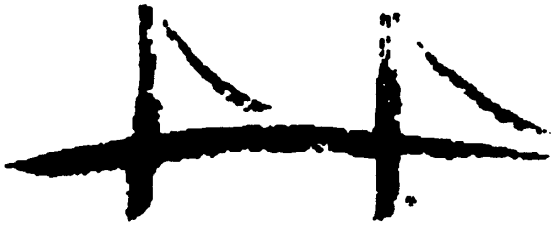
CLICK TO BEGIN APPLICATION



West Coast Life
Insurance Company

A PROTECTIVE COMPANY

FLORIDA
LIFE APPLICATION
PACKET

CONTENTS AND WEBSITE INSTRUCTIONS

CONTENTS

WEBSITE INSTRUCTIONS

1. Log onto **www.westcoastlife.com**
2. Click on **Agent Center**
3. Enter your *agent number* as your **user ID**, then hit the tab key (note: if your agent number consists of more than one letter and four numbers, drop the final number)
4. Enter your *zipcode* as your **password** (note: your zipcode of record may be your BGA's zipcode or your home zipcode – wherever your commissions are mailed.)
5. Click on **Download Forms and Software**
6. Select **Application Packets**
7. Highlight your state and product of choice
8. Click **Execute**
9. To print, click on packet in number column to open document. Print.
10. To save to your desktop, right click on packet in number column and select "save target as" from drop-down menu. Rename and save file as desired.

West Coast Life
Insurance Company
A PROTECTIVE COMPANY
P.O. Box 830570, Birmingham, AL 35283, 1-800-366-9378

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 within the next 24 months?	☐	☐	☐	☐	☐	☐
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 or hang gliding?	☐	☐	☐	☐	☐	☐
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 within the next 2 years?	☐	☐	☐	☐	☐	☐
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?	☐	☐	☐	☐	☐	☐

SECTION V : MEDICAL HISTORY

HAVE YOU EVER BEEN DIAGNOSED OR TREATED BY A LICENSED MEMBER OF THE MEDICAL PROFESSION FOR:	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. Arthritis, gout, or other disorders of muscles, joints, spine, stomach, intestines, or chest pain or asthma?	☐	☐	☐	☐	☐	☐
HAVE YOU:						
13. Tested positive for exposure to the HIV infection or been diagnosed by a licensed member of the medical profession as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection?	☐	☐	☐	☐	☐	☐
14. Within the last 12 months, had any kind of medication prescribed by a licensed member of the medical profession?	☐	☐	☐	☐	☐	☐
15. Been advised by a licensed member of the medical profession to have, or contemplated having a surgical operation?	☐	☐	☐	☐	☐	☐
16. Within the last 5 years, suffered from any disease, or received medical or surgical treatment for any condition not listed in question 12?	☐	☐	☐	☐	☐	☐
17. 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 #16 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 **Part I**

(Must be answered completely on all cases.)

18. 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.)*

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

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

(X) _____ _____
Agent's Printed Name Agent's Florida License Identification Number

West Coast Life Insurance Company
A PROTECTIVE COMPANY

Application Supplement - Part I

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 an intention within 2 years of the effective date of coverage 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?** ☐ 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 Certification" (Application Supplement - Part III).

(4) If the application is for a non-variable permanent plan of insurance **AND** 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).

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. An applicant has the right to designate a secondary addressee to receive notices of unpaid premiums and lapse of coverage notices. I have explained this to the applicant. ☐ Yes ☐ No
6. 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.)
   _____
7. Is Premium Financing involved in this case? *(If YES, please submit a cover letter describing the parameters.)* ☐ Yes ☐ No
8. 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
9. 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 _____	

10. 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 Florida License ID No.

_____
Agent's Name

_____
Agent's Signature

SEND PREMIUM NOTICES TO:
☐ RESIDENCE ☐ OTHER - COMPLETE BELOW
Name: _____
Address: _____
City: _____ State: _____ Zip: _____

_____
Agent's Signature

_____
Agent's Printed Name

_____
Agent's Commission Code No.

_____
Agent's E-Mail Address

_____
Business Phone

_____
Date Place

_____
Agent's Signature

_____
Agent's Printed Name

_____
Agent's Commission Code No.

_____
Agent's E-Mail Address

_____
Business Phone

_____
Date Place

West Coast Life
Insurance Company
A PROTECTIVE COMPANY

P.O. Box 830570 • Birmingham, AL 35283

Continuation of Information for Part I (Non-Medical) and Part II (Medical)

Proposed Insured _____ **Policy #** _____
Last Name First Name M.I.

The above statements and answers are true and complete to the best of my knowledge and belief. I agree that such statements and answers shall be part of the application and shall be considered the basis of any insurance issued.

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

Signed at _____ this _____ day of _____ Year _____

Witness Signature

Proposed Insured Signature

Owner Signature

Signature of Parent or Legal Guardian

WEST COAST LIFE INSURANCE COMPANY • P. O. Box 830570 • Birmingham, AL 35283, 1-800-366-9378
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 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. 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.
6. 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 4 by writing to West Coast Life at P.O. Box 830570 • Birmingham, AL 35283.
   If this authorization is revoked, this would result in the file being closed and no coverage provided.
7. ☐ 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.
8. 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.
9. 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.

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
		Physician Name

WEST COAST LIFE INSURANCE COMPANY • P. O. Box 830570 • Birmingham, AL 35283, 1-800-366-9378
AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

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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 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. 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.
6. 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 4 by writing to West Coast Life at P.O. Box 830570 • Birmingham, AL 35283.
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   ☐ 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.
8. 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.
9. 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 Number	
_____	_____	_____
Proposed Insured 2 (Signature)	Date of Birth	
_____	_____	_____
Print Name	Social Security Number	**Health Care Provider**
_____		_____ _____
Parent or Legal Guardian (Signature)		Physician Name
		_____
		Physician Name

P.O. Box 830570, Birmingham, AL 35283
1-800-366-9378 / FAX 205-268-3282

NOTICE AND CONSENT FOR AIDS-RELATED BLOOD TESTING

To evaluate your insurability, the insurer named above has requested that you provide a sample of your blood for testing and analysis to determine the presence of human immunodeficiency virus (HIV) antibodies and other tests which may include tests for cholesterol and related blood lipids, diabetes, liver or kidney disorders, immune disorders or the presence of medications, drugs, nicotine and their metabolites. By signing and dating this form you agree that these tests may be done and that underwriting decisions will be based on the test results. Regarding the HIV test, a series of three tests will be performed by a licensed laboratory through a medically accepted procedure.

Pre-Testing Considerations

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

Meaning of Positive Test Result

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

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

Confidentiality of Test Results

All of the test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed as required by law or may be disclosed to employees of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer or to outside legal counsel who needs such information to effectively represent the Insurer in regard to your application. The results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover results of test for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular person.

Notification of Test Result

If your HIV test result is negative, no routine notification will be sent to you. If your test result is reported by the laboratory to the Insurer as being positive, you will receive written notification of the result from a physician you have designated or, in the absence of such designation, from the Florida Department of Health and Rehabilitation Services. Because a trained person should deliver that information so you can understand clearly what the test result means, please list your private physician so that the Insurer can have him or her tell you the test result and explain its meaning.

Name of physician for reporting a possible test result: _____

Address: _____

In the event the test is positive and you are denied coverage of that fact and you request the reason for the denial, the insurer may require you to name a physician at that time in order to receive the information.

If the test indicates a positive result, but you do not designate a private physician, the test result will be provided to you by a representative of the Florida Department of Health and Rehabilitation Services.

Consent

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

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original. This authorization is valid for six (6) months from the date signed.

Signature of Proposed Insured	Social Security No. and/or Drivers License No. and State	Date

Witness	Date

P.O. Box 830570, Birmingham, AL 35283
1-800-366-9378 / FAX 205-268-3282

NOTICE AND CONSENT FOR AIDS-RELATED BLOOD TESTING

To evaluate your insurability, the insurer named above has requested that you provide a sample of your blood for testing and analysis to determine the presence of human immunodeficiency virus (HIV) antibodies and other tests which may include tests for cholesterol and related blood lipids, diabetes, liver or kidney disorders, immune disorders or the presence of medications, drugs, nicotine and their metabolites. By signing and dating this form you agree that these tests may be done and that underwriting decisions will be based on the test results. Regarding the HIV test, a series of three tests will be performed by a licensed laboratory through a medically accepted procedure.

Pre-Testing Considerations

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

Meaning of Positive Test Result

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

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

Confidentiality of Test Results

All of the test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed as required by law or may be disclosed to employees of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer or to outside legal counsel who needs such information to effectively represent the Insurer in regard to your application. The results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover results of test for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular person.

Notification of Test Result

If your HIV test result is negative, no routine notification will be sent to you. If your test result is reported by the laboratory to the Insurer as being positive, you will receive written notification of the result from a physician you have designated or, in the absence of such designation, from the Florida Department of Health and Rehabilitation Services. Because a trained person should deliver that information so you can understand clearly what the test result means, please list your private physician so that the Insurer can have him or her tell you the test result and explain its meaning.

Name of physician for reporting a possible test result: _____

Address: _____

In the event the test is positive and you are denied coverage of that fact and you request the reason for the denial, the insurer may require you to name a physician at that time in order to receive the information.

If the test indicates a positive result, but you do not designate a private physician, the test result will be provided to you by a representative of the Florida Department of Health and Rehabilitation Services.

Consent

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

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Signature of Proposed Insured	Social Security No. and/or Drivers License No. and State	Date

Witness	Date

☐ **Term**
☐ **UL**
☐ **VUL**

WEST COAST LIFE INSURANCE COMPANY
P.O. Box 830570, Birmingham, AL 35283

CONDITIONAL RECEIPT AGREEMENT

This agreement provides only a limited amount of insurance, for a limited period of time, and then only if all the terms and conditions of this agreement are met. No Agent of West Coast Life Insurance Company (the Company) can alter or waive any of the provisions of this Agreement. No life insurance is provided under the terms of this document in the event of the death of the proposed insured(s) by suicide. In the event of suicide, while sane or insane, the Company's sole liability will be the return of any money received.

Received: ☐ Check in the amount of $ _____, ☐ Pre-Authorized Funds Withdrawal as conditional payment of the first premium for an insurance policy on the life of Proposed Insured(s) _____.

An application for life insurance on each person proposed for insurance is being made today to the Company. This conditional payment is received under and is subject to the exact conditions set out below, all of which are a part of this Agreement.

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, MONEY ORDERS AND CASHIER'S CHECKS WILL NOT BE ACCEPTED.

NOTE: Premium may not be collected (1) where the face amount applied for <u>plus</u> any in force life insurance and accidental death benefits (including those applied for) on Proposed Insured(s) with the Company and its affiliates exceeds $1,000,000; OR (2) on Proposed Insured(s) under 15 days of age or over age 80; OR (3) for cases in which the Proposed Insured(s) intends to leave the United States within the next 60 days. Any premium received under (1), (2) or (3) of this note will be refunded.

CONDITIONS UNDER WHICH INSURANCE MAY BECOME EFFECTIVE PRIOR TO POLICY DELIVERY

Unless each and every condition below has been fulfilled exactly, no insurance will become effective prior to policy delivery to the Owner:

(A) on the Effective Date the Proposed Insured(s) is (are) insurable exactly as applied for under the Company's published underwriting rules for the plan, amount and premium rate class applied for;
(B) the amount paid with the application and shown above is equal to the first full modal premium for the plan, amount and premium rate class applied for; and
(C) the Proposed Insured(s) has/have completed all examinations and/or tests requested by the Company.

EFFECTIVE DATE OF COVERAGE

Insurance issued based on the application will take effect on the latest of:

(A) the date of the application;
(B) the date requested in the application; or
(C) the date of the last of any medical examinations or tests required under the rules and practices of the Company.

AMOUNT OF COVERAGE - $1,000,000 MAXIMUM (per Proposed Insured)

The total amount of insurance on Proposed Insured(s) which may become effective prior to delivery of the policy to the Owner **shall not exceed $1,000,000** with the Company and its affiliates. This amount includes other life insurance and accidental death benefits on such Proposed Insured(s) currently in force <u>and</u> applied for with the Company and its affiliates.

TERMINATION AND REFUND OF PREMIUM

There shall be no insurance coverage under this Agreement and this Agreement shall be void if:

(A) premium payment is
  (1) by check, and it is not honored by the drawee bank upon presentation;
  (2) by PAW, and the deduction is not honored by the drawee bank;
  (3) by PDA and the Employer does not make payroll deductions as authorized by the Employee; or
(B) if the application to which this Agreement was attached is not approved as applied for by the Company within ninety days from its date, the Company's only liability in such event(s) will be to return any money received.

NOTICE TO APPLICANT: You should retain a copy of this Agreement. The Original will be retained by West Coast Life Insurance Company.

Date: _____ Agent Signature: _____

Date: _____ Owner Signature: _____

☐ **Term**
☐ **UL**
☐ **VUL**

WEST COAST LIFE INSURANCE COMPANY
P.O. Box 830570, Birmingham, AL 35283

CONDITIONAL RECEIPT AGREEMENT

This agreement provides only a limited amount of insurance, for a limited period of time, and then only if all the terms and conditions of this agreement are met. No Agent of West Coast Life Insurance Company (the Company) can alter or waive any of the provisions of this Agreement. No life insurance is provided under the terms of this document in the event of the death of the proposed insured(s) by suicide. In the event of suicide, while sane or insane, the Company's sole liability will be the return of any money received.

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DO NOT MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK. CASH, MONEY ORDERS AND CASHIER'S CHECKS WILL NOT BE ACCEPTED.

NOTE: Premium may not be collected (1) where the face amount applied for plus any in force life insurance and accidental death benefits (including those applied for) on Proposed Insured(s) with the Company and its affiliates exceeds $1,000,000; OR (2) on Proposed Insured(s) under 15 days of age or over age 80; OR (3) for cases in which the Proposed Insured(s) intends to leave the United States within the next 60 days. Any premium received under (1), (2) or (3) of this note will be refunded.

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(A) on the Effective Date the Proposed Insured(s) is (are) insurable exactly as applied for under the Company's published underwriting rules for the plan, amount and premium rate class applied for;
(B) the amount paid with the application and shown above is equal to the first full modal premium for the plan, amount and premium rate class applied for; and
(C) the Proposed Insured(s) has/have completed all examinations and/or tests requested by the Company.

EFFECTIVE DATE OF COVERAGE

Insurance issued based on the application will take effect on the latest of:

(A) the date of the application;
(B) the date requested in the application; or
(C) the date of the last of any medical examinations or tests required under the rules and practices of the Company.

AMOUNT OF COVERAGE - $1,000,000 MAXIMUM (per Proposed Insured)

The total amount of insurance on Proposed Insured(s) which may become effective prior to delivery of the policy to the Owner **shall not exceed $1,000,000** with the Company and its affiliates. This amount includes other life insurance and accidental death benefits on such Proposed Insured(s) currently in force and applied for with the Company and its affiliates.

TERMINATION AND REFUND OF PREMIUM

There shall be no insurance coverage under this Agreement and this Agreement shall be void if:

(A) premium payment is
  (1) by check, and it is not honored by the drawee bank upon presentation;
  (2) by PAW, and the deduction is not honored by the drawee bank;
  (3) by PDA and the Employer does not make payroll deductions as authorized by the Employee; or
(B) if the application to which this Agreement was attached is not approved as applied for by the Company within ninety days from its date, the Company's only liability in such event(s) will be to return any money received.

NOTICE TO APPLICANT: You should retain a copy of this Agreement. The Original will be retained by West Coast Life Insurance Company.

Date: _____ Agent Signature: _____

Date: _____ Owner Signature: _____

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.

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 CA and 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 830570
Birmingham, AL 35283

Return By Fax: 205-268-3282 Attn: Post Issue Department OR 205-268-3402 Attn: Insurance Administration (Inforce Policies)

WCL-414 (9/08)

Electronic Policy Delivery Election Form

West Coast Life now offers you the option of receiving your policy in an electronic PDF format instead of paper. The PDF of your policy will be stored on our secure Customer Service Website which is available 24 hours a day. The Policy Summary Sheet includes an outline of your policy benefits. We recommend that you print and store the Policy Summary Sheet with your financial records.

How Electronic Policy Delivery Works:

- You decide how you want your policy to be delivered - paper or electronic PDF via e-mail.
- Once your policy is approved and issued, your agent will have the opportunity to preview your policy in advance to ensure that it meets your needs.
- The agent will release the policy for your on-line review.
- You will receive an email with a link to a secure West Coast Life website.
- Click on the link and be directed to our Online Customer Service site where you will create your secure, personal User ID and Password.
- Once in the system, you will be able to review the electronic PDF of your policy contract and will electronically sign all delivery requirements and make any necessary premium payments.
- You may make your initial premium payment or pay any balance of the initial premium due on our secure website by either bank draft or credit card.
- Next you will print the Policy Summary Sheet and save it in a secure location. *(We recommend keeping it with other financial planning documents such as your Last Will and Testament.)*
- You can save the electronic PDF of your policy to a secure location on your computer, print it, or refer to the West Coast Life Online Customer Service website at any time to review your stored policy.

To Select Electronic Policy Delivery:

Provide your email address, signature and date signed in the fields provided.

By providing my email address, signature and dating this form I am requesting my policy be delivered electronically.

Email Address for Customer *(Proposed insured, owner and payor must be the same person)*

Customer Signature **Date Signed**

West Coast Life
Insurance Company
A PROTECTIVE COMPANY

West Coast Life
Insurance Company
A PROTECTIVE COMPANY
P.O. Box 830570, Birmingham, AL 35283
1-800-366-9378 • FAX 205-268-3282

NOTICE TO APPLICANT REGARDING REPLACEMENT OF LIFE INSURANCE

A decision to buy a new policy and discontinue or change an existing policy may be a wise choice or a mistake.

Get all the facts. Make sure you fully understand both the proposed policy and your existing policy or policies. New policies may contain clauses which limit or exclude coverage of certain events in the initial period of the contract, such as the suicide and incontestable clauses which may have already been satisfied in your existing policy or policies.

Your best source for facts on the proposed policy is the proposed company and its agent. The best source on your existing policy is the existing company and its agent.

Hear from both before you make your decision. This way you can be sure your decision is in your best interest.

If you indicate that you intend to replace or change an existing policy, Florida regulations require notification of the company that issued the policy.

Florida regulations give you the right to receive a written Comparative Information Form which summarizes your policy values. Indicate whether or not you wish a Comparative Information Form from the proposed company and your existing insurer or insurers by placing your **initials** in the appropriate space below.

_____ **OR** _____

Applicant – Insert Initials for "Yes" **Applicant – Insert Initials for "No"**

DO NOT TAKE ACTION TO TERMINATE YOUR EXISTING POLICY UNTIL YOUR NEW POLICY HAS BEEN ISSUED AND YOU HAVE EXAMINED IT AND FOUND IT ACCEPTABLE.

I have read this notice and received a copy of it.

_____ _____
Applicant's Signature Date

_____ _____
Agent's Signature Date

_____
Agent's Name (Printed or Typed)

_____
Agent's Address (Printed or Typed)

_____
Agent's Company (Printed or Typed)

Information on Policies which may be replaced:

Company Name	Policy Number	Name of Insured

Home Office Copy

West Coast Life
Insurance Company
A PROTECTIVE COMPANY
P.O. Box 830570, Birmingham, AL 35283
1-800-366-9378 • FAX 205-268-3282

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Your best source for facts on the proposed policy is the proposed company and its agent. The best source on your existing policy is the existing company and its agent.

Hear from both before you make your decision. This way you can be sure your decision is in your best interest.

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_____ **OR** _____

Applicant – Insert Initials for "Yes" **Applicant – Insert Initials for "No"**

DO NOT TAKE ACTION TO TERMINATE YOUR EXISTING POLICY UNTIL YOUR NEW POLICY HAS BEEN ISSUED AND YOU HAVE EXAMINED IT AND FOUND IT ACCEPTABLE.

I have read this notice and received a copy of it.

_____ _____
Applicant's Signature Date

_____ _____
Agent's Signature Date

_____
Agent's Name (Printed or Typed)

_____
Agent's Address (Printed or Typed)

_____
Agent's Company (Printed or Typed)

Information on Policies which may be replaced:

Company Name	Policy Number	Name of Insured

Applicant Copy

2801 Highway 280 South, Birmingham, AL 35223
PO Box 830570, Birmingham, AL 35283
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.

NOTIFICATION OF RIGHT TO NAME A SECONDARY ADDRESSEE

Under Florida law, you have the right to designate a secondary addressee to receive a notice concerning the potential lapse of your policy. The notice to the secondary addressee will be sent when the policy has been in force for at least one year, the insured is 64 years or older, and the policy is in danger of lapsing.

If you wish to name a secondary addressee, please call us at 1-800-866-9933, or fax us at 1-205-268-3402, or write us at P.O. Box 12687, Birmingham, AL 35202-6687.

Please Print the Following Information:

Policy Number (if known) _____

Policy Owner's Name _____

Insured's Name _____

Secondary Addressee

Name: _____

Address:_____

_____

_____

WEST COAST LIFE INSURANCE COMPANY
P.O. Box 830570
Birmingham, AL 35283

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 830570, Birmingham, AL 35283. 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.

West Coast Life Insurance Company
P.O. Box 830570 • Birmingham, Alabama 35283

Supplemental Application - Pre-Determined Death Benefit Payout Endorsement

Proposed Insured: _____

1. I wish to elect the Pre-Determined Death Benefit Payout Endorsement.

2. Please indicate the desired Death Benefit Payment Schedule:

   Initial Lump Sum (if any): $ _____

   Benefit Installment Mode / Amount / Duration: ___ Annual $ _____ for _____ Years
   (please select either annual or monthly mode) ___ Monthly $ _____ for _____ Years

   For Annual, would you like to specify the date the beneficiary receives benefit? Yes ___ No ___
   If Yes, what date? _____ (MM/DD). If no date chosen, beneficiary will receive benefit on the anniversary of the original claim processing date.

   For Monthly, would you like to specify the day of the month the beneficiary receives benefit? Yes ___ No ___
   If Yes, what day? _____ (1-28). If no day chosen, beneficiary will receive benefit on the day of the month of the original claim processing date.

3. Beneficiary: If multiple beneficiaries named, shares of both the initial lump sum and each installment will be equally divided among the surviving beneficiaries, unless otherwise specified.

Primary	Relationship	% of Initial Lump Sum (if any)	% of Benefit Installment Amount
Contingent	Relationship	% of Initial Lump Sum (if any)	% of Benefit Installment Amount

Signed at: _____
(City/State)

_____ _____
Signature of Proposed Insured **Date**

_____ _____
Signature of Owner **Date**

_____ _____
Signature of Agent **Date**