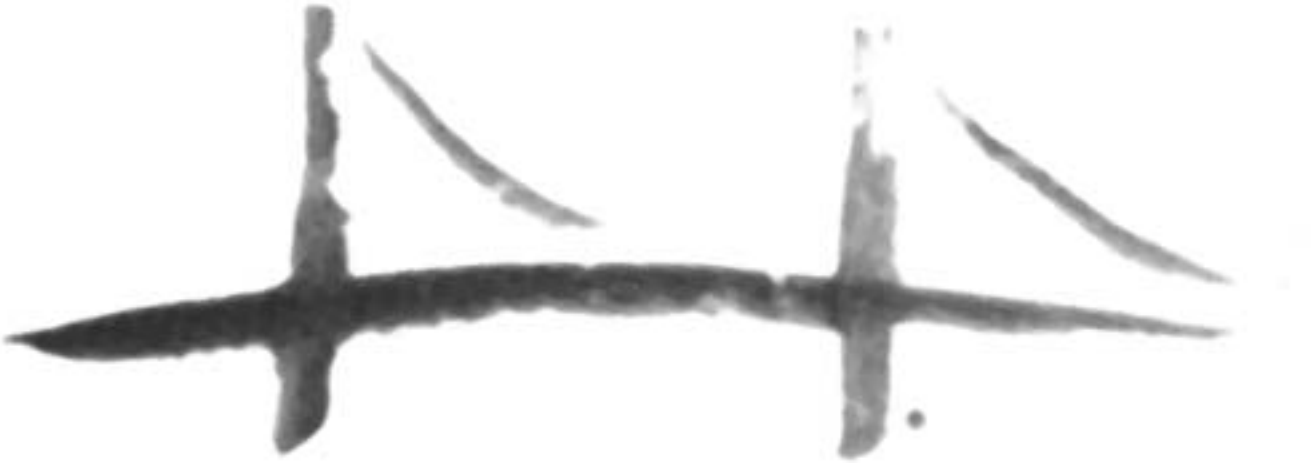
CLICK TO BEGIN APPLICATION



WEST COAST LIFE
INSURANCE COMPANY

CALIFORNIA 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 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

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

Part I
LIFE INSURANCE APPLICATION

SECTION I: INSUREDS

NAME OF PERSONS APPLYING FOR COVERAGE (PRINT IN FULL)	RELATIONSHIP TO PROPOSED INSURED	SEX	DATE OF BIRTH	SOC. SEC. NO.	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 YRS	(Required) ANNUAL INCOME	EMPLOYER	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

BENEFITS

☐ AUTOMATIC PREMIUM LOAN ☐ ACCIDENTAL DEATH $_____ ☐ WAIVER OF PREMIUM

☐ CHILD RIDER - # OF UNITS_____ ☐ OTHER -- DESCRIPTION AND AMOUNT _____

PREMIUM PAYMENT

☐ ANNUAL $_____ ☐ CHECK-O-MATIC $_____ ☐ OTHER_____

☐ ADDITIONAL FIRST YEAR PAYMENT $_____ ☐ CASH WITH APPLICATION $_____

SEND PREMIUM NOTICES TO ☐ RESIDENCE ☐ OTHER -- COMPLETE LINE BELOW

_____
Name Address City State Zip Code

SECTION III: BENEFICIARY

PRIMARY: FULL NAME _____ _____
RELATIONSHIP

_____
ADDRESS CITY STATE ZIP CODE

SECONDARY: FULL NAME _____ _____
RELATIONSHIP

_____
ADDRESS CITY STATE ZIP CODE

SECTION IV: NON-MEDICAL HISTORY (MUST BE ANSWERED FOR ALL PROPOSED INSUREDS) Part I

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

SECTION V: MEDICAL HISTORY

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

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

(MUST BE ANSWERED IF APPLICABLE)

Person's Name	Question Number	Date	Details or Reason	Name, Address and Phone Number of Attending Doctor and Hospital

SECTION VII: EXISTING COVERAGE AND PENDING INSURANCE

(MUST BE ANSWERED COMPLETELY ON ALL CASES)

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

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

SECTION VIII: REPLACEMENT (MUST BE ANSWERED COMPLETELY ON ALL CASES)

18. Is the policy applied for to replace an existing insurance or annuity policies in this or any other company Yes☐ No☐
If "yes," give details in remarks section and complete any State required replacement forms and comparison statements.

Home Office Endorsements:

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. Purpose of 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. Year 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

Your policy is subject to a binding arbitration provision. See your policy for complete details.

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 bases 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 rights or requirements.
3. No insurance shall take effect unless the Proposed Insured(s) is (are) alive and in the same condition of health as described in this application when the policy is delivered to the Owner and the full first premium is paid. However, if the full first premium is paid as set forth in the attached Conditional Coverage Receipt and this Receipt is delivered to the Owner, the terms of this Receipt shall apply.
4. Acceptance of a policy by the Owner shall constitute ratification of any changes made by West Coast Life under "Home Office Endorsements." In those states where it is required, changes in plan of insurance, amount, age at issue, classification of risk or benefits will be made only with the Owner's written consent.

Any person who knowingly with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties according to state law.

AUTHORIZATION TO OBTAIN INFORMATION

I AUTHORIZE any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance or consulting company, the Medical Information Bureau, Inc., consumer reporting agencies or employer having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or my minor children and any other non-medical information about me or my minor children to give West Coast Life Insurance Company, its affiliates, its reinsurers, or persons or organizations providing services for West Coast Life any and all such information. This includes information regarding drugs, alcoholism, and/or mental illness. To aid in collection of such information, I authorize all said sources, except the Medical Information Bureau, to give such records or knowledge to any agency employed by the Insurance Company to collect and transmit such information. **I AUTHORIZE** the Company to obtain an investigative consumer report with respect to me and with respect to any children proposed for insurance. If a report is requested, I know I may elect to be personally interviewed. **I UNDERSTAND** the information obtained by use of this Authorization will be used by the Company to determine eligibility for insurance and eligibility for benefits under an existing policy. Any information obtained will not be released by West Coast Life Insurance Company to any person or organization except to reinsuring companies, the Medical Information Bureau, Inc., or other persons or organizations performing business or legal services in connection with my application, or a claim or as may be otherwise lawfully required or as I may further authorize. **I AGREE** that this authorization shall be valid for a period of two years and six months from the date signed. I further agree that a photocopy of this authorization shall be as valid as the original. **I KNOW** that I may ask to receive a copy of this authorization. **I HAVE** received copies of notices regarding "Pre-Notice Medical Information Bureau, Inc." and "Insurance Information Practices and Investigative Consumer Reports." **I UNDERSTAND** that if this application relates to any Indeterminate Premium Policy or Rider: (1) The premium may be increased or decreased on any policy anniversary. (2) Premiums are not guaranteed, except the maximum premium which may be charged beginning on any policy anniversary. (3) Any increased or decreased premium I am charged will be based on my original classification, age and sex.

Signed At _____ Date _____
(City and State)

(X) _____
Signature of Proposed Insured

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

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

(X) _____
Signature of Agent

SECTION XII: 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 know impairments or disability? Yes ☐ No ☐
5. Do you have any reason to believe that the life insurance policy applied for will replace any life insurance or annuity from West Coast Life or another company? Yes ☐ No ☐

If YES, Provide policy number(s) and company(ies) below, and complete any comparison statements required by law.

_____

6. Have you advised the proposed policyowner or do you know of any advice that has been given to the proposed policyowner to transfer the ownership of the policy being applied for to a life settlement company or other entity associated with stranger owned or investment owned life insurance (commonly called SOLI or IOLI) or are you otherwise aware that the policyowner may be contemplating such a transfer? Yes ☐ No ☐

7. Family History

	Age if Living	Age at Death	Cardiac Conditions or Heart Disease?		Cancer History?		Type
Primary Proposed Insured 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_____	

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

Mark Hollingsworth
Synergy Insurance Mktng
BGA Name

J9822
BGA Contract Number

For Underwriting and New Business Contact Purposes:

(949) 559-1422
BGA Fax Number

mark@synergylink.net
BGA E-Mail Address

Place any special remarks here:

_____ _____
Agent's Signature **Agent's Commission Code No.**

_____ _____
Agent's Printed Name **Agent's E-Mail Address**

_____
Business Phone

_____ _____
Date Place

IF MORE THAN ONE AGENT ----- complete below

_____ _____
Agent's Signature **Agent's Commission Code No.**

_____ _____
Agent's Printed Name **Agent's E-Mail Address**

_____
Business Phone

_____ _____
Date Place

CLICK TO CONTINUE

IMPORTANT NOTICES

MUST BE GIVEN TO THE PROPOSED INSURED

PRE-NOTICE MEDICAL INFORMATION BUREAU, INC.

Information regarding your insurability will be treated as confidential. The West Coast Life Insurance Company or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau, Inc.(MIB), 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 claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of 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 Post Office Box 105, Essex Station, Boston, Massachusetts 02112.

The West Coast Life Insurance Company, or its reinsurers, may also release information in 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.

INSURANCE INFORMATION PRACTICES AND INVESTIGATIVE CONSUMER REPORTS NOTICE.

Thank you for your application. To assure that each insured's premium and coverage is properly related to the probability of loss, we must underwrite your application.

To underwrite your application, we need to obtain information about you. Some of that information will come from you and some will come from other sources.

As part of this process, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This report includes information as to your character, general reputation, personal characteristics and mode of living. This information may be retained by the insurance support organization and disclosed to other persons.

If an investigative consumer report is requested in connection with your application, you have the right to elect to be interviewed. You also have the right to access and to correct any information collected except information which is related to a claim or civil or criminal proceeding. The information collected by us may in certain circumstances be disclosed to third parties without your specific authorization.

It is also possible that we may call you to verify information or to ask additional questions important to the underwriting of your application. After this telephone interview is completed, a copy of it will be sent to you so you can verify its accuracy.

If you wish to have a more detailed explanation of our information practices, please submit a written inquiry to: Chief Underwriter, Underwriting Department, West Coast Life Insurance Company, P.O. Box 193892, San Francisco, CA 94119-3892.

BANK DRAFT INFORMATION

WEST COAST LIFE INSURANCE COMPANY

The company above will withdraw the premiums form the specified account. This company will be referred to hereafter as “Company”.

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

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

Automatic Bank Draft Agreement

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

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

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

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 (1^{st} – 28^{th})_________ ☐ **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.

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

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 the Company can alter or waive any of the provisions of this Agreement. No insurance is provided under the terms of this document in the event of death of the Insured by suicide. In the event of suicide, the Company's sole liability will be the return of any money received.

Received: ☐ Check in the amount of $_____ for an amount equal to the premium due on the policy applied for, or ☐ Check-O-Matic Plan (COM), as conditional payment of the first premiums 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 West Coast Life Insurance 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 AND MONEY ORDERS WILL NOT BE ACCEPTED.

NOTE: Premium may not be collected where the face amount applied for on this application plus any other in force life insurance and accidental death benefits, including those applied for, with this Company on this Insured exceeds $500,000 net amount at risk or on Proposed Insureds under 15 days of age or over age 65.

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 printed underwriting rules for the plan, amount and premium rate class applied for;
(B) that the amount paid with the application and shown above is equal to the first full modal premium for the premium rate class applied for;
(C) the Proposed Insured(s) has/have completed all examinations and/or tests requested by the Company; and
(D) As of the effective date, the state of health and all factors affecting the insurability of each person proposed for insurance must be as stated in the application.

EFFECTIVE DATE OF COVERAGE

If the above conditions are met, Insurance provided under this Agreement shall 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

The total amount of insurance which may become effective prior to delivery of the policy to the Owner **shall not exceed the amount of initial premium plus $500,000.** This amount includes other life insurance and accidental death benefits then in force or applied for with this Company.

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 COM, and the deduction is not honored by the drawee bank;
(B) if the application to which this Agreement was attached is not approved as applied for by the Company within ninety business 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.

Date: _____ Agent: _____

Date: _____ Applicant/Owner: _____

Original – Home Office Copy – Applicant

WEST COAST LIFE
INSURANCE COMPANY

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

Authorization for Release of Health-Related Information

This authorization complies with the Health Insurance Portability and Accountability Act ("HIPAA")

Name of Proposed Insured/Patient (please print) _____ Date of Birth _____

I (we) hereby authorize any physician; medical practitioners; pharmacists; medical and related facilities, including hospitals, clinics, facilities run by the Veteran's Administration, Kaiser Permanente, The Cleveland Clinic Foundation and the Mayo Clinic; insurers; reinsurers; Medical Information Bureau, Inc. (**MIB**); my (our) current and previous employers; and the commercial consumer reporting agencies (**CRA**); or governmental agencies which has/have the type of data defined below to provide West Coast Life Insurance Company, its agents, employees and representatives information, data, or records concerning advice, care, treatment or health history provided to the patient, employee or deceased named above/below, including information relating to mental illness, disability, use of drugs or alcohol, AIDS, or ARC (AIDS related complex) and employment related information which may relate to this request for insurance. This excludes psychotherapy notes.

I (we) acknowledge by signing below, that any agreements that I (we) have made that restrict the release of any of the above outlined information does not apply to this Authorization; and I (we) instruct to release and disclose my (our) information without restriction.

I (we) understand the information obtained in this authorization, will be used by the Recipient to: 1) underwrite my (our) application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or provide coverage I (we) have or have applied for with West Coast Life Insurance Company.

This Authorization shall remain valid for 30 months following the date of my (our) signature (s) below, and a copy of this form is as valid as the original. I (we) understand that; I (we) have the right to revoke this Authorization in writing, at any time, by sending a written notice to West Coast Life Insurance Company at P.O. Box 193892, San Francisco, CA 94119-3892. I (we) understand that my revocation of this authorization will not affect uses and disclosures of my health information by the Recipient for purposes of underwriting, claims administration and other matters associated with my application for insurance coverage and the administration of any policy issued as a result of that application.

I (we) understand that the signing of this authorization is voluntary; however, if I (we) do not sign the authorization, West Coast Life Insurance Company may not be able to obtain the medical information necessary to consider my (our) application. I (we) acknowledge that I (we) have received a copy of this authorization upon signing.

_____ **Date of Authorization:** _____

Proposed Insured 1 (Signature) When applicable, print names of minors below:

_____ _____

Proposed Insured 2 (Signature)

_____ _____

Parent of Legal Guardian (Signature)

THIS AUTHORIZATION MUST BE SIGNED <u>WITHOUT MODIFICATION</u> BEFORE THE APPLICATION CAN BE PROCESSED. PLEASE RETURN THIS AUTHORIZATION WITH THE APPLICATION.

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

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 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 tests for other disease 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. Because a trained person should deliver information regarding a positive test result so that you can understand clearly what the test result means, you are asked to list your private physician so that the Insurer can have him or her tell you its meaning.

Name of physician for reporting a possible positive test result: _____

Address: _____

If you do not wish to know the results of the test, initial here:_____In the event the test is positive and you are denied coverage because 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 you want to know the results of the test but do not at present have a private physician, initial here:_____ The results will be sent to you at the address provided by registered mail with delivery restricted to you only. If you desire the results to be mailed to some Person other than yourself who is not a physician, print that person's name and address here:

_____.

The results will be sent to that person by registered mail with restricted delivery.

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

WEST COAST LIFE
INSURANCE 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.

WEST COAST LIFE INSURANCE COMPANY

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

California Elder Notice to All Purchasers of Life Insurance or Long Term Care Age 65 or Over

You should be aware that the sale or liquidation of any stock, bond, IRA, certificate of deposit, mutual fund, annuity, or other asset to fund the purchase of this life or long term care product may have tax consequences, early withdrawal penalties, or other costs or penalties as a result of the sale or liquidation.

You or your representative may wish to consult independent legal or financial advice before selling or liquidating any assets and prior to the purchase of any life or long term care products being solicited, offered for sale, or sold.

I have read this notice and received a copy.

Date: _____ Signature: _____
Prospective Purchaser

Date: _____ Signature: _____
Prospective Purchaser's Spouse or
Joint Owner

Date: _____ Signature: _____
Prospective Purchaser's representative

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

AUTHORIZATION TO BACKDATE POLICY

If you wish to backdate your policy, please read the following carefully and sign below. If you do not wish to backdate your policy, you do not need to sign below.

1. If your insurance application is accepted by West Coast Life, unless you have obtained a conditional receipt, coverage under your policy does not begin until your policy is delivered, all delivery requirements are met, and you have made your first premium payment.

2. Unless you choose otherwise, your policy will be dated on or after the date of delivery of your policy, completion of all delivery requirements and payment of your first premium.

3. Under certain circumstances, however, you may choose to backdate your policy in order to obtain certain benefits applicable to a policy with an earlier date. You should discuss with your agent whether backdating would be beneficial to you.

4. If your policy is backdated, your premiums will be calculated from a policy date earlier than the date coverage begins. You may therefore pay a premium for a time when no insurance coverage is in effect. You are not required to pay a premium for a time when no coverage is in effect, unless you choose to backdate. If you choose to backdate, but wish to avoid paying a premium for a period of time without insurance in effect, you may choose to pay the first premium with the application in exchange for a conditional receipt. Certain restrictions apply to the use of a conditional receipt. Ask your agent to explain to you the option of a conditional receipt before you submit your application.

5. If you choose to backdate, but do not obtain a conditional receipt, the amount of premiums paid for a time when no insurance coverage is in effect will depend in part on the time it takes to underwrite, issue and deliver your policy to you. You can attempt to reduce the processing time and the amount of these premiums by promptly completing any required medical examination, by promptly submitting all necessary application information, and by promptly taking delivery of any policy after it is issued and promptly making the initial premium payment.

I have read and understand the above and hereby request you backdate any policy issued to me.

_____ _____

Signature of Applicant/Owner Date of Signature

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

STATEMENT REGARDING ILLUSTRATIONS

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

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

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

_____ _____
Applicant Signature Date

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

_____ _____
West Coast Life Agent Signature Date

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