

Internet address: [www.bannerlife.com](http://www.bannerlife.com)

**INSTRUCTIONS**

As the Agent, you are responsible for completing the necessary forms required to process and underwrite this application. All forms must be completed in full and must be legible. Please follow these instructions carefully.

**DO**

- Print application in black ink.
- Verify identification of Proposed Insured.
- Obtain all of the necessary signatures.
- Give the Notice to Proposed Insured to your client.
- Have the Proposed Insured/Owner initial all changes. The Proposed Insured must initial all changes to questions involving insurability. Change an answer by putting a line through the incorrect answer and inserting the correct information.
- Complete Part 2, Medical History, if the Proposed Insured is to be considered without paramedical exam, if an exam on another company's form is being used or if an abbreviated exam will be done.
- Complete section K, Part 1 on all business cases and if required on non-business cases.
- Complete and obtain signature on Consent for HIV Testing Form for each Proposed Insured, if required in your state.
- If you accept payment with the application:
  - Complete the Temporary Insurance Application section of the Temporary Insurance Application and Agreement (TIAA), making sure that all questions are answered. If any are answered Yes, do not accept money.
  - Remit an amount equal to the first modal premium.
  - Explain the terms and conditions of the TIAA to the Owner and Proposed Insured and have them sign it.
  - Complete and sign the Licensed Insurance Agent's Statement on the TIAA.
  - Send the TIAA with the application, give the Owner a copy.
  - All checks collected must be made payable to Banner Life Insurance Company.
- If applicable, complete and obtain signature(s) on the Payment Options form.
- Complete and sign the Agent's Report on page 12. Please be sure to enter all agent information and your Banner agent number.

**DO NOT**

- Do not accept money on applications now applied for or pending with Banner Life Insurance Company totaling over \$1,000,000.
- Do not accept any payment if any question on the Temporary Insurance Application and Agreement is answered Yes or left blank.
- Do not accept cash or cash equivalents (money order, cashiers check) or "starter" checks.
- Do not accept money if the Proposed Insured is over age nearest 70.
- Do not use pencil or correction fluid.

Thank you for applying to Banner Life Insurance Company. The soliciting insurance broker (broker) should be able to answer any questions you may have. This broker is an independent broker, not an employee of Banner Life Insurance Company, and is not authorized to make or modify contracts or to waive any requirements or any information that we may request.

**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 may 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, tell the broker of your intention and answer "yes" to the replacement question in the application; state law may require the broker to give you information that will help you compare the policy you are applying for with the policy you intend to replace. 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. Ask the broker if you are unsure.

**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 Director of Underwriting, Banner Life Insurance Company, 1701 Research Boulevard, Rockville, MD 20850-3191.

**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 directly.

**NOTICE TO PROPOSED INSURED****(Please give to the Proposed Insured)****(continued)**

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**MIB (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 member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply each company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB'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 may be obtained on its website at [www.mib.com](http://www.mib.com).

<b>SECTION A PROPOSED INSURED</b>			
1. Full Name (Include maiden name in parentheses) _____	2. Sex <input type="checkbox"/> M <input type="checkbox"/> F	3. Date of Birth Month _____ Day _____ Year _____	4. Social Security Number _____
5. a. Home Address Street _____ City, State _____ Zip _____			5. b. How Long _____
6. Phone Numbers Home _____ Work _____	7. State/Country of Birth _____	8. U.S. Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No Visa Type _____ If No, Date of Entry into U.S. _____ Country of Citizenship _____	
9. Marital Status <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> W <input type="checkbox"/> D	10. Driver's License Number and State of Issue or State ID Number _____		
11. Occupation (Include duties) _____	12. Annual Income _____	13. Total Net Worth _____	
14. a. Employer's Name and Address and Nature of Business _____			14. b. How Long Employed _____
15. Have you ever used tobacco or nicotine products in any form? <input type="checkbox"/> Yes - give details below <input type="checkbox"/> No			
Product	Date last used (month/year)	Amount / Frequency	
Cigarettes	_____	_____	
Cigars	_____	_____	
Other	_____	_____	
<b>SECTION B BENEFICIARY</b> (Share percentage totals must equal 100%. If necessary, use Remarks section, Question 48. If Beneficiary is a trust, check box <input type="checkbox"/> and complete Section D.)			
16. Primary			
Name _____	Relationship _____	% Share _____	
SSN _____	Date of Birth _____	_____	
Name _____	Relationship _____	% Share _____	
SSN _____	Date of Birth _____	_____	
17. Contingent			
Name _____	Relationship _____	% Share _____	
SSN _____	Date of Birth _____	_____	
Name _____	Relationship _____	% Share _____	
SSN _____	Date of Birth _____	_____	
<b>SECTION C OWNER</b>			
18. Owner is <input type="checkbox"/> Proposed Insured <input type="checkbox"/> Trust (also complete Section D) <input type="checkbox"/> Other than Proposed Insured or Trust			
Complete if the Proposed Insured is not the Owner. (If contingent Owner is required, use Remarks section, Question 48).			
Name _____	SSN or Tax ID # _____	Date of Birth _____	
Address _____	City, State _____	Zip _____	
Contact Phone # _____	Relationship to Proposed Insured _____		
If Owner is a business, web site address _____	Email address _____		
<b>SECTION D TRUST INFORMATION</b> (If trust is Beneficiary and/or Owner).			
19. Exact Name of Trust _____	Trust Tax ID# _____		_____
Current Trustee(s) _____	Date of Trust _____		

**PART 1 (continued)**

**SECTION E PAYOR**

20. Send premium notices to:  Insured  Owner  Other - If Other, complete the information below

Name \_\_\_\_\_ Relationship to Insured/Owners \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

Contact Phone # \_\_\_\_\_ Email address \_\_\_\_\_

**SECTION F INSURANCE APPLIED FOR**

21. Amount of Insurance \$ \_\_\_\_\_ 22. Plan of Insurance \_\_\_\_\_

23. Death Benefit Option (if available with Plan):  Level Death Benefit  Increasing Death Benefit

24. Payment method:  Direct Bill  Electronic Funds Transfer (EFT)

25. Frequency of premium payment:  Single  Annual  Semi-annual  Quarterly  Monthly (EFT only)

26. Planned periodic premium for universal life product: (Provide details in Remarks section, Question 48.)

a.  1st Year Only \$ \_\_\_\_\_ 2nd Year and Thereafter \$ \_\_\_\_\_ b.  Premium For All Years \$ \_\_\_\_\_

27. Will the premiums 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. (Provide details in Remarks section, Question 48.)

28. a. Date to Save Age?  Yes  No b. Specific Policy Date?  Yes  No Date \_\_\_\_\_

**Additional Benefits (if available)**

29.  Waiver of Premium  Other (description and amount) \_\_\_\_\_

**SECTION G OTHER INSURANCE**

30. a. **Excluding** this application, amount of insurance **currently pending** with other companies. If NONE state NONE. \$ \_\_\_\_\_

b. Of the above pending amount in 30.a., how much do you intend to accept? \$ \_\_\_\_\_

c. Provide information for each policy in force (except group insurance). (If necessary, use Remarks section, Question 48.)  
 If NONE state NONE.

Company	Policy Number	Face Amount	Business?		Issue Date	Replacing?		Beneficiary
			Yes	No		Yes	No	
			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	

31. Have you ever had an application for life or health insurance declined, postponed, modified, rated or offered with a reduced face amount? (If Yes, provide details in Remarks section, Question 48.)

Yes No

32. Will you, or are you likely to, replace, end, or change existing insurance or annuity with any company or society with the insurance for which you are applying? (If Yes, the broker may be required to provide additional forms for your review and signature.)

33. Are there any plans to sell or permanently assign the policy to another person or entity, life settlement provider or an investor, or will it replace a policy that has already been sold to another life settlement company or investor? (If Yes, provide details in Remarks section, Question 48.)

**PART 1 (continued)**

<b>SECTION H GENERAL QUESTIONS</b> (Explain all Yes answers in Remarks section, Question 48.)		Yes	No
34. Has any person promised or agreed to give or have they given to any party to the application, any inducement, fee or compensation as an incentive to purchase the policy?		<input type="checkbox"/>	<input type="checkbox"/>
35. Has any party to the application ever sold, transferred or assigned any life insurance policy to a third party, such as a viatical settlement entity, life settlement entity, insurance company, other secondary market provider, or premium financing entity?		<input type="checkbox"/>	<input type="checkbox"/>
36. Has any party to the application ever received inducement, fee or compensation as an incentive to purchase, sell, transfer or assign a policy?		<input type="checkbox"/>	<input type="checkbox"/>
37. In the past 5 years, have you requested or received a Worker's Compensation, Social Security, or disability income payment?		<input type="checkbox"/>	<input type="checkbox"/>
38. Have you ever been convicted of, or are you currently charged with, a felony or misdemeanor, or are you currently on parole or probation?		<input type="checkbox"/>	<input type="checkbox"/>
39. In the past 5 years, has your driver's license been suspended or revoked, or have you been convicted of 2 or more moving violations or accidents?		<input type="checkbox"/>	<input type="checkbox"/>
40. In the past 5 years, have you been convicted of, or plead guilty or no contest to, driving while impaired, intoxicated, or under the influence of alcohol or drugs? (If Yes, complete Alcohol/Drug Usage Questionnaire.)		<input type="checkbox"/>	<input type="checkbox"/>
41. Are you a member, or do you intend to become a member, of the armed forces, including the reserves?		<input type="checkbox"/>	<input type="checkbox"/>
<b>SECTION I OTHER ACTIVITIES</b>		Yes	No
42. Do you hold a current pilot license, or have you in the past 5 years flown, or within the next 2 years do you intend to fly, other than as a passenger in any type of aircraft? (If Yes, complete Aviation Questionnaire.)		<input type="checkbox"/>	<input type="checkbox"/>
43. Have you in the past 2 years engaged in, or within the next 2 years do you intend to engage in, certain activities such as hang gliding, hot-air ballooning, ultra-light flying, heli-skiing, mountain, ice or rock climbing, cliff or base jumping, motor vehicle racing, motorcycle or any other motorized land or water vehicle racing, or scuba or sky diving? (If Yes, complete appropriate questionnaire.)		<input type="checkbox"/>	<input type="checkbox"/>
44. Do you intend to travel outside the U.S. or Canada, or change your country of residence in the next 12 months? (If Yes, list countries, cities, duration and purpose of travel in Remarks section, Question 48.)		<input type="checkbox"/>	<input type="checkbox"/>
<b>SECTION J PROPOSED INSURED FINANCIAL INFORMATION</b>			
<b>Complete this section when applying for face amount over \$1,000,000 or when the Proposed Insured is over age 65:</b>			
45. a. What is the purpose of this insurance? (e.g. income replacement, buy-sell, keyperson, estate conservation)			
_____			
b. How was the need for the face amount determined?	_____	Yes	No
c. In the last 5 years, has the Proposed Insured filed for bankruptcy or had any charge off of bad debts?		<input type="checkbox"/>	<input type="checkbox"/>
If Yes, type of bankruptcy and discharge date or charge off date.	_____		
46. a. Gross annual earned income (salary, bonuses, etc. from W-2 forms)	\$ _____		
b. Gross annual unearned income (dividends, interest, rental income, etc.)	\$ _____		
c. Is the Proposed Insured self-supporting?		<input type="checkbox"/>	<input type="checkbox"/>
If No, how much insurance is in-force on the life of the person providing the support?	\$ _____		
What is that person's relationship to the Proposed Insured?	_____		

**PART 1 (continued)**

**SECTION K BUSINESS FINANCIAL INFORMATION**

Complete this section when applying for face amount over \$1,000,000 and if Beneficiary or Owner is a business:

	Current YTD	Previous Year
47. a. Assets	\$	\$
b. Liabilities	\$	\$
c. Gross Sales	\$	\$
d. Net Income after Taxes	\$	\$
e. Fair Market Value of the business	\$	\$

f. How long has the business been established? \_\_\_\_\_

g. What percentage of the business does the Proposed Insured own? \_\_\_\_\_

h. Are other partners/owners/executives being insured? (If Yes, use Remarks section, Question 48.)

Yes No

i. In the last 5 years, has the business filed for bankruptcy or had any charge off of bad debts?

If Yes, type of bankruptcy and discharge date or charge off date. \_\_\_\_\_

j. Company web site address, if available \_\_\_\_\_

**48. Remarks: Explanations and/or special requests. Use Part 1 Supplement to Application if necessary.**



**FRAUD WARNINGS**

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**Arkansas, Kentucky, Louisiana, New Mexico, and Ohio**

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information on an insurance application is guilty of a crime and may be subject to fines and imprisonment.

**Colorado**

It is unlawful to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding or attempting to defraud. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or insurance agent who knowingly provides false, incomplete or misleading information for the purpose of defrauding or attempting to defraud a policy holder or claimant with regard to a settlement shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**Florida**

Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement or claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

**Georgia, Nebraska, South Carolina, Texas**

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statements may be guilty of insurance fraud.

**Washington, D.C., Maine, Virginia, Tennessee, and Washington**

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or denial of insurance benefits.

**Maryland**

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**New Jersey**

Any person who includes any false or misleading information on an application for insurance is subject to criminal and civil penalties.

**Oklahoma**

Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**Pennsylvania**

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

1. Name of Proposed Insured \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 2. Height \_\_\_\_ ft. \_\_\_\_ in. 3. Weight \_\_\_\_\_ lbs.  
 If your weight has changed by over 10 lbs. in the last year, indicate amount and reason \_\_\_\_\_

**PHYSICIAN INFORMATION**

4. **Primary Physician**

Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 Telephone \_\_\_\_\_ Date last seen \_\_\_\_\_  
 Reason last seen and results of visit \_\_\_\_\_

5. **Physician Last Consulted**

Name \_\_\_\_\_ Specialty \_\_\_\_\_  
 Address \_\_\_\_\_  
 Telephone \_\_\_\_\_ Date last seen \_\_\_\_\_  
 Reason last seen and results of visit \_\_\_\_\_

6. Has a parent or sibling ever been diagnosed or treated by a member of the medical profession for heart or kidney disease, stroke, diabetes, cancer, melanoma, suicide, Huntington's Disease, Sickle Cell Disease or Familial Adenomatous Polyposis (FAP)? If Yes, give details in the Family History chart below. .... Yes No

**Family History: Include the age at onset/event for each medical condition.**

	Medical Conditions	Age at Onset/Event	Age if Living	Cause of Death	Age at Death
Father					
Mother					
Brothers					
Sisters					

**MEDICAL HISTORY -** Provide details to Yes answers in the Remarks section. Include provider, date, symptoms, diagnosis and treatment.

Yes No **Remarks - Explain All Yes Answers**  
 Enter question number before detailed response.

Questions 7-22, have you ever consulted a member of the medical profession regarding or have you been diagnosed or treated for:

- 7. High blood pressure, high cholesterol, abnormal electrocardiogram, chest pain, irregular heart rhythm, palpitations, heart murmur, heart attack, angina, phlebitis, peripheral vascular disease, or any other disease or disorder of the heart or blood vessels? .....
- 8. Hepatitis, ulcer, internal bleeding, colitis, acid reflux, GERD, or any other disease or disorder of the stomach, gall bladder, esophagus, liver, pancreas, spleen, intestines, colon, or rectum? .....
- 9. A disorder of your blood or immune system including anemia, blood clots, bleeding, immune deficiency, leukemia, or lymphoma (excluding HIV)? .....

**PART 2 - Medical History (continued)**

Name of Proposed Insured _____	Yes	No	Remarks - Explain All Yes Answers
10. Cancer, tumor, melanoma, or any other malignant disorder?.....	<input type="checkbox"/>	<input type="checkbox"/>	
11. Diabetes or high blood sugar or any other disease or disorder of the pituitary, thyroid, or endocrine glands? .....	<input type="checkbox"/>	<input type="checkbox"/>	
12. Albumin, protein, blood or sugar in the urine or any other disease or disorder of the kidney or bladder? .....	<input type="checkbox"/>	<input type="checkbox"/>	
13. Cyst, polyp, lump, or other growth, or any disease or disorder of the skin or lymph nodes? .....	<input type="checkbox"/>	<input type="checkbox"/>	
14. Any disease or disorder of the uterus, cervix, ovaries, or breasts?.....	<input type="checkbox"/>	<input type="checkbox"/>	
15. Any disease or disorder of the prostate or reproductive system? .....	<input type="checkbox"/>	<input type="checkbox"/>	
16. Any sexually transmitted disorders or diseases?.....	<input type="checkbox"/>	<input type="checkbox"/>	
17. Pregnancy, complications of pregnancy or infertility? .....	<input type="checkbox"/>	<input type="checkbox"/>	
If now pregnant, what is the expected date of delivery? _____			
18. Asthma, shortness of breath, chronic cough or hoarseness, bronchitis, emphysema, COPD (chronic obstructive pulmonary disease), sarcoidosis, pneumonia, TB (tuberculosis), sleep apnea, or any other disorder of the respiratory system? .....	<input type="checkbox"/>	<input type="checkbox"/>	
19. A disorder of the brain, spinal cord, or nervous system including chronic headaches, convulsions or loss of consciousness, seizures, tremors, paralysis, fainting, stroke, MS (multiple sclerosis), or TIA (transient ischemic attack)? .....	<input type="checkbox"/>	<input type="checkbox"/>	
20. Depression, anxiety, psychosis, suicidal thoughts or attempts of suicide, anorexia or bulimia, obsessive compulsive disorder, bipolar disorder, or other mental, nervous or emotional disorder?.....	<input type="checkbox"/>	<input type="checkbox"/>	
21. Arthritis or disorder of the bones, skin or muscles?.....	<input type="checkbox"/>	<input type="checkbox"/>	
22. Any disease or disorder of the eyes, ears, nose or throat?.....	<input type="checkbox"/>	<input type="checkbox"/>	
23. In the <b>last 5 years</b> , unless previously stated on this application, have you:			
a. Been treated by a member of the medical profession or at a medical facility? ....	<input type="checkbox"/>	<input type="checkbox"/>	
b. Had an electrocardiogram, x-ray, blood test, or other diagnostic test, excluding an HIV test? .....	<input type="checkbox"/>	<input type="checkbox"/>	
c. Had surgery or biopsy, or been an inpatient or outpatient in a hospital, clinic, or other medical or mental health facility? .....	<input type="checkbox"/>	<input type="checkbox"/>	
d. Been advised by a member of the medical profession to have surgery, medical treatment, biopsy, or diagnostic testing, excluding HIV testing, that has not yet been completed?.....	<input type="checkbox"/>	<input type="checkbox"/>	
e. Been referred to any other member of the medical profession or medical facility? .....	<input type="checkbox"/>	<input type="checkbox"/>	
f. Been unable to work, attend school or perform the normal activities of like age and gender, or been confined at home? .....	<input type="checkbox"/>	<input type="checkbox"/>	
24. a. Have you ever used amphetamines, barbiturates, cocaine, heroin, crack, marijuana, LSD, PCP, or other illegal, restricted or controlled substances, except as prescribed by a licensed physician? .....	<input type="checkbox"/>	<input type="checkbox"/>	
If Yes, please provide dates of use: From _____ To _____			
Name of drug used: _____			
Amount and frequency of use: _____			



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.**

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**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 less than 15 days old or more than 70 years old (age nearest birthday) on the date of this TIAA?.....                                                                                                                                                                                                                           | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Does the total amount of insurance on the Proposed Insured's life now applied for or pending with Banner Life Insurance Company exceed \$1,000,000? .....                                                                                                                                                                                               | <input type="checkbox"/> | <input type="checkbox"/> |
| 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, had surgery performed or recommended, or been medically advised to have any diagnostic test (excluding an AIDS-related test) that was not completed?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. In the past 5 years, has the Proposed Insured been diagnosed, treated for, or been advised to be treated for: heart disease; stroke; cancer; alcohol or drug dependence or abuse; or insulin dependent diabetes? .....                                                                                                                                  | <input type="checkbox"/> | <input type="checkbox"/> |

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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.

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**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 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.

**Stop Date.** Temporary insurance automatically ends on 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) the date the Insurer mails or otherwise provides notice to the Owner or his/her agent that it was unable to approve the requested coverage at the premium amount quoted and a counter offer is made by the Insurer; (3) the date the Insurer mails or otherwise provides notice to the Owner or his/her representative that it has declined or cancelled the application; (4) the date the Insurer mails or otherwise provides a premium refund to the Owner or his/her representative; (5) 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 Start Date unless the policy is backdated at the Owner's request. The prepayment for this temporary insurance will be applied to the first premium due if the policy is issued.

**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 or this TIAA contains a misrepresentation material to the Insurer; or (2) the Proposed Insured dies by suicide.



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.**

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**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 less than 15 days old or more than 70 years old (age nearest birthday) on the date of this TIAA?.....                                                                                                                                                                                                                           | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Does the total amount of insurance on the Proposed Insured's life now applied for or pending with Banner Life Insurance Company exceed \$1,000,000? .....                                                                                                                                                                                               | <input type="checkbox"/> | <input type="checkbox"/> |
| 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, had surgery performed or recommended, or been medically advised to have any diagnostic test (excluding an AIDS-related test) that was not completed?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. In the past 5 years, has the Proposed Insured been diagnosed, treated for, or been advised to be treated for: heart disease; stroke; cancer; alcohol or drug dependence or abuse; or insulin dependent diabetes? .....                                                                                                                                  | <input type="checkbox"/> | <input type="checkbox"/> |

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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.

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**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 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.

**Stop Date.** Temporary insurance automatically ends on 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) the date the Insurer mails or otherwise provides notice to the Owner or his/her agent that it was unable to approve the requested coverage at the premium amount quoted and a counter offer is made by the Insurer; (3) the date the Insurer mails or otherwise provides notice to the Owner or his/her representative that it has declined or cancelled the application; (4) the date the Insurer mails or otherwise provides a premium refund to the Owner or his/her representative; (5) 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 Start Date unless the policy is backdated at the Owner's request. The prepayment for this temporary insurance will be applied to the first premium due if the policy is issued.

**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 or this TIAA contains a misrepresentation material to the Insurer; or (2) the Proposed Insured dies by suicide.

**TEMPORARY INSURANCE APPLICATION  
AND AGREEMENT (TIAA)****(continued)**

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) 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; (4) I understand that completing this TIAA does not guarantee that the Insurer will issue a policy on the Proposed Insured's life; (5) 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; and (6) I understand that any premium submitted with this TIAA will be refunded if the Insurer does not approve the requested coverage.

\_\_\_\_\_  
Signature of Proposed Insured\_\_\_\_\_  
Date of this TIAA\_\_\_\_\_  
Signature of Owner (if other than Proposed Insured)**LICENSED INSURANCE AGENT'S STATEMENT**

Amount Remitted \$ \_\_\_\_\_ Person from Whom Received \_\_\_\_\_

On the Date of this TIAA, I received the Amount Remitted 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



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)**

Name of Financial Institution \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

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)

X \_\_\_\_\_  
Account Owner Signature (Must be Payor, Owner  
or Proposed Insured as identified on application)

\_\_\_\_\_ Date

X \_\_\_\_\_  
Proposed Insured Signature

\_\_\_\_\_ Date

X \_\_\_\_\_  
Owner Signature (If other than Proposed Insured)

\_\_\_\_\_ Date



RELEASE OF HEALTH-RELATED INFORMATION

Banner Life Insurance Company
1701 Research Boulevard
Rockville, Maryland 20850

Although the application you completed includes a disclosure authorization, as a result of recent changes in the federal Health Insurance Portability and Accountability Act (HIPAA), your medical provider may ask for this HIPAA specific form.

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, treatment facility, 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 concerning me for the past 10 years to Banner Life Insurance Company, its agents, employees, vendors or representatives. Any and all records and information regarding diagnosis, testing, treatment, and prognosis of my physical or mental condition are to be released. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco.

This protected health 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.

By signing below, I terminate any agreements I have made to restrict my protected health information and I instruct any physician, health care professional, hospital, clinic, medical facility or other health care provider to release and disclose my entire medical record without restriction.

This authorization shall be valid for two (2) years after the date on which it is signed by me, and a copy of this authorization is as valid as the original.

I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to the Company at 1701 Research Boulevard, Rockville, Maryland 20850, Attention: Privacy Official. I understand that a revocation is not effective if any of My Providers has relied on this authorization or to the extent that the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by certain federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization, the Company may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments.

I understand and acknowledge that I will receive or have received a copy of this authorization.

Signature of Proposed Insured / Patient

Date (required)

Social Security Number of Proposed Insured

Agent or Witness Signature



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

## Privacy Policy

### **Our corporate policy.**

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

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

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

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

### **Why does Banner Life collect and maintain information?**

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

### **What type of information does Banner Life collect and maintain?**

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

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

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

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

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

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

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

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

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

or

**E-mail:** [Banner\\_customerservice@LGAmerica.com](mailto:Banner_customerservice@LGAmerica.com)

or

**Phone:** 1-800-638-8428



## NOTICE AND CONSENT FOR AIDS-RELATED BLOOD TESTING

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

Acquired Immunodeficiency Syndrome (AIDS) is a life-threatening disorder of the immune system, caused by a virus, HIV. The virus is transmitted by sexual contact with an infected person, from an infected mother to her newborn infant, or by exposure to infected blood (as in needles shared during intravenous drug use). Persons at high risk of contracting AIDS include males who have had sexual contact with another man, intravenous drug users, hemophiliacs and sexual contacts with any of these persons. Symptoms of HIV infection may include but not be limited to fever, sweats, lethargy, headache, aching of the muscles and joints, diarrhea, sore throat, lymph node enlargement, unintentional weight loss, and a skin rash.

To evaluate your insurability, the Insurer named above has requested that you provide a sample of your blood for testing and analysis to determine the presence of Human Immunodeficiency Virus (HIV) antibodies and other tests which may include tests for cholesterol and related blood lipids, diabetes, liver or kidney disorders, or immune disorders. By signing and dating this form you agree that these tests may be done and that underwriting decisions will be based on the test results. Regarding the HIV test, a series of three tests will be performed by a licensed laboratory through a medically accepted procedure. An initial ELISA blood test will be done. If that is positive it will be repeated. If the second is positive a Western Blot test will be done.

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

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

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

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

Name and Address of designated Physician to whom test results are to be disclosed: \_\_\_\_\_

The following community counseling organizations have been designated by the Pennsylvania Health Department as organizations from which you may choose to have a positive test result sent in lieu of a personal physician. If you wish the results to be mailed to one of these organizations, please check the box preceding the name of the appropriate organization.

- |                                                                                                                                                                                     |                                                                                                                                                                                                                                 |                                                                                                                                                                                                        |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> PA DEPARTMENT OF HEALTH<br>Division of HIV/AIDS<br>Attn: Insurance Information Section<br>Health and Welfare Building<br>PO Box 90<br>Harrisburg, PA 17108 | <input type="checkbox"/> BUCKS COUNTY<br>Bucks County Dept. of Health<br>Counseling & Testing Section<br>Health Building<br>Neshaminy Manor Center<br>Doylestown, PA 18901                                                      | <input type="checkbox"/> PHILADELPHIA<br>Barbara Wills-Hooks<br>City of Philadelphia<br>Department of Public Health<br>Division of Disease Control<br>500 South Broad Street<br>Philadelphia, PA 19146 |
| <input type="checkbox"/> ALLEGHENY COUNTY<br>Tim Carges<br>Allegheny County Health Dept.<br>Insurance Notification Information<br>3441 Forbes Avenue<br>Pittsburgh, PA 15213        | <input type="checkbox"/> CHESTER COUNTY<br>Elizabeth Walls or Sandra Schwartz<br>Chester County Health Dept.<br>Bureau of Personal Health Services<br>601 Westtown Road Suite 180<br>PO Box 2747<br>West Chester, PA 19380-0990 | <input type="checkbox"/> WILKES BARRE CITY<br>Patricia McNulty<br>Wilkes Barre City Health Dept.<br>16 East Northampton Street<br>Wilkes Barre, PA 18701                                               |
| <input type="checkbox"/> ALLENTOWN CITY<br>Vicky Kistler, M.Ed.<br>Communicable Disease Manager<br>Allentown Health Bureau<br>245 North Sixth Street<br>Allentown, PA 18102         | <input type="checkbox"/> ERIE COUNTY<br>Kathy Fatica<br>Erie County Department of Health<br>606 West 2nd Street<br>Erie, PA 16507                                                                                               | <input type="checkbox"/> YORK CITY<br>Marie Deffley<br>York City Bureau of Health<br>One Market Way West, 3rd Floor<br>PO Box 509<br>York, PA 17401                                                    |
| <input type="checkbox"/> BETHLEHEM CITY<br>Jose Cruz<br>AIDS Prevention Coordinator<br>Bethlehem Bureau of Health<br>10 East Church Street<br>Bethlehem, PA 18018                   | <input type="checkbox"/> MONTGOMERY COUNTY<br>Anita Culver<br>Montgomery County Health Dept.<br>Human Services Center<br>1430 DeKalb Street<br>PO Box 311<br>Norristown, PA 19404-0311                                          |                                                                                                                                                                                                        |

For further information about AIDS, the meaning of HIV-related test results and the availability and locations of alternate HIV-related testing sites, you may call the Pennsylvania Health Department at (717) 783-0479.

Consent

I have read and I understand this Notice and Consent for AIDS-Related Blood Testing. I voluntarily consent to the withdrawal of blood from me by needle from a vein or from a finger, the testing of that blood, and the disclosure of that test result as described above. I have read the information on this form about what a test result means and understand that I should contact a local AIDS service group or my private physician for further information and counseling if that test result is positive.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original. In the event the applicant is a minor, this authorization must be approved by a parent/guardian of the applicant in the space provided.

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



**DISCLOSURE STATEMENT**

Banner Life Insurance Company  
1701 Research Boulevard  
Rockville, Maryland 20850

This completed Statement provides basic information about the coverage and cost of life insurance protection you are considering. It is presented to help you understand and appreciate the policy. Please read this Statement carefully before signing any agreement to buy life insurance. It is for your protection. Upon request, the Home Office of Banner Life Insurance Company or the Company's Representative will be happy to furnish you with additional information about the insurance described. Please send all correspondence to our Home Office at 1701 Research Boulevard, Rockville, Maryland 20850.

You should not consider this Statement a final offer by Banner Life Insurance Company to contract for insurance on your life or as altering or modifying any policy or rider that may be issued for you.

**PROPOSED INSURED:** \_\_\_\_\_

	Name	Age	Sex
Descriptive Title	Face Amount or Description	Annual Premium	
Policy _____	_____	_____	
Rider(s) _____	_____	_____	
Supplemental Benefit(s) Built Into Policy _____	_____	This cost is included in the premium for the policy.	

The face amount of the protection provided by the policy and, if applicable, rider(s) and supplemental benefit(s) changes as follows: \_\_\_\_\_  
\_\_\_\_\_

The total initial annual premium for this policy and, if applicable, rider(s) and supplemental benefit(s) will be \$\_\_\_\_\_. You may pay premiums for this policy Annually, Semi-Annually, Quarterly or Monthly. The premium for this policy will change as follows: \_\_\_\_\_ .

Banner Life Insurance Company's policies do not involve dividends.

**PREPARED BY:** \_\_\_\_\_  
NAME  
\_\_\_\_\_  
ADDRESS  
\_\_\_\_\_  
TELEPHONE NUMBER