

LINCOLN BENEFIT LIFE
COMPANY

A Member of Allstate Financial Group

**APPLICATION TO LINCOLN BENEFIT LIFE COMPANY
P.O. BOX 80469, LINCOLN, NEBRASKA 68501**

ANSWER ALL QUESTIONS FULLY. PLEASE PRINT ALL ANSWERS.

1) Name of Proposed Insured (First, Middle, Last)				2) Street Address (Street, City, State, Zip Code)				
3) Date of Birth Month Day Year / /	4) Age	5) Place of Birth	6) Sex Male <input type="checkbox"/> Female <input type="checkbox"/>	7) Social Security Number			8) Height ft. in.	9) Weight lbs.
10) Home Phone Number ()	11) Occupation, Employer, and Duties:			12) Annual Income \$		13) Drivers License #/State of Issue		

14) Plan and Amount of Insurance		15) Additional Benefits		16) If UL:	
Plan _____		UL Only: <input type="checkbox"/> C.O.P. \$ _____		Death Benefit Option:	
Amount \$ _____		Non-UL: <input type="checkbox"/> W.P.		<input type="checkbox"/> One <input type="checkbox"/> Two <input type="checkbox"/> Three	
		<input type="checkbox"/> A.D.B. Amount \$ _____			

17) Primary Beneficiary (a) Full Name			Relationship to the Insured			Date of Birth / /	
Address (No P.O. Box)		City		State	Zip Code	Social Security/Tax I.D. #	
18) Primary Beneficiary (b) Full Name			Relationship to the Insured			Date of Birth / /	
Address (No P.O. Box)		City		State	Zip Code	Social Security/Tax I.D. #	
19) Contingent Beneficiary (a) Full Name			Relationship to the Insured			Date of Birth / /	
Address (No P.O. Box)		City		State	Zip Code	Social Security/Tax I.D. #	
20) Contingent Beneficiary (b) Full Name			Relationship to the Insured			Date of Birth / /	
Address (No P.O. Box)		City		State	Zip Code	Social Security/Tax I.D. #	

21) Mode of Premium Payment				22) Planned Annual Payment		23) Payment with Application	
<input type="checkbox"/> Annual <input type="checkbox"/> Semiannual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly Automatic				\$ _____		\$ _____	

24) Owner Full Name (If other than insured)			Relationship to the Insured				
Address (No P.O. Box)			City		State	Zip Code	
Date of Birth / /		Social Security/Tax I.D. #			Phone Number ()		

HEALTH AND RISK FACTOR QUESTIONS

25) Does anyone proposed for insurance 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	Relative	Disorder	Age at Onset	Age at Death	Cause of Death	Age if Living

26) Have you ever had an application for *life* or *health* insurance rated, postponed, or declined? Yes No
 If yes, explain (Company & Reason): _____

27) In the past 10 years, have you been diagnosed with, or sought treatment or advice for: Yes No
 A. Heart, blood or circulatory disorder, anemia, chest pain, hypertension, cancer or tumor of any kind? Yes No
 B. Stomach, intestinal, liver, brain, kidney, lung, muscular, congenital, nervous or emotional disorder, diabetes, asthma, bronchitis or paralysis? Yes No

28) Have you ever received treatment from a member of the medical profession for AIDS (Acquired Immune Deficiency Syndrome)? Yes No

29) Have you been under medical observation or treatment, had surgery or been hospitalized in the last 5 years? Yes No
 If "yes" to any of questions 26 - 29 , please explain:

30) Personal Doctor — Full Address, Date and Reason Last Seen:

31) Have you: Yes No
 A. In the last 5 years, smoked cigarettes or used tobacco or nicotine in any form? Yes No
 (If yes, provide type of tobacco and date last used.) Type _____ Date _____
 B. Ever been treated for or arrested for the use or possession of alcohol, narcotics, or mind altering drugs not prescribed by a physician, or have you used illegal drugs or narcotics? Yes No
 C. Ever been convicted of a felony? If so, when? Date _____ Yes No
 D. In the past 3 years, participated in scuba or sky diving, hang gliding, racing of any kind, or have you flown as a pilot or crew member or have the intent to do so? (If yes, complete the appropriate questionnaire.) Yes No
 E. In the past 3 years have you received 2 or more driving citations, had a license suspension, or been convicted of driving under the influence of drugs or alcohol? If yes, Drivers License number: _____ Yes No

32) Has a medical exam and/or necessary lab work or other required tests been scheduled on the proposed insured to obtain this insurance? Yes No

33) Have you traveled outside the U.S. in the past 2 years, or do you plan to do so in the next 2 years? Yes No

34) (a) Please list your existing life insurance or annuity policies:

COMPANY	CONTRACT NUMBER	AMOUNT	ISSUE YEAR	TYPE

(b) Will any of the existing coverage or an annuity be replaced, borrowed against or changed if this contract is issued? Yes No
 If yes, circle the contract number above in 34a or provide full information on the annuity.

35) Are the following U.S. Citizens? If No, complete below (If you need more space, use a separate sheet):
 Primary Insured Yes No Beneficiary(ies) Yes No Owner(s) / Payor(s) Yes No

Full Name (If other than insured)	Party (e.g. "Owner")	Country of Citizenship
Permanent Resident Card Number (Attach Copy of Card)	Visa Number and Type (Attach Copy of Visa)	

Permit to Obtain and Disclose Certain Data

- A. The Insurance Company, its reinsurers, and consumer reporting agencies may get data about my health, prescription medication history, and related information, mode of living (except as may be related directly or indirectly to sexual orientation), avocations, and any other medical or non-medical information. I understand that the information obtained by use of this authorization will be used to determine eligibility for insurance and/or benefits, or for The Insurance Company to determine its obligations under the policy issued in connection with this application.
- B. Any doctor, practitioner, medical or medically related facility, Pharmacy Benefit Managers, the Veterans Administration, the Medical Information Bureau, Inc. (MIB, Inc.), viatical settlement company, employer, consumer reporting agency, insurance company or any other person or entity which has such data about me may give such data to The Insurance 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 agencies that The Insurance Company has hired to retrieve the information. The information as provided herein pursuant to the authorization will not be redisclosed unless authorized by you 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 The Insurance Company for medical records, is on my behalf; the information must be provided within any requirements imposed by applicable state statutes governing patient access to medical records.
- D. Data about mental illness, alcoholism, sexually transmitted diseases, and the use of drugs are to be included.
- E. The Insurance Company or its reinsurers may make a brief report about me to the MIB, Inc.
- F. This permit is good for 30 months after it is signed.
- G. The Insurance 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 authorization by writing to The Insurance Company. I also have received the IMPORTANT INFORMATION REGARDING MEDICAL EXAMS, NOTICE REGARDING MIB, INSURANCE INFORMATION PRACTICES, NOTICE UNDER THE FAIR CREDIT REPORTING ACT and other IMPORTANT INFORMATION.

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. Except in Maine, Missouri, Oregon, and South Carolina, The Insurance Company is not presumed to know any information not in this application.
- B. The Insurance Company may add to or correct the application on an addendum page immediately following the application. Any changes are agreed to if the policy issued is accepted by me (us), but written agreement will be obtained from me for any change in insurance amount, plan, benefits, payment class or age at issue. (In West Virginia and Pennsylvania, written consent will be obtained for any changes.)
- 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 acknowledge that I have read and understand this application, including the Important Information Regarding Medical Exams, Notice Regarding MIB, Insurance Information Practices, Notice Under the Fair Credit Reporting Act and other Important Information. I acknowledge receipt of these notices.
- E. Only an officer of The Insurance Company may change this application or waive a right or requirement. No agent 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.

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);
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.

Signed at (City, State)

Date (MM/DD/YY)

Signature(s) of Owner(s)

Signature of Primary Proposed Insured

Title if Owner is a Business or Other Organization