS:
- Are they affordable?
- Could they change?
- You're older - are premiums higher for the proposed new policy?
- How long will you have to pay premiums on the new policy? On the old policy?

POLICY VALUES:
- New policies usually take longer to build cash values and to pay dividends.
- Acquisition costs for the old policy may have been paid, you will incur costs for the new one.
- What surrender charges do the policies have?
- What expense and sales charges will you pay on the new policy?
- Does the new policy provide more insurance coverage?

INSURABILITY:
- If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.
- You may need a medical exam for a new policy.
- Claims on most new policies for up to the first two years can be denied based on inaccurate statements.
- Suicide limitations may begin anew on the new coverage.

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:
- How are premiums for both policies being paid?
- How will the premiums on your existing policy be affected?
- Will a loan be deducted from death benefits?
- What values from the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:
- Will you pay surrender charges on your old contract?
- What are the interest rate guarantees for the new contract?
- Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:
- What are the tax consequences of buying the new policy?
- Is this a tax free exchange? (See your tax advisor.)
- Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?
- Will the existing insurer be willing to modify the old policy?
- How does the quality and financial stability of the new company compare with your existing company?

Notice of Right to Return the Policy

30 Day Right to Examine Policy - Please read your policy upon receipt.

You may return your policy to Banner Life or to the life agent through whom you bought it within 30 days from the date you receive the policy. If you return it within the 30-day period, the policy will be void from the beginning. We will refund any premiums paid, including any fees or charges. For variable life policies, the refund will be the cash surrender value provided under the policy plus any fees and charges deducted.

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

Sales Material Disclosure Form for Replacement of Life Insurance or Annuities

Policy/Contract Application Number _____

Case Number _____

Proposed Insured/Annuitant _____

Banner Life Insurance Company Representative/Producer:

List below all Banner Life Insurance Company preprinted or electronically presented sales material used in connection with the sale of the above new life insurance policy or annuity contract:

Title

1. _____
2. _____
3. _____
4. _____
5. _____

Please attach another Disclosure Form for any additional sales material.

☐ No sales material other than a sales illustration was used in this sale. *Check box if applicable.*

Please Remember:

- Copies of the sales illustration or certification and any individualized or other sales material used in the sale must be submitted with the application.
- The original or a copy of all sales material used during the sale of the policy or contract indicated above must be left with the applicant.
- Electronically presented sales material must be provided to the owner in printed form no later than at the time of delivery of the policy or contract.

Producer Name (print)	Producer Signature	Date

A completed copy of this form must be provided to the applicant and administrative office.

Legal & General AMERICA

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

ELECTRONIC FUNDS TRANSFER PAYMENT OPTIONS

Policy Owner Name_____ Policy Number _____
(leave blank if policy number not yet assigned)

Proposed Insured's Name_____ Date of Birth _____

Authorization

Banner Life will draft the checking account designated on this form for subsequent premiums only (unless initial premium payment is authorized by checking the box below) once the policy has been approved for issue, subject to the terms below.

☐ **Check here to authorize Banner Life to draft my checking account for the initial premium payment and subsequent premium payments subject to the terms of the life insurance contract.**

I understand and agree that this authorization is subject to the following conditions:

- This authorization shall remain in effect until revoked in writing by me or the Company.
- Signing this authorization does NOT mean that coverage is effective; coverage is effective only as stated in the application or Temporary Insurance Agreement, if issued.
- Completion of this form will satisfy the requirement for payment of an amount applied for as required by the Temporary Insurance Application and Agreement.
- Use of the selected payment method does not alter any provisions of any policy issued by Banner Life.
- Banner Life will process the selected payment only when one of the following events occur: 1) Banner Life has approved the policy for issue and there are no documents requiring the owner's and/or insured's signature; or 2) the policy has been accepted and Banner Life has received all of the necessary documents requiring the signature of the owner/insured.
- If necessary, refunds of initial premium will be refunded by Company check.
- If the payment method selected is not honored upon presentation, no coverage will be in effect and Banner Life will terminate any further attempt to use this payment method.

Temporary Insurance is limited to the lesser of: (1) the amount of insurance applied for in the Application or (2) $1,000,000 minus the amount of insurance on the Proposed Insured's life with the Insurer under any other applications for insurance now pending or other temporary insurance agreements.

Bank Account Information for Draft from Checking Accounts (Checking Accounts Only)

PLEASE ATTACH A VOID CHECK

Name of Financial Institution _____

ABA Routing Number _ _ _ _ _ _ _ _ _
(routing number typically located on bottom left of check)

Account Number _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _
(must include dashes and spaces as they appear in your account number)

Please indicate your payment frequency for your premium withdrawals.
(If no selection is made, withdrawals will be made monthly)

☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually

X _____ _____
Bank Account Owner Signature (Must be Payor, Owner or Proposed Insured as identified on application) Date

X _____ _____
Policy Owner Signature (If other than Bank Account Owner) Date

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

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

THIS AUTHORIZATION COMPLIES WITH THE HIPAA PRIVACY RULE

_____ _____/_____/_____
Print Name of Proposed Insured / Patient Date of Birth

_____
Print Name of Person or Organization Providing Information

AUTHORIZATION

I authorize any physician, health plan, medical practitioner, medical care provider, psychologist, chiropractor, physical therapist, hospital, nursing home, mental health facility, rehabilitation or ambulatory care center, medical clinic, laboratory, pharmacy, Pharmacy Benefit Manager, treatment facility, insurer, insurance support organization, service provider, Kaiser Permanente, financial institution, consumer credit reporting agency, certified public accountants and tax preparers, educational institution, Federal, State, or Local Governmental Agency, including the Social Security Administration, Veterans Administration, or Workers Compensation Board, an authorized medical officer of a United States Government facility, law enforcement agencies, state and local tax agencies, or other medical or medically related facility, specifically including those persons/organizations listed above, to give or disclose my entire medical record and any other protected health information, or other personal, private, or privileged information concerning me for the past 10 years to **Banner Life Insurance Company**, its agents, employees, vendors or representatives.

I authorize the disclosure of any and all records and information regarding diagnosis, testing, treatment, and prognosis of my physical or mental condition are to be released, including information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection, ARC (Aids-Related Complex) or AIDS, and sexually transmitted diseases; genetic information and genetic testing results; and information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco; employment information and history, including job duties, earnings, personnel records, and client lists; information on any insurance coverage and claims filed, including all records and information related to such coverage and claims; credit information, including credit reports and credit applications; other financial information, including pension benefits, finances, tax records, and bank records; business transactions including billing, invoice, and payment records; academic transcripts; law enforcement, court and military records; and information concerning Social Security benefits, or other disability or workers' compensation benefits, including monthly benefit amounts, monthly payment amounts, entitlement dates, and information from my Master Beneficiary Record. Such information shall be referred to herein collectively as "My Information".

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

I understand and acknowledge that any agreements I have made to restrict My Information, including protected health information, do not apply to this Authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, other health care provider, or other entity to release and disclose My Information, including my entire medical record, without restriction.

This authorization will be valid for two (2) years or a lesser time limit as required by applicable law in the jurisdiction in which any policy is issued.

I understand that I have the right to refuse to sign or to revoke this authorization in writing, at any time, by sending a written request for revocation to the Company at 3275 Bennett Creek Avenue, Frederick, Maryland 21704, Attention: Privacy Official. I understand that a revocation is not effective if any of My Providers have relied on this authorization or to the extent that the Company has taken action in reliance on this Authorization or has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by certain federal rules governing privacy and confidentiality of health information. I understand that if I refuse to sign, alter, or revoke this Authorization the Company may not be able to process my application and it may be a basis for denying my request for coverage, or if coverage has been issued may not be able to make any benefit payments. I understand and acknowledge that I will receive or have received a copy of this authorization.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization.

_____ _____
Signature of Proposed Insured / Patient Date (required)

_____ _____
Social Security Number of Proposed Insured Agent or Witness Signature

Legal & General AMERICA

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

TRUST CERTIFICATION

Section 1 Purpose of this Form

This form is used for situations where a Trust is the owner or the beneficiary of the life insurance policy issued by our Company. The Trustee(s) should complete and execute this form.

Section 2 General Information

Proposed Insured name _____

Name of Trust _____

State where created _____ Date Trust created _____ Tax ID # _____

- If a living Trust, then the Tax ID may be the same as the grantor's SSN.

Section 3 Type of Trust (check all boxes that apply)

Trust is:

☐ Revocable Trust
☐ Irrevocable Trust
☐ Testamentary Trust under the last will and testament of _____
Date of death _____ Date will was executed _____

AND

Trust is:

☐ Family Trust
☐ Insurance Trust
☐ Trusteed Buy/Sell
☐ Employer Sponsored Trust
☐ Charity Trust
☐ Other type of Trust _____

Section 4 Grantor(s)

Identification information of the Grantor/Settlor(s) who established the Trust:

Name _____

Address _____ City, State, Zip _____

Name _____

Address _____ City, State, Zip _____

Section 5 Beneficiary(ies)

Names and relationships of the beneficiaries of the Trust:

Name _____ Relationship to Proposed Insured/Insured _____

Name _____ Relationship to Proposed Insured/Insured _____

Name _____ Relationship to Proposed Insured/Insured _____

Section 6 Trustee(s)

For multiple Trustees ONLY, please print the names of all Trustees and check one of the following boxes (if no box is checked, the Company will require all signatures on all policy requests).

☐ A majority may act for all
☐ Anyone may act alone
☐ All must act unanimously
☐ Certain trustees must act jointly (print names below)

Trustee #1 _____ Trustee #2 _____ Trustee #3 _____

Note: If the Insurance Producer is a Trustee, please provide the reason and relationship of that individual to the insured.

☐ Immediate family member or
☐ Other _____

Reason _____

I the undersigned Trustee(s) do hereby certify and affirm the following:

1. All information provided on this Certification is accurate and complete.
2. The named trust is currently in effect and has not been revoked, modified or amended in any manner that would cause the representations in this Certification to be incorrect.
3. I/We acknowledge and agree that the Company is relying exclusively on the representations in this Certification and not upon a review of the trust document, even if the trust document has been or is later provided. The Company is permitted to rely upon the representations in this Certification, unless or until notice of any change, amendment, or revocation is provided in writing and delivered to the Company.
4. I/We are duly authorized to act as trustee(s) under the terms of the trust provision and /or applicable law. I/We have the power to exercise all rights associated with ownership of a life insurance policy, including, but not limited to, purchase, surrender, selection of and transfers between variable funding options, withdrawal of funds, taking a loan or other encumberment and assigning the policy.
5. 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).
6. If licensed to sell life insurance for the Company the undersigned trustee has reviewed and has abided by the Company's guidelines on producers acting as trustees.
7. Each of the undersigned, jointly and severally, individually, and as trustee, indemnifies the Company and agrees to hold the Company harmless against all obligations, demands, losses or liabilities (including attorney's fees) that the Company incurred, suffered, or paid or may incur, suffer or pay in the future because of the Company's reliance on this Certification and/or transactions or actions by the undersigned. By indemnifying the Company, each of the undersigned, jointly and severally, individually, and as trustee, indemnifies the Company's agents, officers, employees. This indemnification shall survive termination of this document or the life insurance policy.
8. I/We understand that neither the Company nor its agents are responsible for the estate planning and tax implications of this sale, that they may not give legal or tax advice and that the Company's acceptance of this Certification is not an endorsement of the named trust. I/we have the opportunity to consult with an independent attorney and /or tax advisor, to the extent necessary, before executing this Certification.
9. I/We agree to inform the Company in writing of any trust amendments, changes of trustee(s), or other facts and events that would affect or alter this Certification.
10. For life insurance policy/policies being applied for, the Proposed insured has been informed or is otherwise aware that a policy is being purchased on his/her life.
11. The Trustee(s) may be named as policy owner(s) and have the power to exercise all rights of ownership of a life insurance policy, including, but not limited to, the right to surrender the policy(ies), take a loan or withdrawal, or make changes in the allocation of any invested premium amounts.
12. The Trustee(s) may purchase life insurance in the state in which it is applied for and delivered in, apply for the policy, and invest trust funds in the policy(ies).

Signatures

Print name of Trustee #1 _____

Address _____

Signature _____ Date _____

Print name of Trustee #2 _____

Address _____

Signature _____ Date _____

Print name of Trustee #3 _____

Address _____

Signature _____ Date _____

Note: If more than three Trustees please provide the Trustee names, addresses, signatures, and dates on an additional sheet of paper and attach that paper to this form.