West Coast Life
Insurance Company
A PROTECTIVE 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 IV : NON-MEDICAL HISTORY *(Must be answered for all Proposed Insureds)* **Part I**

HAS PROPOSED INSURED:	Prop. Ins. Yes	Prop. Ins. No	Spouse Yes	Spouse No	Children Yes	Children No
1. Used tobacco or nicotine of any kind over the last 5 years? Type: Frequency: Date last used:	☐	☐	☐	☐	☐	☐
2. Consulted a physician or had treatment for the use or possession of: A. Alcohol?	☐	☐	☐	☐	☐	☐
B. Narcotics, stimulants, sedatives, hallucinogenic drugs?	☐	☐	☐	☐	☐	☐
3. In the past 5 years, been convicted of (i) two or more moving violations, (ii) driving under the influence of alcohol or other drugs, or (iii) had their driver's license suspended or revoked?	☐	☐	☐	☐	☐	☐
4. Have any proposed insureds ever been convicted of, or pled guilty or no contest to a felony, or do they have any such charge pending against them?	☐	☐	☐	☐	☐	☐
5. Flown as a pilot, student pilot, or crew member, or intend to fly as such?	☐	☐	☐	☐	☐	☐
6. Been a member of , or applied to be a member of, or received a notice of required service in, the armed forces, reserves or National Guard? *(If "Yes", please list: branch of service, rank, duties, mobilization category and current duty station in Section VI below.)*	☐	☐	☐	☐	☐	☐
7. Engaged in auto, motorcycle or boat racing, parachuting, skin or SCUBA diving, skydiving, hang gliding or other hazardous avocation or hobby?	☐	☐	☐	☐	☐	☐
8. Had a request for life or health insurance declined, postponed, rated, canceled, or restricted in any way?	☐	☐	☐	☐	☐	☐
9. Any application for any other life or health insurance on your life now pending or contemplated in this or any other company?	☐	☐	☐	☐	☐	☐
10. Is there an intention that any party, other than the owner, will obtain any right, title, or interest in any policy issued on the life of the proposed insured as a result of this application?	☐	☐	☐	☐	☐	☐
11. **Is Proposed Insured:**						
a). A citizen of any other country besides U.S.? If so, what country? _____	☐	☐	☐	☐	☐	☐
b). Have you lived outside of North America at any time during the last 3 years?	☐	☐	☐	☐	☐	☐
c). Intending to reside outside the United States or Canada within the next 12 months?	☐	☐	☐	☐	☐	☐
To where: When:						
Why: For how long:						

SECTION V : MEDICAL HISTORY

HAVE YOU EVER BEEN TREATED FOR OR TOLD YOU HAD:	Prop. Ins. Yes	Prop. Ins. No	Spouse Yes	Spouse No	Children Yes	Children No
12. A. Cancer, diabetes, epilepsy, heart disorder, high blood pressure, stroke, mental or nervous disorders, tumors, ulcers, or any disorder of bladder, kidney, liver or lungs?	☐	☐	☐	☐	☐	☐
B. AIDS (acquired immune deficiency syndrome) or ARC (AIDS-related complex)?	☐	☐	☐	☐	☐	☐
C. Arthritis, gout, or other disorders of muscles, joints, spine, stomach, intestines, or chest pain or asthma?	☐	☐	☐	☐	☐	☐
HAVE YOU:						
13. Within the last 12 months, had any kind of medication prescribed?	☐	☐	☐	☐	☐	☐
14. Been advised to have, or contemplated having a surgical operation?	☐	☐	☐	☐	☐	☐
15. Within the last 5 years, suffered from any disease, or received medical or surgical treatment for any condition not listed in question 12?	☐	☐	☐	☐	☐	☐
16. List current height and weight for all persons proposed for coverage. Height			_____		_____	
(If more than one child proposed for insurance, list in Section VI below.) Weight			_____		_____	

SECTION VI : DETAILS TO ANY "YES" ANSWERS TO QUESTIONS #1 THROUGH #15 ABOVE

(Must be answered, if applicable)

Name of Proposed Insured	Question Number	Date	Details or Reason	Name, Address, and Phone Number of Attending Doctor or Hospital

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 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, age at issue, classification of risk or benefits will be made only with the Owner's written consent.

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 according to state law.

Signed At _____ Date _____
(City and State)

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

(X) _____ (X) _____
Signature of Owner, If Other than Proposed Insured 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
Father			☐ No	☐ Yes, age of onset _____	☐ No	☐ Yes, age of onset _____ If Yes, date of onset _____	
Mother			☐ No	☐ Yes, age of onset _____	☐ No	☐ Yes, age of onset _____ If Yes, date of onset _____	
Siblings			☐ No	☐ Yes, age of onset _____	☐ No	☐ 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: _____

BGA Contract Number: _____

For Underwriting and New Business Contact Purposes:

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

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 to include all dates of service, 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 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 <u>MUST</u> BE SIGNED <u>WITHOUT MODIFICATION</u> AND RETURNED WITH THE APPLICATION BEFORE PROCESSING.

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

Home Office Copy

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

NOTICE AND CONSENT FOR BLOOD, URINE OR OTHER BODY FLUID TESTING WHICH MAY INCLUDE AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING

To determine your insurability, the Insurer named above West Coast Life insurance Company, has requested that you provide a sample of your blood, urine or other body fluid for testing and analysis. All tests will be performed by a licensed laboratory.

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

All 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, independent contractors, and its employees to whom disclosure is reasonably necessary in the ordinary course of business to carry out the purposes for which that disclosure is authorized or required. 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 nonspecific blood test abnormality. The test results may also be disclosed to any member company that receives an application for health or life insurance on your life. If your HIV test is normal, no report will be made about it to the MIB, Inc. Other test results may be reported to the MIB, Inc., in a more specific manner. The organizations described in this paragraph may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or as authorized by you.

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

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

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

I have read and I understand this Notice and Consent For Blood Testing Which May Include HIV Antibody/Antigen Testing. I voluntarily consent to the withdrawal of blood from me by needle, the testing of blood, and the disclosure of the test results as described above. I understand that this consent shall be valid for thirty (30) months following the date shown below.

Home Office Copy

I understand that I have the right to request and receive a copy of this authorization. A photocopy or transmitted facsimile of this form will be as valid as the original. I also have the right, upon written request, to an insurance institution (insurers), agent, or insurance support organization for access to recorded personal information and a copy of same within thirty (30) business days from the date such request is received. I have the right to request, in writing, that any recorded personal information be corrected, amended, or deleted within thirty (30) business days from the date of receipt of my written request by an insurance institution, agent, or insurance support organization. If my request is not honored, I have the right to file a concise statement of the correct, relevant or fair information; and the reasons why I disagree with such refusal to correct, amend, or delete recorded personal information.

Proposed Insured _____ Date of Birth _____

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

OPTIONAL RELEASE OF INFORMATION TO PERSONAL PHYSICIAN

In addition to the release of information as described above, I hereby authorize the release of my HIV test results to my personal physician named below:

Physician's Name _____

Address _____

City _____ State _____ Zip _____

Signature of Proposed Insured _____ Date _____

Home Office Copy

BANK DRAFT INFORMATION

WEST COAST LIFE INSURANCE COMPANY

The company above will withdraw the premiums form 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 you 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.

I understand that authorizing the drafting of the initial premium and providing the account information does not provide any life insurance coverage on myself or any applicant listed on the application for life insurance unless I have signed, dated and met the terms and conditions of the West Coast Life Conditional Receipt/Temporary Receipt* AND the signed and dated receipt is received by the Company along with the application for life insurance.

*Temporary Receipt ONLY available in KS.

Financial Institution Name _____

Financial Institution Address _____ City, State _____ ZIP _____

Routing Number ⑆ | | | | | | | | | | ⑆

Account Number | | | | | | | | | | | | | | | | ⑈

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** _____ Date _____

Day- time Phone Number _____

Please complete and return to our office with a **voided check** by one of the following methods:

Return By Mail: **West Coast Life Insurance Company**
P.O. Box 193892
San Francisco, CA 94119

Return By Fax: **205-268-5077** **Attn: Policy Accounting Department**

WCL-414 (9/08)

West Coast Life
Insurance Company
A PROTECTIVE COMPANY

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

REPLACEMENT NOTICE

REPLACING YOUR LIFE INSURANCE POLICY?

Are you thinking about buying a new policy and discontinuing or changing an existing policy? If you are, your decision could be a good one -- or a mistake. You will not know for sure unless you make a careful comparison of your existing policy and the proposed policy.

Make sure you understand the facts. Georgia law gives you the right to obtain a policy summary statement from your existing insurer at anytime. Ask the company or agent that sold you your existing policy to give you information about it.

The reverse side contains a check list of some of the items you should consider in making your decision. TAKE TIME TO READ IT.

Do not let one agent or insurer prevent you form obtaining information from another agent or insurer which may be to your advantage.

Hear both sides before you decide. This way you can be sure you are making a decision that is in your best interest.

☐ If you wish a policy summary statement from your existing insurer, or insurers, check this box.

We are required to notify your existing company that you may be replacing their policy.

Applicant's signature	Date	Agent's signature	Date
Applicant's Name (printed)		Agent's Name (printed)	
Address		Address	
City State Zip		City State Zip	
		Telephone	
		License No.	

Home Office Copy

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.