INSTRUCTIONS AND CHECKLIST

FOR LA2008 APPLICATION FOR LIFE INSURANCE

Lincoln Benefit Life Company

Standard Mail: P.O. Box 80469, Lincoln, NE 68501
Express Mail: 2940 South 84th Street, Lincoln, NE 68506

IF FAXING APPLICATION: Please fax to 1-866-525-5433. Please do not mail the original. However, if requesting a 1035 Exchange, please mail **ONLY** the original 1035 Exchange documentation in order to process.

IMPORTANT INFORMATION – Please read prior to completing and submitting the application

- **For miscellaneous pertinent information, please utilize Agent Remarks/Special Instructions section**
- **Illustration disclosures and other miscellaneous forms can be downloaded from accessallstate.com**
- **Parameds and labs can be ordered through APPS at 1-800-635-1677 or Exam One at 1-877-933-9261**

THIS PACKAGE CONTAINS THE FOLLOWING DOCUMENTS

- Application for Life Insurance Part 1 and Part 2
- Receipt and Temporary Insurance Agreement
- Agent Report
- Authorization for Release of Medical Information (HIPAA Form)
- Electronic Funds Transfer Agreement

And if applicable in your state:

- HIV Consent Form(s)
- Replacement form(s)

YOU WILL NEED ADDITIONAL FORMS IN THE FOLLOWING SITUATIONS:

- **In states which have adopted the NAIC Illustrations Model Regulation, if you are not including a signed illustration with all fields matching the application, including premium and mode, please submit a Policy Illustration Disclosure, FICCA101. For a listing of NAIC States, go to accessallstate.com, Support Center tab, click on Compliance, then NAIC Status.**

- **For 1035 Exchanges,** also submit LBL842, Absolute Assignment for 1035 Exchange or ACORD951, 1035 Exchange/Rollover/Transfer form. Please mail in the original 1035 exchange documentation after faxing the application.

- **If doing an internal LBL replacement that is not a 1035**, please submit the FIC8, Request for Distribution-Life. This form will ensure the surrender of the existing contract.

- **Ultra Index applications require a state specific supplement**. Please consult accessallstate.com or the Home Office to determine the specific form number.

- **For Variable Life products**, please submit appropriate product/state specific supplemental forms. Please consult accessallstate.com or contact the Home Office to determine specific form numbers.

- **For Premium Finance cases**, please submit LA2008PF, Premium Finance Supplement to Life Application. This supplement is required if Section I, Question 1, of the application is answered “Yes.” It is not required if premiums are being loaned by an employer as part of a split dollar financing arrangement.

- **If utilizing STEP underwriting processes**, you must use the FAA73 series TeleApplication.

There may also be other state or product specific requirements.

Please consult accessallstate.com or contact the Home Office to determine all form requirements.

APPLICATION FOR LIFE INSURANCE

LINCOLN BENEFIT LIFE
AN ALLSTATE COMPANY

Lincoln Benefit Life Company
P. O. Box 80469, Lincoln, NE 68501-0469
Tel: 800-525-9287

PART 1

Section A - Primary Proposed Insured

1. Name (First, Middle, Last)			2. Birth Date (MM/DD/YYYY)	3. Birth State/Country
Home Address			4. How long at this address?	5. Sex ❑ M ❑ F
City	State	ZIP	6. Marital Status ❑ Married ❑ Single ❑ Widowed ❑ Divorced	

7. Home Phone Number ( )	8. Work Phone Number ( )	9. Driver's License Number / State	10. SSN/TIN

11. Employer Name	12. Occupation and Duties	13. Annual Income $	14. Height and Weight Ft. In. Lbs.

15. Has the Primary Insured ever used cigarettes, cigars, a pipe, chewing tobacco, nicotine gum, or any other product containing tobacco or nicotine?
- ❑ No, has never used any tobacco or nicotine product
- ❑ Yes, has used tobacco or nicotine product, but not in the past 5 years
- ❑ Yes, has used tobacco or a nicotine product in the past 5 years, but does not currently (please complete question 17)
- ❑ Yes, currently uses tobacco or a nicotine product (please complete question 16)

16. Tobacco or nicotine products **currently used:**
- ❑ Cigarettes-Packs/Day ______
- ❑ Other ______
- Frequency ______

17. If the Primary Insured used any tobacco or nicotine products **in the past 5 years:**
- ❑ Type ______
- ❑ When quit? ______ (MM/YYYY)

18. Primary Beneficiary (First, Middle, Last)	Relationship to Primary Insured	Birth Date/Date of Trust (MM/DD/YYYY)	SSN/TIN	% Share (if not equal)

Primary Beneficiary's Address: ❑ Same as Primary Insured's ❑ Other Address:

19. Contingent Beneficiary (First, Middle, Last)	Relationship to Primary Insured	Birth Date/Date of Trust (MM/DD/YYYY)	SSN/TIN	% Share (if not equal)

This page must be submitted even if blank.

Section B — Proposed Additional or Joint Insured *(If more than one, submit additional copies of Section B.)*

1. Name (First, Middle, Last)			2. Birth Date (MM/DD/YYYY)	3. Birth State/Country
Home Address			4. How long at this address?	5. Sex ❑ M ❑ F
City	State	ZIP	6. Relationship to Primary Insured	

7. Home Phone Number ( )	8. Work Phone Number ( )	9. Driver's License Number / State	10. SSN/TIN

11. Employer Name	12. Occupation and Duties	13. Annual Income $	14. Height and Weight Ft. In. Lbs.

15. Has the Additional/Joint Insured ever used cigarettes, cigars, a pipe, chewing tobacco, nicotine gum, or any other product containing tobacco or nicotine?
- ❑ No, has never used any tobacco or nicotine product
- ❑ Yes, has used tobacco or nicotine product, but not in the past 5 years
- ❑ Yes, has used tobacco or a nicotine product in the past 5 years, but does not currently (please complete question 17)
- ❑ Yes, currently uses tobacco or a nicotine product (please complete question 16)

16. Tobacco or nicotine products **currently used:**
- ❑ Cigarettes-Packs/Day ________
- ❑ Other ________

Frequency ________

17. If the Additional/Joint Insured used any tobacco or nicotine products **in the past 5 years:**
- ❑ Type ________
- ❑ When quit? ________ (MM/YYYY)

18. Primary Beneficiary (First, Middle, Last) (Only applicable to Additional Insured Rider)	Relationship to Additional Insured	Birth Date/Date of Trust (MM/DD/YYYY)	SSN/TIN	% Share (if not equal)

Primary Beneficiary's Address: ❑ Same as Additional Insured's ❑ Other Address:

19. Contingent Beneficiary (First, Middle, Last) (Only applicable to Additional Insured Rider)	Relationship to Additional Insured	Birth Date/Date of Trust (MM/DD/YYYY)	SSN/TIN	% Share (if not equal)

❑ Contingent Beneficiary(ies) for Additional Insured same as those for Primary Proposed Insured shown in Section A, no. 19.

Section C - Children Proposed for Children's Level Term Rider (CLTR) *[Must be Primary Insured's (a) children, stepchildren living with Primary Insured, or legally adopted children, and (b) age 17 or less. Not available if owner is a business.]*

1. Name (First, Middle, Last)	2. Birth Date (MM/DD/YYYY)	3. Age	4. Sex	5. SSN
			❑ M ❑ F	
			❑ M ❑ F	
			❑ M ❑ F	
			❑ M ❑ F	

Section D - Owner/Payor If Other Than Primary Proposed Insured

1. Name (First, Middle, Last) ❑ Owner ❑ Payor *(as permitted)*

2. Relationship to Primary Insured

Street Address

3. Home Phone Number ( )

4. Other Phone Number ( )

City State ZIP

5. Birth Date (MM/DD/YYYY)

6. SSN/TIN

Section E - Citizenship

1. Are all Proposed Insureds, Beneficiaries, Owners, and Payors citizens of the United States? ❑ Yes ❑ No *(If "no," give details below)*

Name and Party (e.g., "Insured")	Country	❑ Perm. Res. Card No. ______ ❑ Visa No. and Type ______	*Attach copy if available.*
Name and Party (e.g., "Insured")	Country	❑ Perm. Res. Card No. ______ ❑ Visa No. and Type ______	*Attach copy if available.*

Section F - The Policy

1. Plan of Insurance *(for term plans, include level period)*
2. Base Face Amount $
3. Death Benefit Option (UL/VUL only) ❑ 1 ❑ 2 ❑ 3 (if available)
4. ❑ APL *(for Whole Life only)*

5. Additional Benefits, Riders, Options: ❑ WP ❑ COP $ ______ ❑ ROP ❑ CLTR ______ Units ($5,000 per unit)
❑ PTR $ ______ ❑ ADB (Primary Insured) $ ______ ❑ Date policy to save age (if within allowed timeframe)
❑ Other: ______

Additional Insured Rider(s):
❑ Name ______ $ ______ Level Period* ______ ❑ ADB on AIR $ ______
❑ Name ______ $ ______ Level Period* ______ ❑ ADB on AIR $ ______

** Required for AIR on term base policy only.*

6. UL/VUL Premium Information *(must match illustration)*
Planned Modal Premium $ ______ Additional Lump Sum Premium $ ______ *(Includes expected 1035 funds if any.)*

7. Premium Mode/Method *(must match illustration)*
❑ Single ❑ Semiannual ❑ Monthly EFT
❑ Annual ❑ Quarterly ❑ Other ______

Section G - Other Insurance and Replacement

1. Does anyone proposed for this insurance have any life insurance or annuity contracts (includes personal, business or group life):

	Yes	**No**
a. in force or application(s) pending in any company? *(If "yes," list below.)*	❑	❑
b. which have been or will be replaced, exchanged, changed or borrowed against because of this application? *(Circle applicable policy number below.)*	❑	❑
c. which will be part of a 1035 exchange because of this application? *(Must be from life insurance.)*	❑	❑

Give details below and submit any required replacement forms and policy illustrations.

Person Covered	Company	Face Amount	ADB Amount	Date Applied (MM/DD/YYYY)	Policy Number	Plan Type
		$	$			
		$	$			
		$	$			

Section H - Nonphysical Data and Preliminary Health Information

	Yes	No	Details of Yes Answers
1. With regard to driving record, has anyone proposed for insurance:			
a. had any moving violations in the past 3 years?	❑	❑	
b. other than above, been convicted of driving under the influence or reckless driving, or had their driver's license suspended or revoked, in the past 10 years?	❑	❑	
2. In the past 3 years, has anyone proposed for insurance:			
a. flown as a pilot or crew member of any aircraft? *(If "yes," attach questionnaire.)*	❑	❑	
b. engaged in sky or scuba diving, vehicle racing, mountain or rock climbing? *(If "yes," attach applicable questionnaire.)*	❑	❑	
3. Has anyone proposed for insurance EVER had an application for life insurance declined, postponed, rated, or modified?	❑	❑	
4. Are there any Proposed Insureds who have lived in the U.S. less than 3 years OR plan to travel outside the U.S. in the next 2 years? *(If "yes," attach questionnaire.)*	❑	❑	
Do not submit payment with application if any of questions 5(a-f) below are answered "yes" or not answered.			
5. In the past 10 years, has anyone proposed for insurance:			
a. been charged with a felony?	❑	❑	
b. used or been arrested for possession, sale or delivery of illegal drugs?	❑	❑	
c. sought or received treatment or advice for use of cocaine, heroin, narcotics, hallucinogens or other mind-altering substances not prescribed by a physician?	❑	❑	
d. been diagnosed or treated by a physician for heart attack, coronary artery disease or stroke, or been told they had any of these disorders?	❑	❑	
e. been treated for or diagnosed with cancer other than basal cell skin cancer?	❑	❑	
f. been diagnosed or treated by a physician for Acquired Immune Deficiency Syndrome (AIDS) or been told they have AIDS?	❑	❑	

Section I - Premium Funding

	Yes	No	Details of Yes Answers
1. Will premiums for this policy be funded directly or indirectly by any loan or advance from any person or entity other than the Proposed Insured's employer? *(If "yes," complete the Premium Finance Supplement to Life Application.)*	❑	❑	
2. Has any Proposed Insured, Owner, or Beneficiary been given or offered cash, property, gifts, loan proceeds, or any other inducement to apply for or transfer any interest in this policy?	❑	❑	
3. Has any Proposed Insured or Owner agreed, or been advised or encouraged, to sell, assign, or transfer the policy, or any interest in the policy, to a settlement company, investor(s), charity, or other third party?	❑	❑	
4. With respect to this policy, will any trust, LLC, or other entity created by or on behalf of the Proposed Insured or Owner have the right to sell shares or certificates of interest, or any other interest in the policy to other parties?	❑	❑	
5. Are any existing life insurance policies on any Proposed Owner or Insured currently owned by, or in the process of being sold to, a viatical or settlement company, investor(s), or investment fund?	❑	❑	

Section J - Juvenile Insurance *(Complete if Primary or Additional Insured is under 18 years of age.)*

1. Please provide the amount of life insurance in force or applied for on the Primary/Additional Insured's:

   a. Mother (if mother is uninsurable or deceased, so indicate.) $ ____________________

   b. Father (if father is uninsurable or deceased, so indicate.) $ ____________________

2. Is the total insurance coverage in force and applied for equal for all siblings? ❑ Yes ❑ No

   (If "no," give details.) ____

CONTINUATION OF APPLICATION FOR LIFE INSURANCE - PART 2

1. Primary Insured's Physician's Name and Address *(If none, state "None.")*		Phone Number ( )
Date Last Seen	Reason Last Seen	Result (Diagnosis and Treatment)

2. Additional Insured's Physician's Name and Address *(If none, state "None.")*		Phone Number ( )
Date Last Seen	Reason Last Seen	Result (Diagnosis and Treatment)

3. Does any Primary or Additional Proposed Insured have a family history of heart disorder, stroke or cancer beginning before age 65 in any natural parent or sibling? *(If "yes," complete table below.)* ❑ Yes ❑ No

Proposed Insured	Which Relative?	Disorder	Age at Onset	Age at Death	Cause of Death	Age if Living

Questions 4 - 8 apply to all Proposed Insureds, including children proposed for coverage under CLTR.

	Yes	No
4. Has anyone proposed for insurance EVER been diagnosed with, or sought treatment or advice for:		
a. high blood pressure or any disorder of heart or blood vessels?	❑	❑
b. cancer or tumor?	❑	❑
c. dependency on or addiction to alcohol or any drug?	❑	❑
5. In the past 10 years, has anyone proposed for insurance been diagnosed with, or sought treatment or advice for:		
a. epilepsy or seizures, disorder of the brain or nervous system, mental or nervous disorder?	❑	❑
b. diabetes?	❑	❑
c. asthma, emphysema, sleep apnea, or any lung disorder?	❑	❑
d. any disorder of the digestive tract, liver or pancreas?	❑	❑
e. anemia or other disorder of blood or blood cells?	❑	❑
f. disorder of kidneys or reproductive organs?	❑	❑
g. arthritis or disorder of bones, skin or muscle?	❑	❑
6. Other than previously disclosed, in the past 5 years, has anyone proposed for insurance:		
a. had a checkup, consultation, hospitalization, illness, surgery, or medical or diagnostic test?	❑	❑
b. been advised to have a medical consultation, diagnostic test, or surgery that HAS NOT been done?	❑	❑
7. Is anyone proposed for insurance taking any prescription or over-the-counter medications, herbs, supplements, or alternative medications not previously disclosed?	❑	❑
8. Has anyone proposed for insurance been told that any insurance company exams and/or lab specimens are required? *If "yes," give name(s) of Proposed Insured(s) here:* ______________________	❑	❑

Please Provide Details of "Yes" Answers to Questions 4 – 8 Below:

Question #	Proposed Insured	Date(s)	Medical Condition and How Treated	Current Status	Name and Address of Physician/Facility

Use this space if necessary for additional information.

Permit to Obtain and Disclose Certain Data

A. Lincoln Benefit Life Company, its reinsurers, consumer reporting agencies, and other parties acting on Lincoln Benefit Life Company's behalf may get data about my health, medical history, prescription medication history, and related information, mode of living (except as may be related directly or indirectly to sexual orientation), avocations, finances, credit history, driving record, and any criminal record. I understand that the information obtained by use of this authorization will be used to determine eligibility for insurance and/or benefits, or for Lincoln Benefit Life Company to determine its obligations under the policy issued in connection with this application.

B. Any doctor, practitioner, medical or medically related facility, laboratory, Pharmacy Benefit Managers, the Veterans Administration, the Medical Information Bureau, Inc. (MIB, Inc.), viatical settlement company, employer, consumer reporting agency, creditor, government agency, insurance or reinsurance company or any other person or entity which has such data about me may give such data to Lincoln Benefit Life Company and its reinsurers when this Permit or a copy of it is shown. All sources but the MIB, Inc., may give such data to producers or agencies acting on behalf of Lincoln Benefit Life Company. The information as provided herein pursuant to the authorization will not be redisclosed unless authorized by me or otherwise required by law. Covered entities, as defined by the Health Insurance Portability and Accountability Act of 1996, may not condition treatment, payment, enrollment, or eligibility for benefits on whether this Permit is signed.

C. Any request by Lincoln Benefit Life Company for medical records is on my behalf; the information must be provided within any requirements imposed by applicable statutes governing patient access to medical records.

D. Data about mental illness, alcoholism, sexually transmitted diseases, and the use of drugs is to be included.

E. Lincoln Benefit Life Company or its reinsurers may make a brief report about me to the MIB, Inc.

F. This Permit is good for 24 months after it is signed.

G. Lincoln Benefit Life Company may obtain an investigative consumer report ("inspection report") on me. ☐ I want to be interviewed if such a report is obtained.

H. I have read this Permit and know I may request a copy of it. I may revoke this Permit by writing to Lincoln Benefit Life Company. I also have received the Disclosures and Notices.

Declarations

A. I (each undersigned) declare that all answers written on this application are full and correct to the best of my knowledge and belief.

B. Lincoln Benefit Life Company may add to or correct the application on an addendum page immediately following the application. Any changes are agreed to if I (we) accept the policy, but written agreement will be obtained from me for any change in insurance amount, plan, benefits, payment class or age at issue.

C. Insurance will start only as provided in the Receipt and Temporary Insurance Agreement issued in connection with this application. If no receipt is issued or if insurance under it has stopped and not started again, no insurance will start by reason of the application until the policy is delivered and the first premium paid in full. No insurance will start if at that time the health of all Proposed Insureds is not as described in the application.

D. I have read and understand this application, including the Disclosures and Notices, which I acknowledge receiving.

E. Only an officer of Lincoln Benefit Life Company may change this application or waive a right or requirement. No producer may do this.

ALL QUESTIONS WERE ASKED OF ME AND, IF APPLICABLE, THE ADDITIONAL/JOINT INSURED AND PARENTS OF ANY CHILDREN LISTED ON THIS APPLICATION. I (WE) HAVE READ ALL INFORMATION BEFORE SIGNING.

I declare that the answers written above are full and correct to the best of my knowledge and belief. I understand and agree that the statements above, along with the application, will be the basis for any insurance issued.

SUBSTITUTE FORM W-9 **Under penalties of perjury, I certify that:**

1. **The number on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and**
2. **I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and**
3. **I am a U.S. person (including a U.S. resident alien).**

The Internal Revenue Service does not require your consent to any provisions of this document other than the certification required to avoid backup withholding.

Sign Here

Signed at (City, State) Date (MM/DD/YYYY) Signature of Owner (and title, if a business or organization)

Signature of Primary Proposed Insured Signature of Additional/Joint Insured

Signature of Producer Signature of Parent/Legal Guardian (if any Insured is under Age 15)

Disclosures and Notices (Must be provided to the Proposed Insured.)

IMPORTANT INFORMATION REGARDING MEDICAL EXAMS

As part of the underwriting process we may ask for medical tests or exams to be completed at our expense. Common tests may include a paramedical exam, which will consist of questions about your medical history and measurements of your body including, but not limited to height, weight, blood pressure, and pulse. Blood and urine specimens are also generally collected. Undressing is not required for any of these tests.

In some instances, an EKG (Electrocardiogram) may be required. An EKG is a recording of the electrical impulses in the heart. You will be asked to lay down with your shirt unbuttoned so the EKG leads can be placed on your chest.

If you have any questions about the specific tests that will be required of you, please feel free to contact your producer.

NOTICE REGARDING THE MIB

Information regarding your insurability will be treated as confidential. Lincoln Benefit Life Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a non-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 healthy insurance coverage, or a claim for benefits is submitted to such 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 this 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.

Lincoln Benefit Life Company, 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.

INSURANCE INFORMATION PRACTICES

We will rely primarily on the information you give us. We may also get information from other sources, such as doctors, or other medical professionals who have treated you. In some cases, we may ask a consumer reporting agency to gather information and send us an investigative consumer report as explained in the Notice Under the Federal Fair Credit Reporting Act below. You may ask to be interviewed as part of the preparation of any such report.

In certain limited circumstances, we are allowed by law to disclose necessary items of personal information to third parties without your specific authorization.

You have the right to be told about and to see and copy items of personal information about you that appear in our files, including information contained in the investigative consumer reports. You also have the right to seek correction of information you believe to be inaccurate.

We will send you a more detailed explanation of our information practices if you send us a written request. You may send your request to Underwriting Department, Lincoln Benefit Life Company, P.O. Box 80469, Lincoln, Nebraska 68501.

NOTICE UNDER THE FAIR CREDIT REPORTING ACT

In compliance with the Federal Fair Credit Reporting Act, you are hereby notified that an investigative report may be made. This would be by personal interviews with neighbors, friends, associates, or other persons. This will concern the character, general reputation, personal characteristics, and mode of living (except as may be related to sexual orientation) of any person proposed for insurance. You may obtain additional information concerning the nature and scope of this investigation and a written summary of your rights under the Federal Fair Credit Reporting Act by contacting our Home Office. Our address is Lincoln Benefit Life Company, P.O. Box 80469, Lincoln, Nebraska 68501. Upon your written request, you will be informed whether or not an investigation was made by us. If so, you will receive the name and address of the consumer reporting agency involved. You may receive and inspect a copy of the Investigative Consumer Report by contacting the consumer reporting agency.

IMPORTANT INFORMATION

For Applicants in Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines or a denial of insurance benefits.

• Not FDIC, NCUA/NCUSIF insured • Not insured by any federal government agency • Not a deposit • No bank guarantee • May lose value

Receipt and Temporary Insurance Agreement (Referred to as "Agreement")

Lincoln Benefit Life Company, P.O. Box 80469, Lincoln, NE 68501-0469

- **This Agreement must be given if payment is submitted with the application.**
- **Do not submit money or give this Agreement if the amount of insurance applied for on any one life exceeds $1,000,000.**
- **All checks must be made payable to the Lincoln Benefit Life Company. Do not make checks payable to the producer or leave the payee blank.**
- **Do not submit money or give receipt if any questions 5(a-f) in Section H are answered "yes" or not answered.**

$ ______________ has been received from ____ (Payor) as a payment for the life insurance on ____ (Insured/Additional/Joint Insured) applied for on this date, except as limited in the Amount of Insurance section below.

NO INSURANCE WILL TAKE EFFECT EXCEPT AS DESCRIBED BELOW:

When Temporary Insurance Starts

If payment of at least one-twelfth of the annual premium for the policy applied for, including any riders and supplemental benefits, has been accepted by us and the application for life insurance has been completed on or before the date of this Agreement, temporary insurance under the Agreement will start on the later of: (1) the date of the Agreement, or (2) the date when all required medical exams have been completed and/or lab specimens (blood, urine, or oral fluid) provided.

When Temporary Insurance Will Stop

Temporary insurance under this Agreement will stop on the first of the dates below:

1. The date we write to the Owner that we have stopped considering the application, which is our absolute right.
2. The date we advise the Owner that a medical exam or lab specimen is required, in which event insurance will stop with respect only to the person(s) to whom such requirement(s) apply. Insurance under this Agreement will start again for such person when the last of such medical requirements is done. We have the absolute right to require such medical exams and lab specimens.
3. The date we agree to issue the coverage as applied for in the application. The insurance will then be provided by the policy.
4. The date we offer to issue insurance other than as applied for in the application. We may offer to issue insurance other than as applied for in the application on any person(s) proposed for this insurance.

We will refund all payments for which this Agreement was given if we stop considering the application.

Amount of Insurance

If temporary insurance under this Agreement is in effect, it will have the same benefits, provisions, and limitations and be for the same amount as the plan applied for. But we will provide no more than a combined total of $1,000,000 of temporary life insurance and accidental death benefit on any one life under this and any other Temporary Insurance Agreements, regardless of the insurance applied for under this application.

Conditions Under Which There is No Coverage

1. No insurance coverage starts under this Agreement, and we will only pay a refund of the payment made with the application if, in the past 10 years, anyone proposed for insurance has:
   a. been charged with a felony; or
   b. used or been arrested for possession, sale or delivery of illegal drugs; or
   c. sought or received treatment or advice for use of cocaine, heroin, narcotics, hallucinogens or other mind-altering substances not prescribed by a physician; or
   d. been diagnosed or treated by a physician for heart attack, coronary artery disease or stroke, or been told they had any of these disorders; or
   e. been treated for or diagnosed with cancer other than basal cell skin cancer; or
   f. been diagnosed or treated by a physician for Acquired Immune Deficiency Syndrome (AIDS) or been told they have AIDS.
2. No insurance coverage starts under this Agreement if, in the answers in the application, there is any fraud or misrepresentation material to our acceptance of the risk. If there is fraud and/or material misrepresentation, we will only pay a refund of the payment made with this application.
3. No insurance coverage starts under this Agreement if a person proposed for this insurance dies by suicide while sane or self-destruction while insane. In this event, we will only pay a refund of the payment made for that person's insurance. Temporary Insurance will continue on all other Proposed Insureds whose coverage is not contingent on the insurance of the person who died.
4. No insurance coverage starts under this Agreement if no payment is received, if a check or draft given as a payment is not honored by the bank or, in the case of a credit card payment, the charge is refused by the credit card issuer.

No one can waive or change any of the terms of this Agreement.

______________________________________ Producer Name

____________________ Date (MM/DD/YYYY)

Producer's Report

1. Payment with Application $ ______________________
2. Is the Proposed Insured related to you? *(If "yes," explain below.)* ❑ Yes ❑ No
3. Are there any Proposed Insureds whom you did not see when you took the application? *(If "yes," explain below.)* ❑ Yes ❑ No
4. What is the purpose of the insurance? ______________________
5. How long and how well have you known the Proposed Insured? ______________________
6. Have age/amount medical requirements been ordered? ❑ Yes ❑ No ❑ N/A
7. Rate class quoted? ______________________
8. To your knowledge, do all Proposed Insureds meet requirements for the rate class(es) quoted? *(If "no," explain below.)* ❑ Yes ❑ No
9. If Primary Proposed Insured is a nonemployed spouse, how much life insurance does the employed spouse have? $ ______________________

Remarks

Writing Producer Printed Name	Split %	Producer Number	Producer Type (Allstate only) ❑ Multi-Line ❑ Financial Specialist ❑ Sales Producer
Phone Number ( )	Fax Number ( )		E-mail Address
Partnering Producer Printed Name	Split %	Producer Number	Producer Type (Allstate only) ❑ Multi-Line ❑ Financial Specialist ❑ Sales Producer
Phone Number ( )	Fax Number ( )		E-mail Address

Except as otherwise provided in the answer to Question 1 of Section G (Other Insurance and Replacement), the applicant does not own any existing life insurance or annuity and REPLACEMENT of existing life insurance or annuity IS NOT INVOLVED in this transaction. This also certifies that I have complied with all applicable state replacement laws and regulations, and in my professional judgment, if a replacement is involved, it is in the best interest of the policyholder.

I hereby certify that to the best of my knowledge and belief the information provided in this report and by the Proposed Insured(s) in the application is complete, accurate, and correctly recorded; and there is nothing adversely affecting the insurability of the Proposed Insured(s) other than as indicated in the application. I also certify that I gave all required forms on or before the date the application was taken.

Sign Here

______________________ Signature of Writing Producer

______________________ Date (MM/DD/YYYY)

Financial Information

1. *Complete if face amount is > $500,000 or Primary Proposed Insured is age 65+*. Data pertains to Primary Proposed Insured, if insurance need is based on his/her finances, otherwise to: ❑ Spouse ❑ Primary Proposed Insured and Spouse jointly ❑ Parents ❑ Other ____________
   a. Net Worth Calculation
      Assets ____________
      Liabilities ____________
      Net Worth ____________
   b. Total Income Calculation
      Earned Income ____________
      Unearned Income ____________
      Total Income ____________
   c. Source of this information?
      ❑ Primary Proposed Insured
      ❑ Primary Proposed Insured's CPA
      ❑ Producer's best estimate
   d. If face amount is > $4,999,999, a CPA-prepared personal financial statement is: ❑ Attached ❑ Available on request ❑ Contact if needed
2. *Complete for business insurance if face amount is > $500,000.*
   a. Business purpose of coverage: ❑ Buy-sell ❑ Key person ❑ Other ____________
   b. Product/service sold ____________ c. Year started ____________ d. Primary Insured's ownership % ____________
   e. Any pending reorganization, acquisition, merger or expansion of this business? ❑ Yes ❑ No
   f. Has this business ever been subject to bankruptcy proceedings? ❑ Yes ❑ No
   g. Are there any comparable owners/officers who are *not* being similarly insured? ❑ Yes ❑ No
   h. Business Equity (Book Value)
      Assets ____________
      Liabilities ____________
      Equity ____________
   i. Last Year's Net Income (Loss)
      Gross Revenue ____________
      Expenses ____________
      Net Income (Loss) ____________
   j. Source of this information?
      ❑ Primary Proposed Insured
      ❑ Financial Statement
      ❑ Producer's best estimate
   k. Fair Market Value and how determined $ ____________ ____________
   l. Does the business have a Web site? ❑ No ❑ Yes – give address: ____________
   m. *If face amount is > $3,000,000, please submit most recent financial statement for the business.*

WASHINGTON SUITABILITY FOR JUVENILE LIFE INSURANCE
(MUST BE SUBMITTED WITH APPLICATION)

Policy Number (if available): ____________ Juvenile Proposed Insured ("Juvenile"): ____________ Date of Birth: ___/___/___ (MM/DD/YYYY)

- **If any Juvenile is age 15 or older, he/she must sign the application, regardless of amount of insurance.**
- **Complete this form if the total amount of life insurance in force and applied for on a Juvenile (under age 18) issued in the state of Washington exceeds $20,000 (including but not limited to, base coverage, AIR, CLTR and term conversions).**
- **Information provided in this form will be used to assess compliance with Washington Regulation WAC 284-23-806. This regulation requires justification for selling life insurance coverage on a juvenile in excess of reasonably anticipated costs associated with the juvenile's funeral, other death expenses and costs of mental health treatment for family members or loss of income to the family.**

1. Provide the total amount of life and/or accidental death insurance in force or applied for on the following people:

Parent(s)/Legal Guardian(s) of Juvenile:

Name: ____________ Relationship: ____________ $ ____________

Name: ____________ Relationship: ____________ $ ____________

Sibling(s) of the Juvenile:

Name (First and last)	Amount	Name (First and last)	Amount
	$		$
	$		$
	$		$
	$		$
	$		$

2. Is the amount of life insurance on the Juvenile equivalent to the amount on his/her sibling(s)? ❑ Yes ❑ No

If no, explain: ____________

3. Is the father or mother of the Juvenile the household's primary income provider? ❑ Yes ❑ No

If no, provide the name and relationship of the household's primary income provider to the Juvenile:

____

4. Does the amount of life insurance in force and applied for on the Juvenile exceed half the amount of life insurance on the household's primary income provider? ❑ Yes ❑ No

If yes, explain: ____________

5. Is the beneficiary or applicant dependent on the Juvenile for income or other support? ❑ Yes ❑ No

If yes, give details including Juvenile's income and occupation: ____________

6. Does the amount of life insurance in force and applied for on the Juvenile exceed the **total** annual household income? ❑ Yes ❑ No

If no, *this form is complete. Proceed to the signature line.*

If yes, *please provide total annual household income $* ____________

Washington Regulation WAC 284-23-806 requires additional justification for an amount of insurance greater than the total annual household income. Please provide the information in the table below:

Purpose of Insurance (e.g. final expenses, mental health counseling, income replacement, future needs etc.)	Estimated Amount	Explanation of Estimated Amount
	$	
	$	
	$	
	$	

SIGN HERE

____________ Agent's Signature ____________ Agent's Printed Name ____________ Date (MM/DD/YYYY)

Authorization for Release of Health-Related Information to

Lincoln Benefit Life Company, Lincoln, NE 68501

Bar Code Here Home Office Use Only	Bar Code Here Home Office Use Only

Name of Applicant/patient (Please Print) ______ Date of Birth (MM/DD/YYYY)

Name of Joint Applicant/patient (Please Print) ______ Date of Birth (MM/DD/YYYY)

"I," "me," "my" means each Applicant signing this Authorization.

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, Pharmacy Benefit Manager or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record and any other information that may be considered protected health information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") concerning me to The Insurance Company, its agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I terminate any agreements I have made with My Providers to restrict my medical records and any associated HIPAA protected health information and I instruct My Providers to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that The Insurance Company may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with The Insurance Company.

This authorization shall remain in force for 30 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to The Insurance Company. I understand that a revocation is not effective if any of My Providers has relied on this authorization or to the extent that The Insurance Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by certain federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I also understand that if I refuse to sign this authorization, The Insurance Company may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I acknowledge that I have received a copy of this authorization.

Sign Here

Applicant's Signature ______ Date (MM/DD/YYYY)

Joint Applicant's Signature ______ Date (MM/DD/YYYY)

HOME OFFICE COPY

Authorization for Release of Health-Related Information to

Lincoln Benefit Life Company, Lincoln, NE 68501

Bar Code Here Home Office Use Only	Bar Code Here Home Office Use Only

Name of Applicant/patient (Please Print) Date of Birth (MM/DD/YYYY)

Name of Joint Applicant/patient (Please Print) Date of Birth (MM/DD/YYYY)

"I," "me," "my" means each Applicant signing this Authorization.

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SIGNATURES NOT REQUIRED ON CUSTOMER COPY

CUSTOMER COPY

Agreement for Electronic Fund Transfer

Lincoln Benefit Life Company, PO Box 80469, Lincoln, NE 68501 Life Fax: 866-525-5433

I (we) authorize Lincoln Benefit Life Company and its other affiliates to debit my (our) account indicated to pay the premiums/payments, and other charges (such as non-sufficient funds), from the account listed on the attached documentation/voided check. In addition, I (we) have read and agree to the provisions which appear below.

This agreement is for: ❑ New ❑ In-Force Policy(ies)/Contract(s). If for In-Force business, list policy/contract numbers to be billed from this account.

1.________________ 2.________________ 3.________________

4.________________ 5.________________ 6.________________

Lincoln Benefit Life Company will use the policy/contract effective date as the draft date unless an alternate draft date is requested.

❑ I would like to use an alternate draft date ________________ (Additional premium/payment may be required)

FOR CHECKING ACCOUNTS, ATTACH VOIDED CHECK

(DEPOSIT TICKETS FOR CHECKING ACCOUNTS ARE NOT ACCEPTABLE)

FOR SAVINGS ACCOUNTS, ATTACH BANK DOCUMENT ACCOUNT VERIFICATION

The term "debit entry" shall include charges to my (our) account by orders initiated by electronic means, checks drafts or any other order. I have the right to stop payment of a debit entry by giving notice to my Financial Institution ("**The Institution**") in such time as to afford **The Institution** a reasonable opportunity to act prior to charging my (our) account. After my (our) account has been charged, I (we) have the right to have the amount of an erroneous debit immediately credited to such account by **The Institution** up to 15 days following issuance of statement or 45 days after posting, whichever comes first.

The Institution's treatment of each account debit, check, draft or other order initiated by **Lincoln Benefit Life Company**, and its rights with respect to it will be the same as if it were signed personally by me (us). If any such entry is dishonored for any reason, **The Institution** will not be under any liability even though dishonor results in the forfeiture of insurance.

In addition, I (we) have read, fully understand and also agree to the provisions on this form ________________

Dated (MM/DD/YYYY)

Sign Here

________________ Signature of Depositor

________________ Signature of Joint Depositor, if any

________________ Signature of Owner, if other than Depositor

IT IS UNDERSTOOD THAT ALL DEBIT ENTRIES INITIATED BY LINCOLN BENEFIT LIFE COMPANY PURSUANT TO THIS AGREEMENT SHALL BE SUBJECT TO THE FOLLOWING PROVISIONS.

This agreement shall not be effective until accepted by **Lincoln Benefit Life Company**.

Lincoln Benefit Life Company may initiate a debit entry under this Agreement that is different than the immediately preceding debit entry under this Agreement or may change the date of the billing cycle, provided **Lincoln Benefit Life Company** notifies me (either of us) in writing about the amount of the entry or the new date at least 10 days before initiating the entry to my (our) account or making the first entry to be affected by the new date.

Lincoln Benefit Life Company will not send premium/payment notices. Periodic statements, cancelled checks or other orders received by me (either of us) from **The Institution(s)** will be my (our) receipt.

This Agreement will end when (a) **Lincoln Benefit Life Company** or **The Institution** receives a written request from me (either of us) to end it, or (b) when **Lincoln Benefit Life Company** or **The Institution** sends me (either of us) written notice within 30 days prior to **Lincoln Benefit Life Company's** or **The Institution's** termination of this Agreement

This Agreement may be ended automatically by **Lincoln Benefit Life Company** if any debit entry has been refused by **The Institution** because of insufficient funds in my (our) account.

If the Agreement ends for any reason, and no premium/payment is unpaid beyond its grace periods, all premiums/payments due on any policy/contract covered by this agreement will become directly payable to **Lincoln Benefit Life Company** by me (us) until payment/premium plan is agreed to in writing.

Initial Premium Payment by Credit Card for Fixed Life New Business Only

❑ Discover ❑ Master Card ❑ VISA Card Number________________ Expiration Date ________
I understand that Lincoln Benefit Life Company will make a one-time charge to my credit card within 90 days of the date this authorization was signed.

Sign Here

________________ Name of Cardholder

________________ Signature of Cardholder

________________ Date (MM/DD/YYYY)

Agreement for Electronic Fund Transfer

Lincoln Benefit Life Company, PO Box 80469, Lincoln, NE 68501 Life Fax: 866-525-5433

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1.________________ 2.________________ 3.________________

4.________________ 5.________________ 6.________________

Lincoln Benefit Life Company will use the policy/contract effective date as the draft date unless an alternate draft date is requested.

❑ I would like to use an alternate draft date ________________ ***(Additional premium/payment may be required)***

FOR CHECKING ACCOUNTS, ATTACH VOIDED CHECK

(DEPOSIT TICKETS FOR CHECKING ACCOUNTS ARE NOT ACCEPTABLE)

FOR SAVINGS ACCOUNTS, ATTACH BANK DOCUMENT ACCOUNT VERIFICATION

The term "debit entry" shall include charges to my (our) account by orders initiated by electronic means, checks drafts or any other order.

I have the right to stop payment of a debit entry by giving notice to my Financial Institution ("**The Institution**") in such time as to afford **The Institution** a reasonable opportunity to act prior to charging my (our) account. After my (our) account has been charged, I (we) have the right to have the amount of an erroneous debit immediately credited to such account by **The Institution** up to 15 days following issuance of statement or 45 days after posting, whichever comes first.

The Institution's treatment of each account debit, check, draft or other order initiated by **Lincoln Benefit Life Company**, and its rights with respect to it will be the same as if it were signed personally by me (us). If any such entry is dishonored for any reason, **The Institution** will not be under any liability even though dishonor results in the forfeiture of insurance.

In addition, I (we) have read, fully understand and also agree to the provisions on this form ________________

Dated (MM/DD/YYYY)

SIGNATURES NOT REQUIRED ON CUSTOMER COPY

Signature of Depositor | Signature of Joint Depositor, if any | Signature of Owner, if other than Depositor

IT IS UNDERSTOOD THAT ALL DEBIT ENTRIES INITIATED BY LINCOLN BENEFIT LIFE COMPANY PURSUANT TO THIS AGREEMENT SHALL BE SUBJECT TO THE FOLLOWING PROVISIONS.

This agreement shall not be effective until accepted by **Lincoln Benefit Life Company**.

Lincoln Benefit Life Company may initiate a debit entry under this Agreement that is different than the immediately preceding debit entry under this Agreement or may change the date of the billing cycle, provided **Lincoln Benefit Life Company** notifies me (either of us) in writing about the amount of the entry or the new date at least 10 days before initiating the entry to my (our) account or making the first entry to be affected by the new date.

Lincoln Benefit Life Company will not send premium/payment notices. Periodic statements, cancelled checks or other orders received by me (either of us) from **The Institution(s)** will be my (our) receipt.

This Agreement will end when (a) **Lincoln Benefit Life Company** or **The Institution** receives a written request from me (either of us) to end it, or (b) when **Lincoln Benefit Life Company** or **The Institution** sends me (either of us) written notice within 30 days prior to **Lincoln Benefit Life Company's** or **The Institution's** termination of this Agreement.

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If the Agreement ends for any reason, and no premium/payment is unpaid beyond its grace periods, all premiums/payments due on any policy/contract covered by this agreement will become directly payable to **Lincoln Benefit Life Company** by me (us) until payment/premium plan is agreed to in writing.

Initial Premium Payment by Credit Card for Fixed Life New Business Only

❑ Discover ❑ Master Card ❑ VISA Card Number________________ Expiration Date ________

I understand that Lincoln Benefit Life Company will make a one-time charge to my credit card within 90 days of the date this authorization was signed.

SIGNATURES NOT REQUIRED ON CUSTOMER COPY

Name of Cardholder | Signature of Cardholder | Date (MM/DD/YYYY)

LINCOLN BENEFIT LIFE
AN ALLSTATE COMPANY

P.O. BOX 80469
LINCOLN, NE 68501-0469

Name ______________________ Policy # ______________________

Date of Birth ______________________ Social Security # ______________________

NOTICE AND CONSENT FOR TESTING WHICH MAY INCLUDE AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING

Acquired Immunodeficiency Syndrome (AIDS) is a life-threatening disorder of the immune system, caused by a virus, HIV. This virus is transmitted by sexual contact with an infected person, from an infected mother to her new-born infant, or by exposure to infected blood (as in needle sharing during intravenous drug use). Persons at high risk of contracting AIDS include males who have had sexual contact with another male, intravenous drug users, hemo-philiacs, and sexual contacts of any of these persons. AIDS does not typically develop until a person has been infected with HIV for several years. A person may remain free of symptoms for years after becoming infected. An infected person has a significant chance of developing AIDS over the next 10 years.

To determine your insurability, the Insurer named above (the Insurer) has requested that you provide a sample of your blood, urine, or oral fluid for testing and analysis. All tests will be performed by a licensed laboratory. The consent you give by signing this form authorizes the insurer to the collection of blood, urine, or oral fluid and to order laboratory tests only in regard to your present application for insurance.

Unless precluded by law, 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.

On the reverse of this form is located a list of HIV antibody testing/counseling services where you may obtain pre-test counseling.

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 involved solely in the underwriting process such as its affiliates, reinsurers, employees or contractors. If the Insurer is a member of the Medical Information Bureau (MIB, Inc.), and if the test results for HIV antibodies/antigens are other than normal, the Insurer will report to the MIB, Inc. a generic code which signifies only a non-specific test abnormality. If your HIV test is normal, no report will be made about it to the MIB, Inc. Other test results may be reported to the MIB, Inc. in a more specific manner. The organizations described in this paragraph may maintain the test 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. Positive or indeterminate results will not be sent directly to you. Instead, you may designate a health care provider or health care agency to whom the Insurer will provide positive or indeterminate test results for interpretation and post-test counseling. If you do not identify a designate health care provider or health care agency, and your test results are either positive or indeterminate, the Insurer will convey your test results to the local health department for interpretation and post-test counseling.

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 person who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others.

Positive HIV antibody or 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 premium may be charged, or that other policy changes may be necessary.

I have read and I understand this Notice of Consent for blood, urine, or oral fluid Testing Which May Include HIV Antibody/Antigen Testing. I voluntarily consent to the collection of blood, urine, or oral fluid from me, the testing of that specimen, and the disclosure of the test results as described above. 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.

____
Proposed Insured (Print)

Name and address of designated physician:

____

____

____

____
SIGNATURE OF PROPOSED INSURED OR PARENT/GUARDIAN

____
DATE

WASHINGTON STATE
HIV ANTIBODY TESTING/COUNSELING SERVICES

Adams County Health Department
103 West Main
Ritzville, Washington 99169
(509) 659-0090, Ext. 206

Asotin County Health District
c/o North Central Health District
1221 “F” Street
Lewiston, Idaho 83501
(208) 799-1300

Bellingham-Whatcom County Health District
509 Girard Street
Bellingham, Washington 98227
(206) 676-6720

Benton-Franklin Health District
506 Mckenzie
Richland, Washington 99352
(509) 943-2614

Bremerton-Kitsay County Health Department
109 Austin Drive
Bremerton, Washington 98412
(206) 478-5235; 1-800-874-2437

Chelan-Douglas County Health District
316 Washington Street
Wenatchee, Washington 98801
(509) 664-5306

Clallam County Health Department
223 East Fourth Street
Port Angeles, Washington 98362
(206) 452-7831

Cowiltz-Wahkiakum Health District
1516 Hudson
Longview, Washington 98632
(206) 425-7400

Garfield County Health District
P.O. Box 130 (10th & Columbia)
Pomeroy, Washington 99347
(509) 843-3412

Grant County Health District
County Courthouse
P.O. Box 37
Ephrata, Washington 98823
(509) 754-2011, Ext. 372

Grays Harbor County Health Department
2109 Sumner Avenue
Aberdeen, Washington 98520
(206) 532-8631

Island County Health Department
Courthouse Annex
P.O. Box 840
Coupeville, Washington 98239

Jefferson County Health Department
Multi-Services Building, 2nd Floor
802 Sheridan
Port Townsend, Washington 98368
(206) 385-0722

Kittitas County Health Department
507 Nanum
Ellensburg, Washington 98926
(509) 962-6811, Ext. 109

Lewis County Health District
Health Services Building
360 N.W. North Street
P.O. Box 706
Chehalis, Washington 98532
(206) 748-9121, Ext. 2233

Lincoln County Health Department
Nursing Office
Diane A. Martin, R.N., Director
507 - 7th Street
P.O. Box 215
Davenport, Washington 99122
(509) 725-1001

Mason County Health Department
411 North 5th (Nursing Division)
Shelton, Washington 98584
(206) 427-9670, Ext. 400

Northeast Tri-County Health District
East 347 Astor
P.O. Box 270
Colville, Washington 99114
(509) 684-5048

Okanogan County Health District
Administration Building
P.O. Box 231
Okanogan, Washington 98840
(509) 422-3867

Pacific County Health Department
Box 26
South Bend, Washington 98586
(206) 875-6541, Ext. 365

San Juan County Health Department
P.O. Box 607, 145 Rhone
Friday Harbor, Washington 98250-0607
(206) 378-4474

Seattle-King County Health Department
AIDS Prevention Project
(gay/bisexual men preferred)
1116 Summit Avenue, Suite 200
Seattle, Washington 98101
(206) 296-4999, TDD (206) 340-2033

Sexually Transmitted Disease Clinic
325 9th Avenue, 3rd Floor, South Wing
Seattle, Washington
(206) 223-3590

Seattle Gay Clinic
500 - 19th Avenue East
Seattle, Washington 98102
(will see anyone; Tuesday evening,
6:30-9:00p.m.; Saturday, noon-3:00p.m.)
(206) 461-4540

Low Risk Test Sites (Seattle-King Co.)

a) North Seattle Public Health Center
10501 Meridian Avenue North
Seattle, Washington
(206) 367-6900

b) Southeast Public Health Center at Renton
3001 N.E. 4th Street
Renton, Washington
(206) 344-6700

c) Southwest Public Health Center
10821 8th Avenue S.W.
Seattle, Washington
(206) 344-7474

d) East Public Health Center
2424 - 156th Avenue N.E.
Bellevue, Washington
(2060 344-6882

e) Southeast Public Health Center at Auburn
20 Auburn Avenue
Auburn, Washington
(206) 852-8400

Skagit County Health Department
Courthouse Administration Building
Mount Vernon, Washington 98273
(206) 336-9380

Snohomish Health District
2722 Colby Street, Suite 333
Mount Vernon, Washington 98273
(206) 259-2330 or 1-800-344-2437

Southwest Washington Health District
Vancouver-Clark County Health Center
2000 Fort Vancouver Way
P.O. Box 1870
Vancouver, Washington 98663
(206) 695-9215

Spokane County Health District
West 1101 College Avenue
Spokane, Washington 99201
(509 456-3630

Tacoma-Pierce County Health Department
3629 South “D” Street
Tacoma, Washington 98408
(206) 591-6060

Thurston County Health Department
529 Southwest Fourth
Olympia, Washington 98501
(206) 786-5581

Walla Walla County-City Health Department
310 West Poplar, P.O. Box 1753
Walla Walla, Washington 99362
(509) 527-3290

Whitman County Health Department
Public Service Building
North 310 Main Street
Colfax, Washington 99111
(509) 397-3471

Yakima County Health District
104 North First Street
Yakima, Washington 98901
(509) 575-4040

Lincoln Benefit Life Company
P.O. Box 80469
Lincoln, Nebraska 68501

IMPORTANT NOTICE REGARDING REPLACEMENT OF INSURANCE

(Save this notice! It may be important to you in the future.)

The decision to buy a new life insurance policy or annuity and discontinue or change an existing one is very important. Your decision could be a good one--or a mistake. It should be carefully considered. The Washington State Insurance Commissioner requires us to give you this notice to help you make a wise decision.

STATEMENT TO APPLICANT BY AGENT OR BROKER: (Use additional sheets, as necessary.)

I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following factors, which I call to your attention.

1. Can there be reduced benefits or increased premiums in later years? _____ No _____ Yes, explain:

2. Are there penalties, set up or surrender charges for the new policy? _____ No _____ Yes, explain:

3. Will there be penalties or surrender charges under the existing insurance as a result of the proposed transaction? _____ No _____ Yes, explain:

4. Are there adverse tax consequences from the replacement under current tax law? _____ No _____ Yes, explain:

5. a. Are interest earnings a consideration in the replacement? _____ No _____ Yes.
   b. If "yes," explain what portions of premiums or contributions will produce limited or no earnings. As pertinent, include in your explanation the need for minimum deposits to enhance earnings, and the reduction of earnings that may result from set up charges, policy fees, and other factors.

6. Are minimum amounts required to be on deposit before excess interest will be paid? _____ No _____ Yes, explain:

7. If the new program is based on a variable or universal life insurance policy or a single-premium policy or annuity:
   a. Are the interest rates quoted before _______________ or after ________________ fees and mortality charges have been deducted?
   b. Interest rates are guaranteed for how long? _______________
   c. The minimum interest rate to be paid is how much? _______________
   d. If applicable, the rate you pay to borrow is _______________, and the limit on the amount that can be borrowed is _______________.

e. The surrender charges are _______________.

f. The death benefit is _______________.

8. Are there other short or long term effects from the replacement that might be materially adverse? _____ No _____ Yes, explain:

____ ____________________________________

Signature of Agent or Broker Date

____

Name of Agent or Broker
(Print or Type)

____

Address

LIST OF POLICIES OR CONTRACTS TO BE REPLACED

Company	Insured	Contract No.

CAUTION: The insurance commissioner suggests you consider these points:

* Usually, contestable and suicide periods start again under a new policy. Benefits might be excluded under a new policy that would be paid under existing insurance.
* Terminating or altering existing coverage, before new insurance has been issued, might leave you unable to purchase other life insurance or let you buy it only at substantially higher rates.
* You are entitled to advice form the existing agent or company. Such advice might be helpful.
* Study the comments made above by the agent or broker. They apply to you and this proposal. They are important to you and your future.

Completed Copy Received: ____

(Applicant's Signature) (Date)

THIS COMPLETED FORM SHOULD BE FILED PERMANENTLY WITH YOUR NEW INSURANCE POLICY.