



**West Coast Life
Insurance Company**

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

Part I

SECTION I: INSUREDS

[State of Domicile - Nebraska]

LIFE INSURANCE APPLICATION

Name of Persons Applying for Coverage (Print in Full)	Relationship to Prop. Ins.	Sex	Date of Birth	Social Security Number	Birth State	Driver's License Number
Proposed Insured	Self					
Spouse						
Child						
Child						

Residence: _____
Street Apt. No.

City State Zip Code Telephone Number Number of Years

Occupation	# of Years	(Required) Annual Income	(Required) Net Worth	Employer Name and Address	Telephone Number
Proposed Insured's Occupation					
Spouse's Occupation					

SECTION II: PLAN OF INSURANCE

Face Amount \$ _____ \$ _____ \$ _____
Insured Spouse Children

Plan of Insurance (Name of Product) _____

If Universal Life: OPTION I - Level Face Amount OPTION II - Face Amount Plus Cash Value

If Term, Indicate Years: 10 Yrs 15 Yrs 20 Yrs 25 Yrs 30 Yrs

If Income Replacement Term: Complete the Supplemental Application Form #WC-U-413

Not Available on all plans: 1035 Loan Transfer Yes No Section 1035 Yes No

CVAT (unless checked, the Guideline Premium Test will apply.)

Benefits: Automatic Premium Loan Waiver of Premium Accidental Death, Amount: \$ _____

Child Rider, # of Units: _____ Other, Description and Amount: _____

Premium Payment: Annual \$ _____ Check-O-Matic \$ _____ Other _____

Additional 1st Year Payment \$ _____ Cash with Application \$ _____

Send Premium Notices To: Residence Other, Complete Line Below:

Name Address City State Zip

SECTION III: BENEFICIARY

Primary: Full Name _____ Relationship _____

Address City State Zip

Secondary: Full Name _____ Relationship _____

Address City State Zip

SECTION VII : EXISTING COVERAGE AND PENDING INSURANCE

(Must be answered completely on all cases.)

17. Regarding all persons proposed for insurance, list all life insurance policies or annuity contracts in force on each proposed insured's life. Please be sure to include insurance whether owned by the insured or not. **If "none" please state it below.**

Name of Insured	Company	Contract Number	Type of Coverage	Life Amount	Business or Personal	Year Issued

SECTION VIII : REPLACEMENT (Must be answered completely on all cases.)

18. Is the policy applied for to replace an existing insurance or annuity policy(ies) in this or any other company? Yes No
(If 'yes', give details in Section XI below and complete any State required replacement forms and comparison statements.)

SECTION IX : OWNERSHIP OF POLICY

Name of Owner (if other than Proposed Insured) _____ Social Security No. or Taxpayer I.D. No. _____

Address _____ City _____ State _____ Zip Code _____

SECTION X : BUSINESS INSURANCE

- a. What is the purpose of the insurance (Key Person, Buy & Sell, Split Dollar, etc.)? _____
- b. What percent of business does Proposed Insured own or control? _____ %
- c. What is approximate net annual income of business? \$ _____
- d. What is approximate net worth of business? \$ _____
- e. What year was the business established? _____
- f. Business insurance on other Owners, Officers, Partners, or Key Persons

Name and Title	% of Business Owned	Insurance Company	Amount Now Carried or Applied For
	%		\$
	%		\$
	%		\$

SECTION XI : REMARKS AND SPECIAL REQUESTS

Home Office Endorsements:

DECLARATIONS

I (We) represent that all statements and answers made in all parts of this application are full, complete and true to the best of my (our) knowledge and belief. It is agreed that:

1. All such statements and answers shall be the basis for and a part of any policy issued on this application.
2. No agent or medical examiner can accept risks or make or change contracts or waive West Coast Life's rights or requirements.
3. No insurance shall take effect unless the Proposed Insured(s) is (are) alive and in the same condition of health as described in this application when the policy is delivered to the Owner and the full first premium is paid. However, if the full first premium is paid as set forth in the attached Conditional Coverage Receipt and this Receipt is delivered to the Owner, the terms of this Receipt shall apply.
4. Acceptance of a policy by the Owner shall constitute ratification of any changes made by West Coast Life under "Home Office Endorsements." In those states where it is required, changes in plan of insurance, amount of insurance and age at issue, benefits applied for, or classification of risk or benefits will be made only with the Owner's written consent.

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.

Signed At _____
(City and State)

Date _____

(X) _____
Signature of Proposed Insured

(X) _____
Signature of Spouse, If Proposed for Insurance

(X) _____
Signature of Owner, If Other than Proposed Insured

(X) _____
Signature of Agent

(X) _____
Signature of Child (age 18 or older)

AGENT'S REPORT

I CERTIFY THAT: (1) THE ANSWERS GIVEN IN THIS APPLICATION ARE COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF; (2) I KNOW OF NOTHING AFFECTING THE RISK WHICH IS NOT SET FORTH IN MY AGENT'S CONTRACT OR THIS LIFE INSURANCE APPLICATION; AND (3) I CAREFULLY EXPLAINED EACH QUESTION BEFORE RECORDING EACH ANSWER AND BEFORE THE APPLICATION WAS SIGNED.

1. Do you understand that no final underwriting offer is valid unless a policy has been issued and delivered? Yes No
2. How long have you known insured? _____ Years _____ Months
3. Is insured a relative or does the insured have a business relationship with you? Yes No
4. Does proposed insured appear healthy and free from visible or known impairments or disability? Yes No
5. Do you have any reason to believe that the life insurance policy applied for will replace any life insurance or annuity from West Coast Life or another company? Yes No
(If YES, Provide policy number(s) and company(ies) below, and complete any comparison statements required by law.)

6. Have you advised the proposed policyowner or do you know of any advice that has been given to the proposed policyowner to transfer the ownership of the policy being applied for to a life settlement company or other entity associated with stranger owned or investment owned life insurance (commonly called SOLI or IOLI) or are you otherwise aware that the policyowner may be contemplating such a transfer? Yes No
7. Is Premium Financing involved in this case? *(If YES, please submit a cover letter describing the parameters.)* Yes No

8. Family History

Primary Proposed Insured	Age if Living	Age at Death	Cardiac Conditions or Heart Disease?		Cancer History?		Type
			<input type="checkbox"/> No	<input type="checkbox"/> Yes, age of onset _____	<input type="checkbox"/> No	<input type="checkbox"/> Yes, age of onset _____ If Yes, date of onset _____	
Father			<input type="checkbox"/> No	<input type="checkbox"/> Yes, age of onset _____	<input type="checkbox"/> No	<input type="checkbox"/> Yes, age of onset _____ If Yes, date of onset _____	
Mother			<input type="checkbox"/> No	<input type="checkbox"/> Yes, age of onset _____	<input type="checkbox"/> No	<input type="checkbox"/> Yes, age of onset _____ If Yes, date of onset _____	
Siblings			<input type="checkbox"/> No	<input type="checkbox"/> Yes, age of onset _____	<input type="checkbox"/> No	<input type="checkbox"/> Yes, age of onset _____ If Yes, date of onset _____	

9. INDICATE CLASSIFICATION BASIS FOR THIS SALE: Super Preferred Preferred Standard
 Rated Table A, B, C, D, E, F, H (circle one) Other _____ Non-Tobacco Tobacco

Place any special remarks here:

I have verified the identity of the Owner by picture I.D. (Does not apply to direct marketing situations.) Identification type: _____
 Please include Driver's License Number if Owner is other than the Proposed Insured. _____
 In Georgia, please include a copy of the Driver's License with application.

BGA Name: _____	For Underwriting and New Business Contact Purposes:
BGA Contract Number: _____	BGA Fax Number: _____
	BGA E-Mail Address: _____

Agent's Signature _____	Agent's Commission Code No. _____	Business Phone _____
Agent's Printed Name _____	Agent's E-Mail Address _____	Date _____ Place _____
Agent's Signature _____	Agent's Commission Code No. _____	Business Phone _____
Agent's Printed Name _____	Agent's E-Mail Address _____	Date _____ Place _____

WEST COAST LIFE INSURANCE COMPANY
P.O. Box 193892
San Francisco, CA 94119-3892

DESCRIPTION OF INFORMATION PRACTICES

(Including Medical Information Bureau Notice and Fair Credit Reporting Act Notice)

In considering your application for insurance, information from various sources must be considered. These include the results of your physical examination, if required, and any reports West Coast Life may receive from doctors and hospitals who have attended you.

Information regarding your insurability will be treated as confidential. West Coast Life, 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 such 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 the 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, Massachusetts 02184-8734.

West Coast Life, 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.

Furthermore, as part of our procedures for processing your insurance application, an investigative consumer report may be prepared by one or more of the commercial agencies offering this service whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics and mode of living except as may be related directly or indirectly to your sexual orientation. You have the right to be personally interviewed if we order an investigative consumer report. You also have the right to receive a copy of the report, and by making a written request to West Coast Life within a reasonable period of time to receive additional detailed information about the nature and scope of this investigation.

As a general practice, we will not disclose personal or privileged information about you to anyone else without your consent, unless a legitimate business need exists or disclosure is required or permitted by law. You are entitled, upon request, to receive a more detailed statement of our information practices. You also have the right to access the personal information about you that we have in our records. You may see and copy the information, or we will send it to you, whichever you prefer. You also have the right to request correction of personal information we may have about you which you think is wrong. To exercise these rights, please write to us at the address appearing at the end of this notice.

Ask our agent for assistance, or call or write us at West Coast Life Insurance Company, Attention: Chief Underwriter, Underwriting Department, P.O. Box 193892, San Francisco, CA 94119-3892. Telephone 800-366-9378

**THIS NOTICE MUST BE GIVEN TO
PROPOSED INSURED**

Producer Compensation Disclosure

Agents/Producers receive compensation from an insurer or third party, which may differ depending upon the product or insurer. Additional compensation may be received by the Agent/Producer based on other factors including premium volume placed with the company and loss or claim experience.



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

Conditional Receipt

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 _____.

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO WEST COAST LIFE INSURANCE COMPANY. DO NOT MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK. CASH OR CASH EQUIVALENTS (MONEY ORDERS, TRAVELERS CHECKS, CASHIER'S CHECKS, THIRD PARTY CHECKS, AGENCY CHECKS) WILL NOT BE ACCEPTED. PREMIUM CANNOT BE ACCEPTED FOR CASES IN WHICH THE PROPOSED INSURED INTENDS TO LEAVE THE UNITED STATES WITHIN THE NEXT 60 DAYS.

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, 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 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, 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 _____ this _____ date of _____, 20____
(City, State)

Signature of Agent

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.



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PO Box 193892, San Francisco, CA 94119-3892
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(City, State)

Signature of Agent

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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.

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

1. This authorization to obtain and disclose information complies with HIPAA regulations that exempt the minimum necessary rules as they apply to life insurance. I (we) authorize West Coast Life Insurance Company (West Coast Life) and its reinsurers to obtain directly through designated third parties and use any information about or relating to me (us) that may affect my (our) insurability. West Coast Life and its reinsurers may obtain and use health and medical information, including but not limited to information about chart notes, EKG's, drug use, alcohol use, nicotine use, physical and mental diseases and illness, and psychiatric disorders. West Coast Life and its reinsurers may also obtain and use non-health and non-medical information, including but not limited to financial information, credit reports, consumer reports, driving record, criminal record, and information about avocations and aviation activity. All of this information may be used to evaluate an application for insurance, a claim for insurance benefits, or both. Information relating to communicable diseases and other risk factors relating to me or to my spouse and life partner may be used to evaluate an application for insurance on either me or my spouse and life partner. The West Coast Life sales agent or regional sales office representing me on my (our) application for insurance may obtain the information described in this paragraph directly from any of the persons or organizations listed in paragraph 2 in order to expedite the delivery of the information to West Coast Life.
2. I (we) authorize the following persons and organizations to release and disclose the information described in paragraph 1 to West Coast Life, directly through designated third parties or its agents acting on its behalf; (i) my (our) doctor(s); (ii) medical practitioners; (iii) pharmacists and Pharmacy Benefit Managers; (iv) medical and related facilities, including hospitals, clinics, facilities run by the Veteran's Administration, Kaiser Permanente, The Cleveland Clinic Foundation including all satellite facilities and The Mayo Clinic; (v) insurers; (vi) reinsurers; (vii) Medical Information Bureau, Inc. (**MIB**); (viii) my (our) current and previous employers; and (ix) commercial consumer reporting agencies (**CRA**). All of these persons and organizations other than **MIB** may release the information described above to a **CRA** acting for West Coast Life. **MIB** may not release the information described in paragraph 1 to a **CRA**.
3. I (we) authorize West Coast Life to draw and test my (our) blood, and/or oral fluids, and urine as may be necessary to obtain information to be used to underwrite my (our) application for insurance. These tests may include, but are not limited to, tests for cholesterol and related blood lipids, diabetes, liver or kidney disorders, immune disorders (other than HIV/AIDS; reference number 5 below), and the presence of drugs, nicotine, or their metabolites. This authorization does not include genetic testing. Unless otherwise required by law or regulation, West Coast Life may, but is not obligated to, release any of these test results directly to me or to my spouse and life partner.
4. I (we) authorize West Coast Life to release and disclose the information described in paragraphs 1 and 3 to its affiliates, its reinsurers, persons or organizations providing services relating to insurance underwriting for West Coast Life, **MIB**, and as otherwise required by law. West Coast Life may release and disclose the information described in paragraphs 1 and 3 to other insurers if I (we) have applied or apply to the other insurers for insurance. West Coast Life may release and disclose the information described in paragraphs 1 and 3 to the sales agent representing me on my (our) application for insurance if it is necessary to provide an explanation of the reasons for West Coast Life's decision to impose special underwriting requirements, whenever my application cannot be approved as submitted, or in connection with a claim for benefits.
5. **SPECIAL REQUIREMENT FOR HIV/AIDS TESTING.** If West Coast Life intends to test for the presence of antibodies to the Human Immunodeficiency Virus (HIV), which is the virus that has been associated with Acquired Immune Deficiency Syndrome (AIDS), West Coast Life may require me (us) to authorize that testing separately. I (we) hereby authorize West Coast Life to obtain and use the results of any HIV tests that I (we) separately authorize, and if permitted by law, to disclose the results of those tests to its reinsurers and **MIB**.
6. This authorization shall be valid for 12 months from the date shown below or, in the event of a claim for benefits, for the duration of such claim.
7. During the evaluation of my (our) insurance application, I (we) understand that I (we) have the right to revoke the authorizations in paragraphs 1 through 5 by writing to West Coast Life at P.O. Box 193892 • San Francisco, CA 94119-3892.
If this authorization is revoked, this would result in the file being closed and no coverage provided.
8. I (we) have been given a copy of this authorization form and West Coast Life's Description of Information Practices.
 I (we) would like to be interviewed if an investigative consumer report will be made. *(Please check the box if you wish to be interviewed.)*
 If performed, I (we) would like copies of my (our) blood profile test results.
9. I (we) understand that information about me (us) may be disclosed under this authorization to persons or organizations that are not subject to the Health Insurance Portability and Accountability Act (**HIPAA**) and that the information would then no longer be protected by **HIPAA** and any related regulations.
I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization 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. Any modifications to this authorization may preclude our ability to process this application.
10. I understand I do not have to sign this authorization in order to obtain **health care benefits (treatment, payment or enrollment)**.

THIS AUTHORIZATION MUST BE SIGNED WITHOUT MODIFICATION AND RETURNED WITH THE APPLICATION BEFORE PROCESSING.

Proposed Insured 1 (Signature)	Date of Birth	Date of Authorization: _____ When applicable, print name(s) of minor(s) below:
Print Name	Social Security Number	
Proposed Insured 2 (Signature)	Date of Birth	
Print Name	Social Security Number	Health Care Provider
Parent or Legal Guardian (Signature)		Physician Name
Child Age 12 or Older (Signature)		Physician Name



West Coast Life Insurance Company

A PROTECTIVE COMPANY
P.O. Box 193892, San Francisco, CA 94119-3892
1-800-366-9378 / (415) 591-8200

NOTICE AND CONSENT FOR AIDS VIRUS (HIV) TESTING

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 needle sharing during IV 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. AIDS does not typically develop until a person has been infected with HIV for several years. A person may remain free of symptoms for years after becoming infected. Infected persons have a 25 percent to 50 percent chance of developing AIDS over the next 10 years. Symptoms which may develop include fever (including night sweats), weight loss, swollen lymph glands, fatigue, diarrhea and white spots or unusual blemishes in the mouth.

1. PURPOSE OF THE HIV TEST. To evaluate your insurability, the Insurer named above, West Coast Life Insurance Company, has requested that you provide a sample of your blood or urine for testing and analysis to determine the presence of human immunodeficiency virus (HIV) antibodies. This is not a test for AIDS; AIDS can only be diagnosed by medical evaluation.

2. HIV-RELATED TESTING AND COUNSELING. Because of the serious nature of HIV-related illnesses, many public health organizations have recommended that before taking an AIDS-related test, a person seek counseling to become informed concerning the implications of such a test. You may secure additional information on alternative HIV testing sites and counseling by calling the Pennsylvania Health Department at (717) 783-0479 or by writing to Bureau of HIV/AIDS, P.O. Box 90, Harrisburg, PA 17106.

3. METHOD AND ACCURACY OF THE HIV TEST. The HIV antibody test that is to be performed is actually a series of tests done by a medically accepted procedure. Your laboratory sample will first be subjected to a test known as ELISA (enzyme-linked immunosorbent assay). If the result of this test is positive, the ELISA test will be repeated. If this repeat ELISA test is also positive, your specimen will then be subjected to another, more specific technique called the Western Blot test, for confirmation. Your test result is considered positive only after positive results are obtained on two ELISA test and a Western Blot test.

The HIV antibody test is extremely accurate. However, in rare instances the test may be positive in persons who are not infected with the virus (a false positive). This may include persons who have not engaged in high risk behavior. These individuals are encouraged to seek retesting to help confirm the validity of the positive test. Additionally, the test may occasionally be negative in persons who are infected with HIV (a false negative) especially when the infection occurred recently; it takes at least 4-12 weeks for a positive test result to develop after a person is infected.

4. CONFIDENTIALITY OF HIV TEST RESULTS. All test 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 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 are other than normal, the insurer will report to the MIB, Inc. a generic code which signifies only a non-specific laboratory 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 result in a file or data bank. There will be no other disclosure of the test results or that the tests have been done except as may be required or permitted by law or as authorized by you.

5. POSITIVE TEST RESULTS. Positive HIV antibody 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 positive should be considered infected with the AIDS virus and capable of infecting others. Positive HIV antibody test results or other significant laboratory abnormalities will adversely affect your application for insurance. This means that your application may be declined, or that an increased premium may be charged.

6. NOTIFICATION OF HIV TEST RESULTS. If the test results are negative, no routine notification will be sent to you. Positive or indeterminate test results will be provided to the personal physician you indicate below:

Physician

Address

W-7604 PA (10/03)

Original : Home Office
Copy: Proposed Insured

1

Other organizations that the Pennsylvania Health Department has designated for notification of positive test results, in lieu of a personal physician, are listed below (check box):

**PENNSYLVANIA DEPARTMENT OF HEALTH
Bureau of Communicable Disease
Division of HIV / AIDS**

- | | |
|--|--|
| <p><input type="checkbox"/> PA Department of Health
Division of HIV/Aids
Insurance Section
P.O. Box 90
7th & Foster Streets
Harrisburg, PA 17108</p> <p><input type="checkbox"/> Vicky Kistler
AIDS Program Coordinator
Allentown Bureau of Health
Alliance Hall
245 North 6th Street
Allentown, PA 18102</p> <p><input type="checkbox"/> Ruth Fugua
Bucks County Department of Health
Health Building
Neshaminy Manor Center
Doylestown, PA 18901</p> <p><input type="checkbox"/> Jose Cruz
AIDS Prevention Coordinator
Bethlehem Bureau of Health
10 East Church Street
Bethlehem, PA 18018</p> <p><input type="checkbox"/> Mr. William Smith
Public Health Administrator
Allegheny County Health Department</p> <p><input type="checkbox"/> Barbara Kovacs
York City Bureau of Health
One Market Way West, 3rd Floor
P.O. Box 509
York, PA 17401</p> | <p><input type="checkbox"/> Sara Sievila, Rn
Supervising Public Health Nurse
Chester County Department of Health
601 Westtown Road, Suite 180
West Chester, PA 19382</p> <p><input type="checkbox"/> Kathy Fatica
Erie County Department of Health
606 West 2nd Street
Erie, PA 16507</p> <p><input type="checkbox"/> Anita Culver, RN
Montgomery County Health Department
P.O. Box 311
1430 DeKalb Street
Norristown, PA 19404</p> <p><input type="checkbox"/> Patricia McNulty
Wilkes Barre City Health Department
16 East Northampton Street
Wilkes Barre, PA 18701
570-208-2468
FAX: 570-208-4272</p> <p><input type="checkbox"/> Patricia Bass/ Joseph Cronauer
Co-Directors
AIDS Activities Coordinator Office
1101 Market Street - 9th Floor
Philadelphia, PA 19107</p> |
|--|--|

CONSENT:

I have read and I understand this Notice and Consent for HIV (AIDS) - Related Testing. I voluntarily consent to testing and disclosure as described above. I understand that I have the right to withdraw this consent prior to being tested and that I may request and receive a copy of this form. A photocopy of this form will be as valid as the original.

Proposed Insured (PRINT)

Date of Birth

Signature of Proposed Insured or Parent/ Guardian

Date

State of Residence



**West Coast Life
Insurance Company**

A PROTECTIVE COMPANY

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

CERTIFICATION OF DISCLOSURE STATEMENT DELIVERY

I certify that the written disclosure statement required by Chapter 83 of the Pennsylvania

Regulations was given to _____ on or before the date
(Applicant's name)

the application was completed.

Dated _____ 20 _____

Signature of agent

AGENT'S REPORT

I CERTIFY THAT: (1) THE ANSWERS GIVEN IN THIS APPLICATION ARE COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF; (2) I KNOW OF NOTHING AFFECTING THE RISK WHICH IS NOT SET FORTH IN MY AGENT'S CONTRACT OR THIS LIFE INSURANCE APPLICATION; AND (3) I CAREFULLY EXPLAINED EACH QUESTION BEFORE RECORDING EACH ANSWER AND BEFORE THE APPLICATION WAS SIGNED.

1. Do you understand that no final underwriting offer is valid unless a policy has been issued and delivered? Yes No
2. How long have you known insured? _____ Years _____ Months
3. Is insured a relative or does the insured have a business relationship with you? Yes No
4. Does proposed insured appear healthy and free from visible or known impairments or disability? Yes No
5. Do you have any reason to believe that the life insurance policy applied for will replace any life insurance or annuity from West Coast Life or another company? Yes No
(If YES, Provide policy number(s) and company(ies) below, and complete any comparison statements required by law.)

6. Have you advised the proposed policyowner or do you know of any advice that has been given to the proposed policyowner to transfer the ownership of the policy being applied for to a life settlement company or other entity associated with stranger owned or investment owned life insurance (commonly called SOLI or IOLI) or are you otherwise aware that the policyowner may be contemplating such a transfer? Yes No
7. Is Premium Financing involved in this case? *(If YES, please submit a cover letter describing the parameters.)* Yes No

8. Family History

Primary Proposed Insured	Age if Living	Age at Death	Cardiac Conditions or Heart Disease?		Cancer History?		Type
			<input type="checkbox"/> No	<input type="checkbox"/> Yes, age of onset _____	<input type="checkbox"/> No	<input type="checkbox"/> Yes, age of onset _____ If Yes, date of onset _____	
Father			<input type="checkbox"/> No	<input type="checkbox"/> Yes, age of onset _____	<input type="checkbox"/> No	<input type="checkbox"/> Yes, age of onset _____ If Yes, date of onset _____	
Mother			<input type="checkbox"/> No	<input type="checkbox"/> Yes, age of onset _____	<input type="checkbox"/> No	<input type="checkbox"/> Yes, age of onset _____ If Yes, date of onset _____	
Siblings			<input type="checkbox"/> No	<input type="checkbox"/> Yes, age of onset _____	<input type="checkbox"/> No	<input type="checkbox"/> Yes, age of onset _____ If Yes, date of onset _____	

9. INDICATE CLASSIFICATION BASIS FOR THIS SALE: Super Preferred Preferred Standard
 Rated Table A, B, C, D, E, F, H (circle one) Other _____ Non-Tobacco Tobacco

Place any special remarks here:

I have verified the identity of the Owner by picture I.D. (Does not apply to direct marketing situations.) Identification type: _____

Please include Driver's License Number if Owner is other than the Proposed Insured. _____

In Georgia, please include a copy of the Driver's License with application.

BGA Name: _____	For Underwriting and New Business Contact Purposes:
BGA Contract Number: _____	BGA Fax Number: _____
	BGA E-Mail Address: _____

Agent's Signature _____	Agent's Commission Code No. _____	Business Phone _____
Agent's Printed Name _____	Agent's E-Mail Address _____	Date _____ Place _____
Agent's Signature _____	Agent's Commission Code No. _____	Business Phone _____
Agent's Printed Name _____	Agent's E-Mail Address _____	Date _____ Place _____

Authorization to Release Underwriting Information

("The Company")¹

West Coast Life Insurance Company¹

Protective Life Insurance Company¹

Protective Life and Annuity Insurance Company¹

Applicant Name: _____

Administrative Office:

P.O. Box 830570

Birmingham, AL 35283

Policy # _____

1. As a Proposed Insured, I signed an Authorization to Obtain and Disclose Information through which I authorized The Company to obtain and disclose information about me for underwriting purposes.
2. Through the Authorization to Obtain and Disclose Information, "The Company" did obtain personal, financial and health information, such as pre-existing records from my doctors, laboratory test results, and a report of a paramedical examination ("Underwriting Information").
3. By signing this Authorization to Release Underwriting Information ("Authorization"), I authorize "The Company" to release and disclose the Underwriting Information to _____; provided however, that no item of information which may be obtained or disclosed only through a separate informed written consent, such as psychotherapy notes and the results of an HIV test, and no test results indicative of the presence of sexually transmitted disease may be disclosed by "The Company" pursuant to this Authorization.
4. I authorize _____, upon release of the Underwriting Information by "The Company", to submit the Underwriting Information to insurance companies other than "The Company" ("Other Insurers listed on this form") for use by any such Other Insurer in underwriting an application for life insurance with me as the Proposed Insured. Except as may be required by law, I expressly prohibit _____ from using or disclosing the Underwriting Information for any purpose or under any circumstance other than as specifically described in this paragraph.
5. I may revoke this Authorization at any time by sending a signed written statement to _____. My revocation shall in no way affect an authorized submission of the Underwriting Information, which occurred prior to _____'s receipt of my revocation.
6. This Authorization shall expire 60 days after the date on which I signed it. The expiration of this Authorization shall in no way affect an authorized submission of the Underwriting Information which occurred prior to the expiration of this Authorization.
7. Within 7 business days of the occurrence of an event named below, I direct _____ to deliver the Underwriting Information remaining in _____'s possession, including copies of documents containing the Underwriting Information, to me or to a physician designated by me or to destroy it in a manner reasonably calculated to preserve the confidential nature of the information contained in the Underwriting Information, whichever I prefer. The events triggering delivery or destruction of the Underwriting Information are (a) acceptance of delivery of a policy of life insurance insuring my life by the policy owner, (b) revocation of this Authorization; or (c) expiration of this Authorization.
8. I understand that "The Company" incurred expenses in obtaining the Underwriting Information and will incur expenses in preparing the Underwriting Information for release to _____ pursuant to this Authorization. I further understand and agree that as a condition to releasing the Underwriting Information to _____ pursuant to this Authorization, "The Company" will require reimbursement from _____ of a portion of the expenses described above.

Applicant Name: _____

Policy # _____

9. I release "The Company" from any liability for any misuse, unauthorized disclosure, breach of confidentiality, failure to safeguard or other act or omission by or of any person to whom the Underwriting Information is directly or indirectly disclosed pursuant to this Authorization.

Name of Proposed Insured (Please Print)

Signature

Date

To be completed by _____; I have read this authorization and agree to its terms. I also specifically agree that the reimbursement expenses referred to in paragraph 8 shall be paid, if at all, only by me, and no portion of any such expenses shall be paid either directly or indirectly by the Proposed Insured who signed this authorization or if different from the Proposed Insured, the applicant for life insurance insuring the life of the Proposed Insured.

Email the completed form to: recordsrequest@protective.com or FAX to 205-268-4315

Representative of Agency (Please Print)

Agent Number

Email Address

Date

INSURERS TO WHOM INFORMATION MAY BE RELEASED:

A copy of this signed Authorization must be given to the Proposed Insured.



WEST COAST LIFE
INSURANCE COMPANY

343 Sansome Street, San Francisco, CA 94104
P.O. Box 193892, San Francisco, CA 94119-3892
1-800-366-9378 • (415) 433-6200

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize any physician, medical practitioner, hospital, clinic, medical record organization, insurance examining organization, paramedical organization or other medical or medically related facility to release copies of medical records to

(agent's name)

(address)

This information is required for consideration of an application for life insurance. If confirmation of this authorization is required, you may call me for verification. This authorization shall be valid for a period of 6 months from the date of signature. I agree that a photocopy of this authorization shall be as valid as the original.

Dated: _____

Signed at _____
(city, state)

(signature)

(address)

(printed name)

(phone)

(signature of witness)



WEST COAST LIFE
INSURANCE COMPANY

P.O. Box 193892, San Francisco, CA 94119-3892
Home Office: San Francisco, California
1-800-366-9378

STATEMENT REGARDING ILLUSTRATIONS

(This form must be submitted with the application in lieu of a signed illustration)

Sales illustrations are required for any product sold by West Coast Life Insurance Company which sets out non-guaranteed elements. An illustration conforming in all respects to the policy applied for by the applicant may not always be immediately available to the agent when an application is solicited.

I did not sign an illustration conforming to the policy as applied for. If a policy contract is issued as a result of this application, I understand that at the time of delivery I will be provided with an illustration which conforms to the policy being delivered. My signature on that illustration will be required by West Coast Life as an acceptance requirement.

Applicant Signature

Date

I certify that the applicant whose signature appears above did not sign an illustration conforming to the policy as applied for. I have informed the applicant that an illustration conforming to the policy as issued will be provided at the time of policy delivery and that West Coast Life will require the applicant to sign that illustration if the applicant wishes to accept the policy as delivered.

West Coast Life Agent Signature

Date

A completed copy of this form must be provided to the Applicant and the Home Office.



Supplement to Life Insurance Application

The statements and answers to the questions listed below shall become a part of the attached application; shall be subject to the terms of the attached application; and shall become a part of any policy based on this application.

Print Name of Proposed Insured(s): _____

- (1) **For any policy to be issued as a result of this application, will any portion of the initial or future premiums be borrowed, loaned or otherwise financed?** Yes No

If yes, complete the "Statement of Owner Intent" (Application Supplement - Part II) and the "Premium Financing Disclosure and Acknowledgement" form.

- (2) **Is there any intention that any party other than the Owner(s) will obtain any right, title or interest in any policy issued on the life of the Proposed Insured(s) as a result of this application?** Yes No

If yes, complete the "Statement of Owner Intent" (Application Supplement - Part II).

- (3) **Is a trust to be an Owner of any policy issued as a result of this application?** Yes No

If yes, complete the "Trust Representation" (Application Supplement - Part III).

- (4) **If the issue age of any Proposed Insured is 65 or older AND the total coverage currently applied for across all Protective companies is \$1,000,000 or more, complete the "Statement of Owner Intent" (Application Supplement - Part II).**



Statement of Owner Intent

This supplement will be attached to and become part of the application with which it is used.

It is the policy of West Coast Life Insurance Company ("the Company") that life insurance should only be purchased to provide protection to those with an insurable interest in the life of the insured. The Company will not knowingly participate in life insurance sales motivated by the possible sale of policies in a secondary market or participation of investors in policy death benefits. Accordingly, we ask the Proposed Insured(s) and Owner(s) (if different) to answer the following questions.

This supplement must be completed and signed by the Proposed Insured(s) and the Owner(s) applying for a life insurance policy to be issued by the Company whenever:

- 1) There is any intention that any party other than the Owner(s) will obtain any right, title or interest in any policy issued on the life of the Proposed Insured(s) as a result of the life application; or
- 2) If the issue age of any Proposed Insured is 65 or older **AND** the total coverage currently applied for across all Protective companies is \$1,000,000 or more; or
- 3) Any Proposed Insured or Owner has indicated that any portion of the initial or future premiums will be borrowed, loaned or otherwise financed; or
- 4) Upon the request of the underwriter.

PROPOSED INSURED 1: Name _____

PROPOSED INSURED 2: Name _____

Owner(s) / Trustee(s) 1: Name _____

Owner(s) / Trustee(s) 2: Name _____

REGARDING ALL PERSONS PROPOSED FOR INSURANCE: Give full details in "Remarks" for any YES answers.	Prop Ins 1		Prop Ins 2	
	Yes	No	Yes	No
1. 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 the Proposed Insured(s) or immediate family members of the Proposed Insured(s)? <i>If YES, please identify all parties involved (in Remarks); and please attach copies of any trust documents, all financing agreements or promissory notes and all related side agreements and schedules.</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Answer this question <u>ONLY</u> if the answer to Question 1 is YES . a.) Is there any collateral for the loan other than the life insurance policy?..... <i>If YES, please describe the additional collateral in "Remarks".</i> b.) Is there an explicit exit strategy for repayment of the loan? <i>If YES, please attach all supporting documentation; and (in Remarks) please describe the exit strategy, the gift, income and estate tax implications of all transactions, and the financial implications of any mechanism used to execute the strategy.</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Will any premiums for this policy be paid by any individual(s) or entity(ies) - other than the Proposed Insured(s), employer(s) of the Proposed Insured(s), or immediate family member(s) of the Proposed Insured(s) - in exchange for any portion of the policy's death benefit? <i>If YES, please specify (in Remarks) how death benefits will be distributed upon the death(s) of the Proposed Insured(s), including each recipient's name and percentage or amount to be received.</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

ADDITIONAL REMARKS:

I (We) have read or have had read to me (us) the completed Supplement before signing below. All statements and answers in this Supplement are correctly recorded and are full, complete and true. I (We) understand that the information being provided in this Supplement is being relied upon in considering the application for life insurance and is subject to the applicable Fraud Statement as provided in the Application for Life Insurance.

Signed in _____, this _____ day of _____, _____.
(State) (Month) (Year)

Signature(s) of Proposed Insured(s): _____

Signature(s) of Owner(s)/Trustee(s): _____
(provide officer's title if policy is owned by a corporation)

(provide officer's title if policy is owned by a corporation)

Signature of Witness: _____

PRODUCER CERTIFICATION:

By signing below, I hereby certify that to the best of my knowledge and belief, the information provided herein is complete, accurate, and correct and that the life insurance being applied for conforms to the Company's guidelines.

Producer Name (PRINT)

Signature of Producer Date Signed at (City, State)

I (We) have read or have had read to me (us) the completed Supplement before signing below. All statements and answers in this Supplement are correctly recorded and are full, complete and true. I (We) understand that the information being provided in this Supplement is being relied upon in considering the application for life insurance and is subject to the applicable Fraud Statement as provided in the Application for Life Insurance.

I (We) represent that:

- a) The Trustee(s) is (are) allowed by the terms of the Trust to purchase life insurance and securities;
- b) The Trust permits the Trustee(s) to exercise all ownership rights provided by the policy that is issued by the Company to the Trust, including but not limited to the right to surrender, pledge or encumber the policy or make withdrawals;
- c) The Trustee(s) is (are) permitted to distribute the policy to any beneficiary of the Trust or to sell and transfer ownership of the policy pursuant to the sale;
- d) 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);
- e) Neither the Company nor anyone acting as its agent is responsible to determine the authority of the Trustee(s) or the validity of the trust or to inquire into or review the provisions of the Trust;
- f) Neither the Company nor anyone acting as its agent shall be charged with knowledge of the terms of the Trust; and
- g) The Company may rely on the evidence submitted for any change of the Trustee(s) and/or the appointment of any successor Trustee(s) and is not responsible to determine that the change or the appointment of any additional or successor Trustee(s) conforms to the provisions of the Trust.

Signed in _____, this _____ day of _____, _____.
(State) (Month) (Year)

Signature(s) of Owner(s)/Trustee(s): _____

Signature(s) of Grantor(s): _____

Signature of Witness: _____

Producer Certification:

By signing below, I hereby certify that to the best of my knowledge and belief, the information provided herein is complete, accurate, and correct and that the life insurance being applied for conforms to the Company's guidelines.

Producer Name (PRINT): _____

Producer Signature: _____

Date: _____ Signed at (City, State): _____



Disclosure and Acknowledgement

If any portion of the initial or future premiums will be borrowed, loaned or otherwise financed, this Disclosure and Acknowledgement form must be signed by the Proposed Insured(s) and the Owner(s), if different.

The Proposed Insured(s) or the Owner(s), if different, also called "the applicant(s)" herein, has (have) applied for a life insurance policy from West Coast Life Insurance Company ("the Company"). The applicant(s) is (are) considering borrowing from a third-party lender to pay for some or all of the premiums for the proposed policy. To clarify the roles of the parties involved, the Company is providing this Disclosure and Acknowledgement form but notes that all the statements may not pertain to all premium financing arrangements and that it is the responsibility of the applicant(s) to discuss the particular risks and benefits of any premium financing arrangement with his or her (their) advisors.

I (We) understand and agree as follows:

1. The Company does not authorize any of its representatives to endorse or recommend premium financing; the Company does not provide lending, tax, or legal advice; and the applicant(s) has (have) not relied on the Company or any of its representatives in deciding whether to enter into any premium financing arrangement.
2. The applicant(s) is (are) solely responsible for the selection of the lender and the negotiation of the terms of any loan/financing agreement.
3. Notwithstanding its acceptance of any particular program, neither the Company nor any of its representatives express any opinion or endorse any specific financing arrangement or lender.
4. Premium financing involves certain lending risks, including but not limited to: change in interest rates, increased premium costs, market volatility, change in collateral valuation, margin calls, and termination, modification, or non-renewal of the loan. These risks include the risk that the policy will not be in force at the time of the death of the Proposed Insured(s) because either the lender has foreclosed on the policy or the amount owed to the lender exceeds the insurance proceeds, in which case additional funds may be needed to repay the loan. If the policy is surrendered, the Owner(s) will be taxed on any policy gain even though the policy proceeds are paid to the collateral assignee.
5. The applicant(s) is (are) relying solely on the advice and recommendation of his or her (their) own tax and legal advisors about whether to enter into a premium financing arrangement, including but not limited to any advice regarding: the Federal and state income, gift, and estate tax implications of premium financing; and premium financing involving policies classified as Modified Endowment Contracts ("MEC").
6. The Company is not a party to and is not bound by any of the provisions or representations relating to any premium financing arrangement related to the proposed policy, except as may be required under any properly executed collateral assignment(s).
7. Illustrated premium payments, policy values and death benefits are hypothetical and are not guaranteed. These hypothetical values are based on the age, sex and risk class of the Proposed Insured(s), the death benefit option, and any riders shown. Actual credited interest rates, actual cost of insurance rates, any policy loans or partial surrenders, and any policy or rider changes will affect actual results and may impact the financing arrangement and duration of the policy.
8. Issuance of any life insurance policy by the Company to the applicant(s) is in no way contingent upon his or her (their) receipt of financing for any or all of the premiums related to the proposed policy.
9. In general, interest on a loan to finance the purchase of insurance is not tax deductible.

Acknowledging the above, I (we) hereby release and hold the Company, and its directors, officers, employees, and representatives, harmless from any and all claims, demands, expenses, actions, causes of action, or suits of any kind or nature, both known and unknown, arising out of, related to, or in any manner connected with any premium financing entered into in connection with the proposed policy.

Proposed Insured (PRINT) _____ Signature _____ Date _____

Proposed Insured (PRINT) _____ Signature _____ Date _____

Owner/Trustee (if different) _____ Signature _____ Date _____

Owner/Trustee (if different) _____ Signature _____ Date _____

Producer Certification:

By signing below, I hereby certify that I have presented copies of this form to the Proposed Insured(s) and Owner(s), that I have made no statements and provided no information to the Proposed Insured(s) and Owner(s) inconsistent with the information provided in this form, and that the life insurance being applied for conforms to the Company's guidelines.

Producer Name (PRINT) _____ Signature _____

Date: _____ Signed at (City, State): _____



WEST COAST LIFE
INSURANCE COMPANY

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)

A completed copy of this form must be provided to the
Proposed Insured and Home Office.