

Pre-Qualification Questionnaire

Your Guide to More Accurate Quotes

Applicant's Name _____

Date of Birth _____

1. Have you (proposed insured) used any form of tobacco (cigarettes, pipe, cigars, chew, nicotine gum, or patches) in the last:
- 60 months Yes No *If "yes," Super Preferred is not available.*
- 12 months Yes No *If "yes," Standard at best, tobacco rates will apply.*

2. Has insured ever been rated or declined for insurance?
 Yes No

If so, why? _____

If "yes" quote should be based on Standard rate class. (You may want to contact your Broker General Agent before submitting as a TeleLife case.)

3. Height _____ Weight _____

If weight is within the limits on the table, you may quote the appropriate class. Weight outside of the table would qualify for Standard at best.

4. Have you ever been treated for high blood pressure?
 Yes No *If "yes," Super Preferred is not available.*

5. Has any member of your family (parent or sibling) been treated for cancer, heart disease, or any cardiac related condition prior to age 60?

Yes No *If "yes," Super Preferred is not available.**

6. Has any member of your family (parent or sibling) died from cancer, heart disease, or any cardiac related condition prior to age 60?

Yes No *If "yes," Preferred is not available.**

7. Are you currently taking or have you been advised to take any prescription medications?

Yes No

If so, what type and why? _____

West Coast Life Build Chart (07/06)

Height	Super Preferred Maximum	Preferred Maximum
4'8"		
4'9"		
4'10"		
4'11"		
5'0"	137	156
5'1"	142	160
5'2"	147	165
5'3"	152	170
5'4"	157	175
5'5"	161	178
5'6"	167	185
5'7"	171	190
5'8"	177	195
5'9"	182	200
5'10"	187	205
5'11"	192	211
6'0"	198	217
6'1"	204	224
6'2"	210	233
6'3"	216	238
6'4"	222	245
6'5"	227	252
6'6"	234	259
6'7"	240	267
6'8"	246	275
6'9"	253	283
6'10"	n/a	291
6'11"	n/a	300

Treatment for diabetes, cancer, heart disease, alcohol or drug abuse, a DUI/reckless driving conviction in last five years, or two or more moving violations in last three years preclude Super Preferred and Preferred.

Refer to the West Coast Life Underwriting Guide W-8507 (07/01/06), for an easy reference guide to our Super Preferred and Preferred rate classes.

*Waived if the applicant is actual age 60 or older unless both natural parents died from one of the same preceding impairments prior to age 60.

Policy Number



Fax: 888-615-9619

APPLICATION FOR INDIVIDUAL LIFE INSURANCE		Owner, if other than proposed insured (N/A for CR)	Owner's address
Proposed Primary Insured <input type="checkbox"/> Proposed Other Insured <input type="checkbox"/>		Relationship to Proposed Insured	Social Security or Tax ID #
Name Last First MI <input type="checkbox"/> Male <input type="checkbox"/> Female			
Street		Primary Beneficiary	Relationship to Proposed Insured
City State Zip			
Social Security number Occupation		Does the proposed insured have life insurance inforce other than group insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Birthplace Birthdate Age at nearest birthday		Is this policy to replace any existing insurance or annuity(ies)? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, indicate Company name(s):	
Home phone () Business phone ()		Has the owner been provided a written illustration which conforms to this application? <input type="checkbox"/> Yes <input type="checkbox"/> No If "no," owner acknowledges that owner will receive an illustration conforming to the policy as issued no later than at the time of the policy delivery for policies that are illustrated.	
Where can you be reached for additional information? <input type="checkbox"/> Home <input type="checkbox"/> Work Best days: Best times: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		Is Proposed Insured a U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No (If No:) Country of citizenship _____ Permanent Visa? <input type="checkbox"/> Yes <input type="checkbox"/> No How long in U.S.?	
Initial death benefit \$		Has Proposed Insured used tobacco in any form in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No 60 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Issue Best Rate Class		Has the proposed insured ever been told he had or been treated for: diabetes, cancer, heart disease, alcoholism, drug abuse, or high blood pressure or does proposed insured have any other health problems, habits, or hobbies that may affect insurability? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, preferred rates are unlikely.)	
Plan of insurance:		Mode of premium payment: <input type="checkbox"/> Annual <input type="checkbox"/> SA <input type="checkbox"/> Qtrly <input type="checkbox"/> COM	
Riders: <input type="checkbox"/> WP <input type="checkbox"/> ADB <input type="checkbox"/> CR <input type="checkbox"/> Other: Indicate amount for Riders: \$ _____			
Amount remitted with this application, in exchange for this Company receipt: \$ Do not submit money if death benefit exceeds \$1,000,000 or insured's age exceeds 65 or health questions below answered yes.			
Special Request:			
Any person who knowingly with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties according to state law.			
Authorization To Obtain And Disclose Information: I (we) have read all the questions and answers in the application. All responses are true and complete to the best of my (our) knowledge and belief. No coverage will be in effect until: a full application has been signed by the proposed insured; and a policy has been issued; and the full first premium has been received by the company; and any amendments are signed. Any coverage will be subject to the terms and conditions of the policy. I (we) have received the notification about the Federal Fair Credit Reporting Act and the Medical Information Bureau. I (we) hereby authorize: any licensed physician or medical practitioner; any hospital, clinic or other medical or medically related facility; any insurance company; the Medical Information Bureau; and any other organization, institution or person that has any records or knowledge of me or my health, to give West Coast Life Insurance Company, its affiliates, or their reinsurers or the Medical Information Bureau, any such information. This authorization is valid for two years from the date this form is signed. An exact copy of this authorization is as valid as the original.			
Signed at: (city and state) _____		Signature of Proposed Insured (if age 18 or over) _____	
Date signed: (month/day/year) _____		Signature of Owner/Applicant, if other than Proposed Insured _____	
Agent: To the best of your knowledge will this policy replace or change any existing life insurance or annuity policy(ies)? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes," complete any required replacement forms.) Has the Owner been provided an illustration which conforms to this application? <input type="checkbox"/> Yes <input type="checkbox"/> No If "no," agent hereby certifies that no illustration was used in connection with the solicitation of the policy applied for. Is there any third party other than the proposed insured that will obtain any ownership rights on any policy issued as a result of this application? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Print BGA's name		Print Agent's name/Social Security Number or Agent Code	
Agent's Signature		Date	
BGA's telephone: _____		Agent's Telephone number _____	
		BGA email address: _____	



Supplement to Life Insurance Application

The statements and answers to the questions listed below shall become a part of the attached application; shall be subject to the terms of the attached application; and shall become a part of any policy based on this application.

Print Name of Proposed Insured(s): _____

- (1) **For any policy to be issued as a result of this application, will any portion of the initial or future premiums be borrowed, loaned or otherwise financed?** Yes No

If yes, complete the "Statement of Owner Intent" (Application Supplement - Part II) and the "Premium Financing Disclosure and Acknowledgement" form.

- (2) **Is there any intention that any party other than the Owner(s) will obtain any right, title or interest in any policy issued on the life of the Proposed Insured(s) as a result of this application?** Yes No

If yes, complete the "Statement of Owner Intent" (Application Supplement - Part II).

- (3) **Is a trust to be an Owner of any policy issued as a result of this application?** Yes No

If yes, complete the "Trust Certification" (Application Supplement - Part III).

- (4) **If the issue age of any Proposed Insured is 65 or older AND the total coverage currently applied for across all Protective companies is \$1,000,000 or more, complete the "Statement of Owner Intent" (Application Supplement - Part II).**



**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 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 \$ _____ Credit Card Authorization 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 \$1,000,000 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 \$1,000,000.** 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;
 - (3) by credit card and the payment is not honored by the credit card Company.
- (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

BANK DRAFT INFORMATION

WEST COAST LIFE INSURANCE COMPANY

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

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

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

Automatic Bank Draft Agreement

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

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

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

Financial Institution Name _____

Financial Institution Address _____ City, State _____ ZIP _____

Routing Number | :

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 : |

Account Number

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Type of Account: Checking Saving Credit Union: Yes No

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

Premium Amount \$ _____

Frequency: Annual Semi-Annual Quarterly Monthly

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

Print Bank Account Owner(s) Name _____

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

Please attach a voided check.



Applicant's Checklist

Thank you for applying for life insurance via the unique West Coast Life Insurance Company TeleLifeSM Process. A West Coast Life representative will call you soon to complete your application by phone.

In addition to routine questions (name, address, employer, income, etc.), you will be asked several questions about your medical history. To complete the phone interview as quickly as possible, please have the following information available for each proposed insured.

Personal Information

- Social Security number
- Driver's license number
- Other life insurance policies, including company names and coverage amounts
- If not a U.S. citizen, type of visa and visa number

Medical Information

- Name, address, and phone number of doctor(s) and hospital(s)
- Current treatment by any doctor or hospital
- Reasons for past treatment, with date(s)
- Medications you are currently taking, including dosage, frequency, and reason

When the application is completed, our representative will make an appointment with you for a paramedical professional to visit and obtain other medical information, including samples for lab tests. The paramed also will ask you to review and sign the application and any other required forms.

TeleLifeSM Processing Contact Information

- Phone Number: (888) 800-6608
- Fax Number: (888) 615-9619
- Email Address: telelife@wclife.com
- Address: West Coast Life Insurance Company
TeleLifeSM Processing Center
1707 Randall Road, Suite 310
Elgin, IL 60123-9409
- Hours of Operation: Monday-Friday 7:00am to 11:00pm
CT, and Saturday 9:00am to 2:00pm CT.



**West Coast Life
Insurance Company**

A PROTECTIVE COMPANY

www.westcoastlife.com