



**West Coast Life
Insurance Company**

A P R O T E C T I V E C O M P A N Y

**PENNSYLVANIA
LIFE APPLICATION
PACKET**

CONTENTS AND WEBSITE INSTRUCTIONS

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WEBSITE INSTRUCTIONS

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



West Coast Life Insurance Company

A PROTECTIVE COMPANY

P.O. Box 193892

San Francisco, CA 94119-3892

Part I

SECTION I: INSUREDS

LIFE INSURANCE APPLICATION

Table with 7 columns: 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. Rows include PROPOSED INSURED (Self), SPOUSE, CHILD, CHILD.

RESIDENCE: STREET APT. NO.

CITY STATE ZIP CODE TELEPHONE NUMBER NUMBER OF YEARS

Table with 6 columns: OCCUPATION, # OF YRS, (Required) ANNUAL INCOME, EMPLOYER, ADDRESS, TELEPHONE NUMBER. Rows include 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.		Spouse		Children	
	Yes	No	Yes	No	Yes	No
1. Used tobacco or nicotine of any kind over the last 5 years? Type: _____ Frequency: _____ Date last used: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Consulted a physician or had treatment for the use or possession of: A. Alcohol? B. Narcotics, stimulants, sedatives, hallucinogenic drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Flown as a pilot, student pilot, or crew member, or intend to fly as such?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Engaged in auto, motorcycle or boat racing, parachuting, skin or scuba diving, skydiving, or hang gliding or other hazardous avocation or hobby?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Had a request for life or health insurance declined, postponed, rated, canceled, or restricted in any way?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Any application for any other life or health insurance on your life now pending or contemplated in this or any other company?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SECTION V: MEDICAL HISTORY

HAVE YOU EVER BEEN TREATED FOR OR TOLD YOU HAD:	Prop. Ins.		Spouse		Children	
	Yes	No	Yes	No	Yes	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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HAVE YOU:						
13. Within the last 12 months, had any kind of medication prescribed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Been advised to have, or contemplated having a surgical operation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Within the last 5 years, suffered from any disease, or received medical or surgical treatment for any condition not listed in question 12?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. List current height and weight for all persons proposed for coverage. If more than one child proposed for insurance, list below						

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

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.
5. 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.

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 is a crime and subjects such person to criminal and civil penalties.

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.

Signed At _____
(City and State)

Date _____

(X) _____
Signature of Proposed Insured

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

(X) _____
Signature of Child, If Over Age 18, If Proposed for Coverage

(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 known 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. Is Premium Financing involved in this case? Yes No
If YES, please submit a cover letter describing the parameters.

8. Family History

	Age if Living	Age at Death	Cardiac Conditions or Heart Disease?		Cancer History?		Type
Primary Proposed Insured							
Father			<input type="checkbox"/> No	<input type="checkbox"/> Yes, age of onset ____	<input type="checkbox"/> No	<input type="checkbox"/> Yes, age of onset ____ If Yes, date of onset _____	
Mother			<input type="checkbox"/> No	<input type="checkbox"/> Yes, age of onset ____	<input type="checkbox"/> No	<input type="checkbox"/> Yes, age of onset ____ If Yes, date of onset _____	
Siblings			<input type="checkbox"/> No	<input type="checkbox"/> Yes, age of onset ____	<input type="checkbox"/> No	<input type="checkbox"/> Yes, age of onset ____ If Yes, date of onset _____	

9. INDICATE CLASSIFICATION BASIS FOR THIS SALE:

- Super Preferred
- Preferred
- Standard
- Rated Table A, B, C, D, E, F, H (circle one)
- Other _____
- Non-Tobacco
- Tobacco

_____ BGA Name _____ BGA Contract Number	For Underwriting and New Business Contact Purposes: _____ BGA Fax Number _____ BGA E-Mail Address
---	--

Place any special remarks here:

I have verified the identity of the Owner by picture I.D. (Does not apply to direct marketing situations.)
 Identification type: _____
 Please include Driver's License number if Owner is other than the Proposed Insured. _____
 In Georgia, please include a copy of the Driver's License with application.

_____ Agent's Signature	_____ Agent's Commission Code No.	_____ Business Phone
_____ Agent's Printed Name	_____ Agent's E-Mail Address	_____ Date
		_____ Place

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

_____ Agent's Signature	_____ Agent's Commission Code No.	_____ Business Phone
_____ Agent's Printed Name	_____ Agent's E-Mail Address	_____ Date
		_____ Place

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 MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of 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

The West Coast Life Insurance 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 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 help the government fight the funding of terrorism and money laundering activities, Federal law requires all financial institutions to obtain, verify and record information of its customers. We may ask for information or identifying documents that will allow us to verify the identity of our customers.

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.

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.

PRODUCER COMPENSATION DISCLOSURE

Agents/Producers receive compensation from an insurer or third party, which may differ depending upon the product of insurer. Additional compensation may be received by the Agent/Producer based on other factors including premium volume placed with the company and loss or claim experience.



**West Coast Life
Insurance Company**

A PROTECTIVE COMPANY

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

Conditional Receipt

THIS RECEIPT IS TO BE GIVEN TO THE APPLICANT AT THE TIME OF APPLICATION IF ANY MONEY IS TAKEN

Received from _____ in connection with the application

dated _____ for life insurance totaling \$ _____, on the life (lives) of _____.

1. NO COVERAGE WILL BECOME EFFECTIVE PRIOR TO DELIVERY OF THE POLICY APPLIED FOR UNLESS AND UNTIL ALL THE CONDITIONS OF THIS RECEIPT HAVE BEEN FULFILLED EXACTLY:
 - a. The amount of payment taken with the application must be at least equal to the amount of the full first premium for the mode of payment selected in the application and for the amount of insurance which may become effective prior to delivery of the policy.
 - b. All medical examinations, tests, x-rays and electrocardiograms required by the company must be completed and received at its home office within 60 days from the date of completion of Part 1 of this application.
 - c. As of the effective date, as defined below, each person proposed for insurance in this application must be a risk insurable in accordance with the company's rules, limits and standards for the plan and the amount applied for without any modification either as to plan, amount, riders, supplemental agreements and/or the rate of premium paid.
 - 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.
2. Subject to the conditions of paragraph 1, insurance, as provided by the terms and conditions of the policy applied for and in use on the effective date, but for an amount not exceeding that specified in paragraph 3, will become effective as of the effective date. "Effective date" as used herein, is the later of: (a) the date of completion of Part 1 of the application, or (b) the date of completion of all medical examination, tests, x-rays and electrocardiograms required by the company, or (c) the date of issue if any, requested in the application.
3. The total amount of insurance which may become effective on any person proposed for insurance shall not exceed \$ 1,000,000 of life insurance, including any accidental death insurance benefits.
4. If one or more of the conditions of paragraph 1 have not been fulfilled exactly, there shall be no liability on the part of the Company except to return the applicable payment in exchange for this Receipt.
5. NO AGENT OR ANY OTHER PERSON IS AUTHORIZED BY THE COMPANY TO WAIVE OR MODIFY IN ANY WAY ANY OF THE PROVISIONS OF THIS CONDITIONAL RECEIPT. **ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO WEST COAST LIFE INSURANCE COMPANY – DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAY BLANK.**

Dated at _____

Signature of Agent

this _____ day of _____, 20____

I acknowledge possession of this receipt and I certify that I have read it and the agreement in the application. The terms and conditions of this receipt, to which I agree, and the agreement in this application have been explained to me fully by the agent and I understand them.

Signature of Applicant

NOTE

If all the conditions are not fulfilled exactly, the insurance will take effect when the policy is delivered to the owner stated in the application; but only if at the time of such delivery there has been no change in insurability as represented in the application.

Home Office Copy



**West Coast Life
Insurance Company**

A PROTECTIVE COMPANY

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

Conditional Receipt

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dated _____ for life insurance totaling \$ _____, on the life (lives) of _____.

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 - a. The amount of payment taken with the application must be at least equal to the amount of the full first premium for the mode of payment selected in the application and for the amount of insurance which may become effective prior to delivery of the policy.
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 - c. As of the effective date, as defined below, each person proposed for insurance in this application must be a risk insurable in accordance with the company's rules, limits and standards for the plan and the amount applied for without any modification either as to plan, amount, riders, supplemental agreements and/or the rate of premium paid.
 - 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.
2. Subject to the conditions of paragraph 1, insurance, as provided by the terms and conditions of the policy applied for and in use on the effective date, but for an amount not exceeding that specified in paragraph 3, will become effective as of the effective date. "Effective date" as used herein, is the later of: (a) the date of completion of Part 1 of the application, or (b) the date of completion of all medical examination, tests, x-rays and electrocardiograms required by the company, or (c) the date of issue if any, requested in the application.
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5. NO AGENT OR ANY OTHER PERSON IS AUTHORIZED BY THE COMPANY TO WAIVE OR MODIFY IN ANY WAY ANY OF THE PROVISIONS OF THIS CONDITIONAL RECEIPT. **ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO WEST COAST LIFE INSURANCE COMPANY – DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAY BLANK.**

Dated at _____

Signature of Agent

this _____ day of _____, 20____

I acknowledge possession of this receipt and I certify that I have read it and the agreement in the application. The terms and conditions of this receipt, to which I agree, and the agreement in this application have been explained to me fully by the agent and I understand them.

Signature of Applicant

NOTE

If all the conditions are not fulfilled exactly, the insurance will take effect when the policy is delivered to the owner stated in the application; but only if at the time of such delivery there has been no change in insurability as represented in the application.

Applicant Copy

WEST COAST LIFE INSURANCE COMPANY
P.O. Box 193892 • San Francisco, CA 94119-3892

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

1. This authorization to obtain and disclose information complies with HIPAA regulations as they relate to life insurance. I (we) authorize West Coast Life Insurance Company (West Coast Life) and its reinsurers to obtain and use any information about or relating to me (us) that may affect my (our) insurability. West Coast Life and its reinsurers may obtain and use health and medical information, including but not limited to information about drug use, alcohol use, nicotine use, physical and mental diseases and illness, and psychiatric disorders. West Coast Life and its reinsurers may also obtain and use non-health and non-medical information, including but not limited to financial information, credit reports, consumer reports, driving record, criminal record, and information about avocations and aviation activity. All of this information may be used to evaluate an application for insurance, a claim for insurance benefits, or both. Information relating to communicable diseases and other risk factors relating to me, to my spouse or life partner may be used to evaluate an application for insurance on either me, my spouse or life partner. The West Coast Life sales agent or regional sales office representing me on my (our) application for insurance may obtain the information described in this paragraph directly from any of the persons or organizations listed in paragraph 2 in order to expedite the delivery of the information to West Coast Life.
2. I (we) authorize the following persons and organizations to release and disclose the information described in paragraph 1 to West Coast Life or its agents acting on its behalf: (i) my (our) doctor(s); (ii) medical practitioners; (iii) pharmacists and Pharmacy Benefit Managers; (iv) medical and related facilities, including hospitals, clinics, facilities run by the Veteran's Administration, Kaiser Permanente, The Cleveland Clinic Foundation and The Mayo Clinic; (v) insurers; (vi) reinsurers; (vii) Medical Information Bureau, Inc. (**MIB**); (viii) my (our) current and previous employers; and (ix) commercial consumer reporting agencies (**CRA**). All of these persons and organizations other than **MIB** may release the information described above to a **CRA** acting for West Coast Life. **MIB** may not release the information described in paragraph 1 to a **CRA**.
3. I (we) authorize West Coast Life to draw and test my (our) blood, and/or oral fluids, and urine as may be necessary to obtain information to be used to underwrite my (our) application for insurance. These tests may include, but are not limited to, tests for cholesterol and related blood lipids, diabetes, liver or kidney disorders, immune disorders (other than HIV/AIDS; reference number 5 below), and the presence of drugs, nicotine, or their metabolites. This authorization does not include genetic testing. Unless otherwise required by law or regulation, West Coast Life may, but is not obligated to, release any of these test results directly to me, to my spouse or life partner.
4. I (we) authorize West Coast Life to release and disclose the information described in paragraphs 1 and 3 to its affiliates, its reinsurers, persons or organizations providing services relating to insurance underwriting for West Coast Life, **MIB**, and as otherwise required by law. West Coast Life may release and disclose the information described in paragraphs 1 and 3 to other insurers if I (we) have applied or apply to the other insurers for insurance. West Coast Life may release and disclose the information described in paragraphs 1 and 3 to the sales agent representing me on my (our) application for insurance if it is necessary to provide an explanation of the reasons for West Coast Life's decision to impose special underwriting requirements, whenever my application cannot be approved as submitted, or in connection with a claim for benefits.
5. **SPECIAL REQUIREMENT FOR HIV/AIDS TESTING.** If West Coast Life intends to test for the presence of antibodies to the Human Immunodeficiency Virus (HIV), which is the virus that has been associated with Acquired Immune Deficiency Syndrome (AIDS), West Coast Life may require me (us) to authorize that testing separately. I (we) hereby authorize West Coast Life to obtain and use the results of any HIV tests that I (we) separately authorize, and if permitted by law, to disclose the results of those tests to its affiliates, reinsurers, and **MIB**.
6. This authorization shall be valid for 24 months from the date shown below or, in the event of a claim for benefits, for the duration of such claim.
7. During the evaluation of my (our) insurance application, I (we) understand that I (we) have the right to revoke the authorizations in paragraphs 1 through 5 by writing to West Coast Life at P.O. Box 193892 • San Francisco, CA 94119-3892.
If this authorization is revoked, this would result in the file being closed and no coverage provided.
8. I (we) have been given a copy of this authorization form and West Coast Life's Description of Information Practices.
 I (we) would like to be interviewed if an investigative consumer report will be made.
(Please check the box if you wish to be interviewed if an investigative consumer report will be made.)
 If performed, I (we) would like copies of my (our) blood profile test results.
9. I (we) understand that information about me (us) may be disclosed under this authorization to persons or organizations that are not subject to the Health Insurance Portability and Accountability Act (**HIPAA**) and that the information would then no longer be protected by **HIPAA** and any related regulations.
I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction. Any modifications to this authorization may preclude our ability to process this application.
10. I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment).

Proposed Insured 1 (Signature)

Print Name

Proposed Insured 2 (Signature)

Print Name

Parent or Legal Guardian(Signature)

Date of Authorization: _____
When applicable, print name(s) of minor(s) below:

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

Home Office Copy

WEST COAST LIFE INSURANCE COMPANY
P.O. Box 193892 • San Francisco, CA 94119-3892

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

1. This authorization to obtain and disclose information complies with HIPAA regulations as they relate to life insurance. I (we) authorize West Coast Life Insurance Company (West Coast Life) and its reinsurers to obtain and use any information about or relating to me (us) that may affect my (our) insurability. West Coast Life and its reinsurers may obtain and use health and medical information, including but not limited to information about drug use, alcohol use, nicotine use, physical and mental diseases and illness, and psychiatric disorders. West Coast Life and its reinsurers may also obtain and use non-health and non-medical information, including but not limited to financial information, credit reports, consumer reports, driving record, criminal record, and information about avocations and aviation activity. All of this information may be used to evaluate an application for insurance, a claim for insurance benefits, or both. Information relating to communicable diseases and other risk factors relating to me, to my spouse or life partner may be used to evaluate an application for insurance on either me, my spouse or life partner. The West Coast Life sales agent or regional sales office representing me on my (our) application for insurance may obtain the information described in this paragraph directly from any of the persons or organizations listed in paragraph 2 in order to expedite the delivery of the information to West Coast Life.
2. I (we) authorize the following persons and organizations to release and disclose the information described in paragraph 1 to West Coast Life or its agents acting on its behalf: (i) my (our) doctor(s); (ii) medical practitioners; (iii) pharmacists and Pharmacy Benefit Managers; (iv) medical and related facilities, including hospitals, clinics, facilities run by the Veteran's Administration, Kaiser Permanente, The Cleveland Clinic Foundation and The Mayo Clinic; (v) insurers; (vi) reinsurers; (vii) Medical Information Bureau, Inc. (**MIB**); (viii) my (our) current and previous employers; and (ix) commercial consumer reporting agencies (**CRA**). All of these persons and organizations other than **MIB** may release the information described above to a **CRA** acting for West Coast Life. **MIB** may not release the information described in paragraph 1 to a **CRA**.
3. I (we) authorize West Coast Life to draw and test my (our) blood, and/or oral fluids, and urine as may be necessary to obtain information to be used to underwrite my (our) application for insurance. These tests may include, but are not limited to, tests for cholesterol and related blood lipids, diabetes, liver or kidney disorders, immune disorders (other than HIV/AIDS; reference number 5 below), and the presence of drugs, nicotine, or their metabolites. This authorization does not include genetic testing. Unless otherwise required by law or regulation, West Coast Life may, but is not obligated to, release any of these test results directly to me, to my spouse or life partner.
4. I (we) authorize West Coast Life to release and disclose the information described in paragraphs 1 and 3 to its affiliates, its reinsurers, persons or organizations providing services relating to insurance underwriting for West Coast Life, **MIB**, and as otherwise required by law. West Coast Life may release and disclose the information described in paragraphs 1 and 3 to other insurers if I (we) have applied or apply to the other insurers for insurance. West Coast Life may release and disclose the information described in paragraphs 1 and 3 to the sales agent representing me on my (our) application for insurance if it is necessary to provide an explanation of the reasons for West Coast Life's decision to impose special underwriting requirements, whenever my application cannot be approved as submitted, or in connection with a claim for benefits.
5. **SPECIAL REQUIREMENT FOR HIV/AIDS TESTING.** If West Coast Life intends to test for the presence of antibodies to the Human Immunodeficiency Virus (HIV), which is the virus that has been associated with Acquired Immune Deficiency Syndrome (AIDS), West Coast Life may require me (us) to authorize that testing separately. I (we) hereby authorize West Coast Life to obtain and use the results of any HIV tests that I (we) separately authorize, and if permitted by law, to disclose the results of those tests to its affiliates, reinsurers, and **MIB**.
6. This authorization shall be valid for 24 months from the date shown below or, in the event of a claim for benefits, for the duration of such claim.
7. During the evaluation of my (our) insurance application, I (we) understand that I (we) have the right to revoke the authorizations in paragraphs 1 through 5 by writing to West Coast Life at P.O. Box 193892 • San Francisco, CA 94119-3892.
If this authorization is revoked, this would result in the file being closed and no coverage provided.
8. I (we) have been given a copy of this authorization form and West Coast Life's Description of Information Practices.
 I (we) would like to be interviewed if an investigative consumer report will be made.
(Please check the box if you wish to be interviewed if an investigative consumer report will be made.)
 If performed, I (we) would like copies of my (our) blood profile test results.
9. I (we) understand that information about me (us) may be disclosed under this authorization to persons or organizations that are not subject to the Health Insurance Portability and Accountability Act (**HIPAA**) and that the information would then no longer be protected by **HIPAA** and any related regulations.
I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction. Any modifications to this authorization may preclude our ability to process this application.
10. I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment).

Proposed Insured 1 (Signature)

Print Name

Proposed Insured 2 (Signature)

Print Name

Parent or Legal Guardian(Signature)

Date of Authorization: _____
When applicable, print name(s) of minor(s) below:

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

Applicant Copy



West Coast Life Insurance Company

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

NOTICE AND CONSENT FOR AIDS VIRUS (HIV) TESTING

Acquired Immunodeficiency Syndrome (AIDS) is a life-threatening disorder of the immune system, caused by a virus, HIV. The virus is transmitted by sexual contact with an infected person, from an infected mother to her newborn infant, or by exposure to infected blood (as in needle sharing during IV drug use). Persons at high risk of contracting AIDS include males who have had sexual contact with another man, intravenous drug users, hemophiliacs, and sexual contacts with 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. Infected persons have a 25 percent to 50 percent chance of developing AIDS over the next 10 years. Symptoms which may develop include fever (including night sweats), weight loss, swollen lymph glands, fatigue, diarrhea and white spots or unusual blemishes in the mouth.

1. PURPOSE OF THE HIV TEST. To evaluate your insurability, the Insurer named above, West Coast Life Insurance Company, has requested that you provide a sample of your blood or urine for testing and analysis to determine the presence of human immunodeficiency virus (HIV) antibodies. This is not a test for AIDS; AIDS can only be diagnosed by medical evaluation.

2. HIV-RELATED TESTING AND COUNSELING. Because of the serious nature of HIV-related illnesses, many public health organizations have recommended that before taking an AIDS-related test, a person seek counseling to become informed concerning the implications of such a test. You may secure additional information on alternative HIV testing sites and counseling by calling the Pennsylvania Health Department at (717) 783-0479 or by writing to Bureau of HIV/AIDS, P.O. Box 90, Harrisburg, PA 17106.

3. METHOD AND ACCURACY OF THE HIV TEST. The HIV antibody test that is to be performed is actually a series of tests done by a medically accepted procedure. Your laboratory sample will first be subjected to a test known as ELISA (enzyme-linked immunosorbent assay). If the result of this test is positive, the ELISA test will be repeated. If this repeat ELISA test is also positive, your specimen will then be subjected to another, more specific technique called the Western Blot test, for confirmation. Your test result is considered positive only after positive results are obtained on two ELISA test and a Western Blot test.

The HIV antibody test is extremely accurate. However, in rare instances the test may be positive in persons who are not infected with the virus (a false positive). This may include persons who have not engaged in high risk behavior. These individuals are encouraged to seek retesting to help confirm the validity of the positive test. Additionally, the test may occasionally be negative in persons who are infected with HIV (a false negative) especially when the infection occurred recently; it takes at least 4-12 weeks for a positive test result to develop after a person is infected.

4. CONFIDENTIALITY OF HIV TEST RESULTS. 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 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 are other than normal, the insurer will report to the MIB, Inc. a generic code which signifies only a non-specific laboratory 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 result in a file or data bank. There will be no other disclosure of the test results or that the tests have been done except as may be required or permitted by law or as authorized by you.

5. POSITIVE TEST RESULTS. Positive HIV antibody 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 persons who are HIV antibody positive should be considered infected with the AIDS virus and capable of infecting others. Positive HIV antibody test results or other significant laboratory abnormalities will adversely affect your application for insurance. This means that your application may be declined, or that an increased premium may be charged.

6. NOTIFICATION OF HIV TEST RESULTS. If the test results are negative, no routine notification will be sent to you. Positive or indeterminate test results will be provided to the personal physician you indicate below:

Physician

Address

W-7604 PA (10/03)

Home Office Copy

Other organizations that the Pennsylvania Health Department has designated for notification of positive test results, in lieu of a personal physician, are listed below (check box):

**PENNSYLVANIA DEPARTMENT OF HEALTH
Bureau of Communicable Disease
Division of HIV / AIDS**

- | | |
|--|---|
| <input type="checkbox"/> PA Department of Health
Division of HIV/Aids
Insurance Section
P.O. Box 90
7 th & Foster Streets
Harrisburg, PA 17108 | <input type="checkbox"/> Sara Sievila, Rn
Supervising Public Health Nurse
Chester County Department of Health
601 Westtown Road, Suite 180
West Chester, PA 19382 |
| <input type="checkbox"/> Vicky Kistler
AIDS Program Coordinator
Allentown Bureau of Health
Alliance Hall
245 North 6 th Street
Allentown, PA 18102 | <input type="checkbox"/> Kathy Fatica
Erie County Department of Health
606 West 2 nd Street
Erie, PA 16507 |
| <input type="checkbox"/> Ruth Fugua
Bucks County Department of Health
Health Building
Neshaminy Manor Center
Doylestown, PA 18901 | <input type="checkbox"/> Anita Culver, RN
Montgomery County Health Department
P.O. Box 311
1430 DeKalb Street
Norristown, PA 19404 |
| <input type="checkbox"/> Jose Cruz
AIDS Prevention Coordinator
Bethlehem Bureau of Health
10 East Church Street
Bethlehem, PA 18018 | <input type="checkbox"/> Patricia McNulty
Wilkes Barre City Health Department
16 East Northampton Street
Wilkes Barre, PA 18701
570-208-2468
FAX: 570-208-4272 |
| <input type="checkbox"/> Mr. William Smith
Public Health Administrator
Allegheny County Health Department | <input type="checkbox"/> Patricia Bass/ Joseph Cronauer
Co-Directors
AIDS Activities Coordinator Office
1101 Market Street - 9 th Floor
Philadelphia, PA 19107 |
| <input type="checkbox"/> Barbara Kovacs
York City Bureau of Health
One Market Way West, 3 rd Floor
P.O. Box 509
York, PA 17401 | |

CONSENT:

I have read and I understand this Notice and Consent for HIV (AIDS) - Related Testing. I voluntarily consent to testing and disclosure as described above. I understand that I have the right to withdraw this consent prior to being tested and that I may request and receive a copy of this form. A photocopy of this form will be as valid as the original.

Proposed Insured (PRINT)

Date of Birth

Signature of Proposed Insured or Parent/ Guardian

Date

State of Residence



West Coast Life Insurance Company

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

NOTICE AND CONSENT FOR AIDS VIRUS (HIV) TESTING

Acquired Immunodeficiency Syndrome (AIDS) is a life-threatening disorder of the immune system, caused by a virus, HIV. The virus is transmitted by sexual contact with an infected person, from an infected mother to her newborn infant, or by exposure to infected blood (as in needle sharing during IV drug use). Persons at high risk of contracting AIDS include males who have had sexual contact with another man, intravenous drug users, hemophiliacs, and sexual contacts with 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. Infected persons have a 25 percent to 50 percent chance of developing AIDS over the next 10 years. Symptoms which may develop include fever (including night sweats), weight loss, swollen lymph glands, fatigue, diarrhea and white spots or unusual blemishes in the mouth.

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Physician

Address

W-7604 PA (10/03)

Applicant Copy

Other organizations that the Pennsylvania Health Department has designated for notification of positive test results, in lieu of a personal physician, are listed below (check box):

**PENNSYLVANIA DEPARTMENT OF HEALTH
Bureau of Communicable Disease
Division of HIV / AIDS**

- | | |
|--|--|
| <p><input type="checkbox"/> PA Department of Health
Division of HIV/Aids
Insurance Section
P.O. Box 90
7th & Foster Streets
Harrisburg, PA 17108</p> <p><input type="checkbox"/> Vicky Kistler
AIDS Program Coordinator
Allentown Bureau of Health
Alliance Hall
245 North 6th Street
Allentown, PA 18102</p> <p><input type="checkbox"/> Ruth Fugua
Bucks County Department of Health
Health Building
Neshaminy Manor Center
Doylestown, PA 18901</p> <p><input type="checkbox"/> Jose Cruz
AIDS Prevention Coordinator
Bethlehem Bureau of Health
10 East Church Street
Bethlehem, PA 18018</p> <p><input type="checkbox"/> Mr. William Smith
Public Health Administrator
Allegheny County Health Department</p> <p><input type="checkbox"/> Barbara Kovacs
York City Bureau of Health
One Market Way West, 3rd Floor
P.O. Box 509
York, PA 17401</p> | <p><input type="checkbox"/> Sara Sievila, Rn
Supervising Public Health Nurse
Chester County Department of Health
601 Westtown Road, Suite 180
West Chester, PA 19382</p> <p><input type="checkbox"/> Kathy Fatica
Erie County Department of Health
606 West 2nd Street
Erie, PA 16507</p> <p><input type="checkbox"/> Anita Culver, RN
Montgomery County Health Department
P.O. Box 311
1430 DeKalb Street
Norristown, PA 19404</p> <p><input type="checkbox"/> Patricia McNulty
Wilkes Barre City Health Department
16 East Northampton Street
Wilkes Barre, PA 18701
570-208-2468
FAX: 570-208-4272</p> <p><input type="checkbox"/> Patricia Bass/ Joseph Cronauer
Co-Directors
AIDS Activities Coordinator Office
1101 Market Street - 9th Floor
Philadelphia, PA 19107</p> |
|--|--|

CONSENT:

I have read and I understand this Notice and Consent for HIV (AIDS) - Related Testing. I voluntarily consent to testing and disclosure as described above. I understand that I have the right to withdraw this consent prior to being tested and that I may request and receive a copy of this form. A photocopy of this form will be as valid as the original.

Proposed Insured (PRINT)

Date of Birth

Signature of Proposed Insured or Parent/ Guardian

Date

State of Residence



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

NOTICE REGARDING REPLACEMENT OF LIFE INSURANCE & ANNUITIES

Definition: Replacement is any transaction where, in connection with the purchase of new insurance or annuity coverage, you lapse, surrender, convert to paid-up insurance, place on extended term, reduce benefits or term of coverage, reduce cash value or borrow all or part of the policy loan values on an existing insurance policy or annuity.

In connection with the purchase of this coverage, IF YOU HAVE REPLACED OR INTEND TO REPLACE your present life insurance or annuity coverage, you should be certain that you understand all of the relevant factors involved.

You should BE AWARE that you may be required to provide evidence of insurability and:

If your HEALTH condition has CHANGED since the application was taken on your present policies, you may be required to pay ADDITIONAL PREMIUMS under the NEW POLICY, or be DENIED COVERAGE.

Your present occupation or activities may not be covered or could require additional premiums.

The INCONTESTABLE and SUICIDE CLAUSE will begin anew in a new policy. This could RESULT in a CLAIM under the new policy BEING DENIED that would otherwise have been paid.

Current law DOES NOT require your present insurer(s) to REFUND any premiums.

It may be to your advantage to OBTAIN INFORMATION regarding your existing policies from the insurer or agent from whom you purchased the policy. Your existing company will provide this information to you.

CAUTION: If after studying the information available to you, you decide to replace your existing life insurance or annuity coverage with our policy, you are urged not to take any action to terminate or alter your existing coverage until after you have been issued the new policy, examined it and found it to be acceptable to you. If you should terminate or otherwise materially alter your existing coverage and fail to qualify for the life insurance or annuity coverage for which you have applied, you may find yourself unable to purchase other life insurance or annuity coverage or be able to purchase it only at substantially higher rates.

(Applicant's Signature)

(Date)

(Agent's Signature)

(Date)



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

**NOTICE REGARDING REPLACEMENT OF LIFE
INSURANCE & ANNUITIES**

Definition: Replacement is any transaction where, in connection with the purchase of new insurance or annuity coverage, you lapse, surrender, convert to paid-up insurance, place on extended term, reduce benefits or term of coverage, reduce cash value or borrow all or part of the policy loan values on an existing insurance policy or annuity.

In connection with the purchase of this coverage, IF YOU HAVE REPLACED OR INTEND TO REPLACE your present life insurance or annuity coverage, you should be certain that you understand all of the relevant factors involved.

You should BE AWARE that you may be required to provide evidence of insurability and:

If your HEALTH condition has CHANGED since the application was taken on your present policies, you may be required to pay ADDITIONAL PREMIUMS under the NEW POLICY, or be DENIED COVERAGE.

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Current law DOES NOT require your present insurer(s) to REFUND any premiums.

It may be to your advantage to OBTAIN INFORMATION regarding your existing policies from the insurer or agent from whom you purchased the policy. Your existing company will provide this information to you.

CAUTION: If after studying the information available to you, you decide to replace your existing life insurance or annuity coverage with our policy, you are urged not to take any action to terminate or alter your existing coverage until after you have been issued the new policy, examined it and found it to be acceptable to you. If you should terminate or otherwise materially alter your existing coverage and fail to qualify for the life insurance or annuity coverage for which you have applied, you may find yourself unable to purchase other life insurance or annuity coverage or be able to purchase it only at substantially higher rates.

(Applicant's Signature)

(Date)

(Agent's Signature)

(Date)



**West Coast Life
Insurance Company**

A PROTECTIVE COMPANY

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

DISCLOSURE STATEMENT

THIS DISCLOSURE STATEMENT WITH ALL APPLICABLE BLANKS FILLED IN IS FOR YOUR PROTECTION. IT GIVES YOU BASIC INFORMATION ABOUT THE COST AND COVERAGE OF THE INSURANCE BEING SOLICITED. READ IT CAREFULLY BEFORE SIGNING ANY AGREEMENT TO BUY LIFE INSURANCE.

THIS DISCLOSURE STATEMENT SHALL NOT BE CONSIDERED AS AN OFFER TO CONTRACT OR AS ALTERING ANY POLICY OR RIDER THAT MAY BE ISSUED.

Name of Proposed Insured: _____ Age _____ Sex _____

Name of Agent preparing disclosure: _____

Agent Home or Agency Address: _____

Telephone Number of Agent: _____ Name of Insurer: West Coast Life Insurance Company

Home Office Address of Insurer: 343 Sansome Street, San Francisco, CA 94104

Direct all correspondence to the Administrative Office at P. O. Box 193892, San Francisco, CA 94119-3892

	Descriptive Title of Coverage	Face Amount of Coverage If not applicable, Description of Coverage	Annual Premium If not known, Premium for Mode Quoted
Policy			
Rider(s)			
Supplemental Benefit(s) (Built into policy)			This cost is included in the premium for the policy.

1. The face amount of coverage of the (policy, rider, supplemental benefit) changes as follows _____

2. Total initial (annual, semi-annual, quarterly & monthly) premium for the policy and riders, if any, will be _____

* Guaranteed Cash Value. If you continuously pay your premiums on this policy as they come due, you will have the following guaranteed cash value for each \$1,000 (or face amount). * You may borrow against this cash value at an annual _____ % loan interest charge.

Age	5	10	20	65
Number of Years Policy Has Been in Force				
Total Accumulated Cash Value per \$1,000 (or Total Face Amount)	\$	\$	\$	\$

* A Surrender Comparison Index will be provided upon delivery of the policy or earlier if requested. This Index provides one means of comparing the relative costs of two or more similar policies.

* The prospective insured has _____ has not _____ requested an earlier delivery of the Index.

Upon request either the company or agent will furnish you with additional information about the insurance described.

* If inapplicable to insurance being offered, section may be deleted entirely or clearly marked "Not Applicable."

SURRENDER COMPARISON INDEX DISCLOSURE PER \$1,000 OF FACE AMOUNT OF BASIC INSURANCE

Name of Proposed Insured _____ Age _____ Sex _____

Face Amount of Policy \$ _____

Type of Product _____

*10 Year Surrender Index: _____

*20 Year Surrender Index: _____

The Surrender Comparison Index was designed to measure the relative cost of insurance protection and may be useful for comparison of similar policies offered by other companies. Technically, the Index shows the relationship between the amounts paid by the insured and the amounts paid by the insurer (the cash value of the policy in the event of surrender over periods of 10 and 20 years all adjusted for compound interest at the rate of five percent per annum to reflect the timing of the payments).

When comparing similar policies, if all things are equal, the policy with the lower Index is generally the lower cost policy and the better buy in the event that the policy was surrendered at the end of the designated period. If death would occur during the designated period, the policy with the lower Index would not necessarily be the lower cost policy. The Index does not take into account, among other things: (1) the value of the services of an agent or company; (2) the relative strength and reputation of the company; and (3) small differences in policy provisions. The Index does assume that annual premiums are paid and that no additional benefit provisions are included.

* If inapplicable to insurance being offered, section may be deleted entirely or clearly marked "Not Applicable."

Certification of Disclosure

I certify that the written disclosure statement required by Chapter 83 of the Pennsylvania Regulations was given to proposed insured above on or before the date the application was completed.

Dated _____

Signature of Agent _____



Notice Regarding the Application for Life Insurance After Using/Viewing a Computer Screen Illustration

If an application is taken based on a computer screen illustration for which a printed basic illustration has not been provided to the applicant/policyowner, this NOTICE must be completed and signed by both the applicant/policyowner and the agent (or authorized representative) of West Coast Life Insurance Company. The information below **must correspond** to the computer screen illustration.

Name of Insured(s): _____ Sex: _____ Age: _____ Class: _____ Substandard Ratings: _____ Initial Face Amount: \$ _____ Initial Death Benefit Option: <input type="checkbox"/> Level <input type="checkbox"/> Increasing Policy Years Illustrated: _____ Guaranteed Interest Rate: _____ % Current (non-guaranteed) Interest Rate: _____ % Specified (non-guaranteed) Interest Rates(s) (list below): Percentage For Policy Years	Generic Name of the Policy: <input type="checkbox"/> Graded premium life <input type="checkbox"/> Individual universal life <input type="checkbox"/> Survivorship universal life <input type="checkbox"/> Survivorship term life <input type="checkbox"/> Interest sensitive whole life Policy Form Number _____ Company Product Name: _____ Payment Mode: _____ Yearly Premium Outlay (list below): Amount For Policy Years
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Check each illustrated rider and include the indicated benefit information:

Accidental Death Benefit: \$ _____

Family Rider _____ units

Children's Rider _____ units

Waiver of Premium

4-year Last Survivor Term

Identify and describe other illustration details such as face changes, death benefit option changes, loans, withdrawals, 1035 deposits, or riders which are not covered above:

I certify that the application for life insurance has been taken using a computer screen illustration and that a corresponding, printed, basic illustration will be hand-delivered or mailed to the applicant/policyowner before the application is forwarded to West Coast Life Insurance for processing. In addition, I certify that the illustration details listed above are the same as those used to generate the computer screen illustration.

Agent or Authorized Representative Date

I acknowledge that the application for life insurance has been taken using a computer screen illustration and that a corresponding, printed, basic illustration will be hand-delivered or mailed to me before the application is forwarded to West Coast Life Insurance Company for processing. In addition, I agree that the illustration details listed above are the same as those used to generate the computer screen illustration.

Applicant/Policyowner Date

Original - Home Office Copy - Applicant Copy Agent



**West Coast Life
Insurance Company**

A PROTECTIVE COMPANY

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.