



West Coast Life
Insurance Company
 A PROTECTIVE COMPANY
 Elgin, Illinois 60123



Fax: 888-615-9619

Policy Number

APPLICATION FOR INDIVIDUAL LIFE INSURANCE		Owner, if other than proposed insured (N/A for CR)	Owner's address
Proposed Primary Insured <input type="checkbox"/> Proposed Other Insured <input type="checkbox"/>		Relationship to Proposed Insured	Social Security or Tax ID #
Name Last	First MI	<input type="checkbox"/> Male <input type="checkbox"/> Female	Primary Beneficiary
Street		Relationship to Proposed Insured	
City	State	Zip	Does the proposed insured have life insurance in force other than group insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No
Social Security number		Occupation	
Birthplace	Birthdate	Age at nearest birthday	
Home phone () ()		Business phone () ()	
Where can you be reached for additional information? <input type="checkbox"/> Home <input type="checkbox"/> Work Best days: Best times: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.			
Initial death benefit \$			
Issue Best Rate Class			
Plan of insurance:			
Riders: <input type="checkbox"/> WP <input type="checkbox"/> ADB <input type="checkbox"/> CR <input type="checkbox"/> Other: Indicate amount for Riders: \$			
Amount remitted with this application, in exchange for this Company receipt: \$ Do not submit money if death benefit exceeds \$1,000,000 or insured's age exceeds 65 or health questions below answered yes.			
Special Request:			

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

Authorization To Obtain And Disclose Information: I (we) have read all the questions and answers in the application. All responses are true and complete to the best of my (our) knowledge and belief. **No coverage will be in effect until: a full application has been signed by the proposed insured; and a policy has been issued; and the full first premium has been received by the company; and any amendments are signed.** Any coverage will be subject to the terms and conditions of the policy. I (we) have received the notification about the Federal Fair Credit Reporting Act and the Medical Information Bureau. I (we) hereby authorize: any licensed physician or medical practitioner; any hospital, clinic or other medical or medically related facility; any insurance company; the Medical Information Bureau; and any other organization, institution or person that has any records or knowledge of me or my health, to give West Coast Life Insurance Company, its affiliates, or their reinsurers or the Medical Information Bureau, any such information. This authorization is valid for two years from the date this form is signed. An exact copy of this authorization is as valid as the original.

Signed at: (city and state) _____ Signature of Proposed Insured (if age 18 or over)

Date signed: (month/day/year) _____ Signature of Owner/Applicant, if other than Proposed Insured

Agent: To the best of your knowledge will this policy replace or change any existing life insurance or annuity policy(ies)? Yes No
 (If "Yes," complete any required replacement forms.)
 Has the Owner been provided an illustration which conforms to this application? Yes No
 If "no," agent hereby certifies that no illustration was used in connection with the solicitation of the policy applied for.
 Is there any third party other than the proposed insured that will obtain any ownership rights on any policy issued as a result of this application? Yes No

Print BGA's name _____ Print Agent's name/Social Security Number or Agent Code _____

Agent's Signature _____ Date _____ Agent's Telephone number _____

BGA's telephone: _____ BGA email address: _____



**West Coast Life
Insurance Company**

A PROTECTIVE COMPANY

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

CONDITIONAL RECEIPTS

THIS RECEIPT IS TO BE GIVEN TO THE APPLICANT AT THE TIME OF APPLICATION IF ANY MONEY IS TAKEN

Received from _____ in connection with the application

dated _____ for life insurance totaling \$ _____, on the life (lives) of _____.

1. NO COVERAGE WILL BECOME EFFECTIVE PRIOR TO DELIVERY OF THE POLICY APPLIED FOR UNLESS AND UNTIL ALL THE CONDITIONS OF THIS RECEIPT HAVE BEEN FULFILLED EXACTLY:
 - a. The amount of payment taken with the application must be at least equal to the amount of the full first premium for the mode of payment selected in the application and for the amount of insurance which may become effective prior to delivery of the policy.
 - b. All medical examinations, tests, x-rays and electrocardiograms required by the company must be completed and received at its home office within 60 days from the date of completion of Part 1 of this application.
 - c. As of the effective date, as defined below, each person proposed for insurance in this application must be a risk insurable in accordance with the company's rules, limits and standards for the plan and the amount applied for without any modification either as to plan, amount, riders, supplemental agreements and/or the rate of premium paid.
 - d. As of the effective date, the state of health and all factors affecting the insurability of each person proposed for insurance must be as stated in the application.
2. Subject to the conditions of paragraph 1, insurance, as provided by the terms and conditions of the policy applied for and in use on the effective date, but for an amount not exceeding that specified in paragraph 3, will become effective as of the effective date. "Effective date" as used herein, is the later of: (a) the date of completion of Part 1 of the application, or (b) the date of completion of all medical examination, tests, x-rays and electrocardiograms required by the company, or (c) the date of issue if any, requested in the application.
3. **The total amount of insurance which may become effective on any person proposed for insurance shall not exceed \$1,000,000 of life insurance, including any accidental death insurance benefits.**
4. If one or more of the conditions of paragraph 1 have not been fulfilled exactly, there shall be no liability on the part of the Company except to return the applicable payment in exchange for this Receipt.
5. NO AGENT OR ANY OTHER PERSON IS AUTHORIZED BY THE COMPANY TO WAIVE OR MODIFY IN ANY WAY ANY OF THE PROVISIONS OF THIS CONDITIONAL RECEIPT.

Dated at _____

Signature of Agent

this _____ day of _____, 20_____

I acknowledge possession of this receipt and I certify that I have read it and the agreement in the application. The terms and conditions of this receipt, to which I agree, and the agreement in this application have been explained to me fully by the agent and I understand them.

Signature of Applicant

NOTE

If all the conditions are not fulfilled exactly, the insurance will take effect when the policy is delivered to the owner stated in the application; but only if at the time of such delivery there has been no change in insurability as represented in the application.

BANK DRAFT INFORMATION

WEST COAST LIFE INSURANCE COMPANY

The company above will withdraw the premiums from the specified account. This company will be referred to hereafter as "Company".

"You", "your", "I" and "me" refer to the bank account owner whose name appears below.

How automatic bank draft works: Automatic bank draft is a debit service that offers a convenient way to pay life insurance premiums. The Company will collect the life insurance premiums from your bank account electronically – you do not need to write checks or mail in any payments. Premium withdrawals will appear on your bank statement, and your statements will be your receipts for payment of your premium.

Automatic Bank Draft Agreement

I hereby authorize and request the Company to initiate electronic or other commercially accepted-type debits against the indicated bank account in the depository institution named ("Depository") for the payment of premiums and other indicated charges due on the insurance policy, and to continue to initiate such debits in the event of a conversion, renewal, or other change to any such contract(s). I hereby agree to indemnify and hold the Company harmless from any loss, claim or liability of any kind by reason or dishonor of any debit.

I understand that this authorization will not affect the terms of the contract(s), other than the mode of payment, and that if premiums are not paid within the applicable grace period, the contract(s) will terminate, subject to any applicable nonforfeiture provision. I acknowledge that the debit appearing on my bank statement shall constitute my receipt of payment, but no payment is deemed made until the Company receives actual payment.

I agree that this authorization may be terminated by me or the Company at any time and for any reason by providing written notice of such termination to the non-terminating party and may be terminated by the Company immediately if any debit is not honored by the Depository named for any reason. This must be dated and signed by the bank account owner(s) as his/her name appears on bank records for the account provided on this authorization.

Financial Institution Name _____

Financial Institution Address _____ City, State _____ ZIP _____

Routing Number | :

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 : |

Account Number

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Type of Account: Checking Saving Credit Union: Yes No

Name of Primary Proposed Insured _____ Policy Number(s): _____

Premium Amount \$ _____

Frequency: Annual Semi-Annual Quarterly Monthly

Preferred Withdrawal Date (1st – 28th) _____ Please debit my account for all outstanding premiums due.

Print Bank Account Owner(s) Name _____

Signature(s) of Bank Account Owner(s) **X** _____

Please attach a voided check.

Pre-Qualification Questionnaire Your Guide to More Accurate Quotes

Applicant's Name _____

Date of Birth _____

1. Have you (proposed insured) used any form of tobacco (cigarettes, pipe, cigars, chew, nicotine gum, or patches) in the last:
 60 months Yes No *If "yes," Super Preferred is not available.*
 12 months Yes No *If "yes," Standard at best, tobacco rates will apply.*

2. Has insured ever been rated or declined for insurance?
 Yes No

If so, why? _____

If "yes" quote should be based on Standard rate class. (You may want to contact your Broker General Agent before submitting as a TeleLife case.)

3. Height _____ Weight _____

If weight is within the limits on the table, you may quote the appropriate class. Weight outside of the table would qualify for Standard at best.

4. Have you ever been treated for high blood pressure?
 Yes No *If "yes," Super Preferred is not available.*

5. Has any member of your family (parent or sibling) been treated for cancer, heart disease, or any cardiac related condition prior to age 60?
 Yes No *If "yes," Super Preferred is not available.**

6. Has any member of your family (parent or sibling) died from cancer, heart disease, or any cardiac related condition prior to age 60?
 Yes No *If "yes," Preferred is not available.**

7. Are you currently taking or have you been advised to take any prescription medications?
 Yes No

If so, what type and why? _____

West Coast Life Build Chart (07/06)

Height	Super Preferred Maximum	Preferred Maximum
4'8"		
4'9"		
4'10"		
4'11"		
5'0"	137	156
5'1"	142	160
5'2"	147	165
5'3"	152	170
5'4"	157	175
5'5"	161	178
5'6"	167	185
5'7"	171	190
5'8"	177	195
5'9"	182	200
5'10"	187	205
5'11"	192	211
6'0"	198	217
6'1"	204	224
6'2"	210	233
6'3"	216	238
6'4"	222	245
6'5"	227	252
6'6"	234	259
6'7"	240	267
6'8"	246	275
6'9"	253	283
6'10"	n/a	291
6'11"	n/a	300

Treatment for diabetes, cancer, heart disease, alcohol or drug abuse, a DUI/reckless driving conviction in last five years, or two or more moving violations in last three years preclude Super Preferred and Preferred.

Refer to the West Coast Life Underwriting Guide W-8507 (07/01/06), for an easy reference guide to our Super Preferred and Preferred rate classes.

*Waived if the applicant is actual age 60 or older unless both natural parents died from one of the same preceding impairments prior to age 60.



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

**NOTICE REGARDING REPLACEMENT OF LIFE
INSURANCE & ANNUITIES**

Definition: Replacement is any transaction where, in connection with the purchase of new insurance or annuity coverage, you lapse, surrender, convert to paid-up insurance, place on extended term, reduce benefits or term of coverage, reduce cash value or borrow all or part of the policy loan values on an existing insurance policy or annuity.

In connection with the purchase of this coverage, IF YOU HAVE REPLACED OR INTEND TO REPLACE your present life insurance or annuity coverage, you should be certain that you understand all of the relevant factors involved.

You should BE AWARE that you may be required to provide evidence of insurability and:

If your HEALTH condition has CHANGED since the application was taken on your present policies, you may be required to pay ADDITIONAL PREMIUMS under the NEW POLICY, or be DENIED COVERAGE.

Your present occupation or activities may not be covered or could require additional premiums.

The INCONTESTABLE and SUICIDE CLAUSE will begin anew in a new policy. This could RESULT in a CLAIM under the new policy BEING DENIED that would otherwise have been paid.

Current law DOES NOT require your present insurer(s) to REFUND any premiums.

It may be to your advantage to OBTAIN INFORMATION regarding your existing policies from the insurer or agent from whom you purchased the policy. Your existing company will provide this information to you.

CAUTION: If after studying the information available to you, you decide to replace your existing life insurance or annuity coverage with our policy, you are urged not to take any action to terminate or alter your existing coverage until after you have been issued the new policy, examined it and found it to be acceptable to you. If you should terminate or otherwise materially alter your existing coverage and fail to qualify for the life insurance or annuity coverage for which you have applied, you may find yourself unable to purchase other life insurance or annuity coverage or be able to purchase it only at substantially higher rates.

(Applicant's Signature)

(Date)

(Agent's Signature)

(Date)

