

Policy Number



Fax: 888-615-9619

APPLICATION FOR INDIVIDUAL LIFE INSURANCE				Owner, if other than proposed insured (N/A for CR)	Owner's address
Proposed Primary Insured <input type="checkbox"/>		Proposed Other Insured <input type="checkbox"/>		Relationship to Proposed Insured	
Name Last	First	MI	<input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security or Tax ID #	
Street					
City		State	Zip	Primary Beneficiary	
Social Security number			Occupation		
Birthplace		Birthdate	Age at nearest birthday		
Home phone ()			Business phone ()		
Where can you be reached for additional information? <input type="checkbox"/> Home <input type="checkbox"/> Work Best days: Best times: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.					
Initial death benefit \$					
Issue Best Rate Class					
Plan of insurance:					
Riders: <input type="checkbox"/> WP <input type="checkbox"/> ADB <input type="checkbox"/> CR <input type="checkbox"/> Other: Indicate amount for Riders: \$					
Amount remitted with this application, in exchange for this Company receipt: \$ Do not submit money if death benefit exceeds \$1,000,000 or insured's age exceeds 65 or health questions below answered yes.					
Special Request:					
Any person who knowingly with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties according to state law.					
Authorization To Obtain And Disclose Information: I (we) have read all the questions and answers in the application. All responses are true and complete to the best of my (our) knowledge and belief. No coverage will be in effect until: a full application has been signed by the proposed insured; and a policy has been issued; and the full first premium has been received by the company; and any amendments are signed. Any coverage will be subject to the terms and conditions of the policy. I (we) have received the notification about the Federal Fair Credit Reporting Act and the Medical Information Bureau. I (we) hereby authorize: any licensed physician or medical practitioner; any hospital, clinic or other medical or medically related facility; any insurance company; the Medical Information Bureau; or pharmacy, to give West Coast Life Insurance Company, its affiliates, or their reinsurers or the Medical Information Bureau, any such information. This authorization is valid for two years from the date this form is signed. An exact copy of this authorization is as valid as the original.					
Signed at: (city and state) _____			Signature of Proposed Insured (if age 18 or over) _____		
Date signed: (month/day/year) _____			Signature of Owner/Applicant, if other than Proposed Insured _____		
Agent: To the best of your knowledge will this policy replace or change any existing life insurance or annuity policy(ies)? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes," complete any required replacement forms.) Has the Owner been provided an illustration which conforms to this application? <input type="checkbox"/> Yes <input type="checkbox"/> No If "no," agent hereby certifies that no illustration was used in connection with the solicitation of the policy applied for. Is there any third party other than the proposed insured that will obtain any ownership rights on any policy issued as a result of this application? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Print BGA's name			Print Agent's name/Social Security Number or Agent Code		
Agent's Signature		Date	Agent's Telephone number		
BGA's telephone:			BGA email address:		

TEMPORARY LIFE INSURANCE RECEIPT

THIS RECEIPT PROVIDES A LIMITED AMOUNT OF LIFE INSURANCE COVERAGE, FOR A LIMITED PERIOD OF TIME, SUBJECT TO THE TERMS OF THIS RECEIPT. Premium payment in the amount of \$_____ is made for Life Insurance on each person proposed for insurance. **ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE INSURANCE COMPANY - DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.**

QUALIFYING SCREENING QUESTIONS

1	Has any person proposed for insurance in this application:	Yes	No
	a. within the past 90 days been admitted to a hospital or other medical facility, been advised to be admitted, or had surgery performed or recommended?	<input type="checkbox"/>	<input type="checkbox"/>
	b. within the past 2 years, been treated for heart trouble, stroke, or cancer, or had such treatment recommended by a physician or other practitioner?	<input type="checkbox"/>	<input type="checkbox"/>

2	Is any person proposed for insurance in this application under 15 days of age or over the age of 80 years (nearest birthday)?	<input type="checkbox"/>	<input type="checkbox"/>
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If any of the above questions, including any subpart thereof, is answered YES or LEFT BLANK, no representative of West Coast Life Insurance Company is authorized to accept a premium and NO COVERAGE will take effect under this Receipt. No one is authorized to accept a premium on Proposed Insureds under 15 days of age or over age 80 and NO Coverage will take effect under this Receipt.

TERMS AND CONDITIONS

AMOUNT OF COVERAGE - \$1,000,000 OVERALL MAXIMUM FOR ALL POLICIES, APPLICATIONS, AND RECEIPTS
 If a premium has been accepted by West Coast Life Insurance Company for an application for Life Insurance and any person proposed for Insurance in such application dies while this temporary life receipt is in effect, West Coast Life will pay, subject to the conditions and limitations contained herein, to the beneficiary designated in such application a death benefit equal to the lesser of:

- a. the amount of life insurance applied for under such application, or
- b. the greater of (i) \$1,000,000 less the amount of death benefits due to and payable by virtue of the insured's death under any other West Coast Life policy, application, temporary receipt or the like, or (ii) \$50,000.

In no event shall West Coast Life's liability under this Receipt exceed \$1,000,000. Any money received will be refunded.

DATE COVERAGE BEGINS: Temporary Life Insurance under this Receipt will begin on the date this Receipt is executed and the application has been completed.

DATE COVERAGE TERMINATES: Temporary Life Insurance under this Receipt will terminate automatically on the earlier of:

- a. the date that West Coast Life mails notice of termination of coverage and refund of the advance premium payment to the Applicant at the address designated in this application, or
- b. the date that West Coast Life approves for issue the policy applied for at the rate class and for the amount indicated in this application. In no event shall coverage be provided under this Receipt if the policy applied for has been issued.

LIMITATIONS: This receipt does not provide benefits for disability. If Temporary Life Insurance is terminated in accordance with (a) above, West Coast Life's liability under this Receipt is limited to a refund of the premium payment made. If any person proposed for insurance dies by suicide, West Coast Life's liability under this Receipt is limited to a refund of the payment made. There is no coverage under this Receipt if the check submitted as payment is not honored by the bank on first presentation. No one is authorized to waive or modify any of the provisions of this Receipt. **COVERAGE UNDER THIS RECEIPT SHALL BE VOID IF THERE IS FRAUD OR A MATERIAL MISREPRESENTATION IN THE APPLICATION FOR LIFE INSURANCE OR IN ANY ANSWER TO THE QUALIFYING SCREENING QUESTIONS OF THIS RECEIPT. I (WE) HAVE RECEIVED A COPY OF AND HAVE READ THIS TEMPORARY INSURANCE RECEIPT AND DECLARE THAT THE ANSWERS ARE TRUE TO THE BEST OF MY (OUR) KNOWLEDGE AND BELIEF. I (WE) UNDERSTAND AND AGREE TO ALL ITS TERMS.**

Signed At _____	(X)	
		Proposed Insured 1 (Sign Name in Full)
Date _____	(X)	
		Proposed Insured 2 (Sign Name in Full)
(X) _____	(X)	
Witnessed by Agent		Signature of Parent or Guardian, if Minor
_____	(X)	
Agent Name (Printed)		*Applicant/Owner, if Other than Proposed Insured

Street Address		*If owner is Corporation, Partnership or Trust, a Corporate Officer, Partner of the Trustee must sign and state title.

City, State and Zip		

NOTICE TO APPLICANT: You should retain the copy of this Receipt. The original will be retained by West Coast Life. If you do not hear from us regarding the insurance applied for within 100 days from the date of this Receipt, notify us at West Coast Life Insurance Company, P.O. Box 193892, San Francisco, CA 94119-3892, 1-800-366-9378, Attn: Underwriting Services.

BANK DRAFT INFORMATION

WEST COAST LIFE INSURANCE COMPANY

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

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

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

Automatic Bank Draft Agreement

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

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

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

Financial Institution Name _____

Financial Institution Address _____ City, State _____ ZIP _____

Routing Number | :

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 : |

Account Number

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Type of Account: Checking Saving Credit Union: Yes No

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

Premium Amount \$ _____

Frequency: Annual Semi-Annual Quarterly Monthly

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

Print Bank Account Owner(s) Name _____

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

Please attach a voided check.

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 Online 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.
- 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 website 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:

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

Yes – I would like my policy 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



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A PROTECTIVE COMPANY

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

**NOTICE REGARDING REPLACEMENT
REPLACING YOUR LIFE INSURANCE POLICY OR ANNUITY**

Are you thinking about buying a new life insurance policy or annuity and discontinuing or changing an existing one? 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 benefits and the proposed benefits.

Make sure you understand the facts. You should ask the company or agent that sold you your existing policy to give you information about it.

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

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

Policy # Being Replaced	Company	Policy Type
date	print agent's name	
applicant's signature	agent's signature	

**ATTENTION CONSUMER. THIS NOTICE IS REQUIRED BY THE INSURANCE COMMISSIONER.
PLEASE READ IT CAREFULLY BEFORE SIGNING.**

A completed copy of this form must be provided to the Proposed Insured and 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 Certification" (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).**