Life Benefits

Final Expense Whole Life Insurance

BC Life & Health Insurance Company

An important part of your financial strategy

FE 300 1/05

Life Benefits

Final Expense
Whole Life Insurance

▪ Rates are Guaranteed and fixed for life ▪

▪ Issue Ages 45-80 ▪

▪ Minimum $3,000 Benefit ▪

▪ Maximum $25,000 Benefit ▪

▪ Full Benefits Payable Immediately ▪

▪ Guaranteed Cash Value ▪

▪ No Medical Exam Required ▪

▪ Simplified Issue; those with Health conditions may qualify ▪

▪ Affordable Rates ▪

▪ Guaranteed Noncancelable ▪

![Life Benefits]

Final Expense Whole Life Insurance

ANNUAL PREMIUMS FOR SELECTED PLANS

(Does not include $30 Annual Policy Fee)

	$4,000 Policy		$7,000 Policy		$15,000 Policy		Annual Premium per $1000 of Face Amounts	
Age	Male	Female	Male	Female	Male	Female	Male	Female
45	$96	$72	$168	$126	$360	$270	$24	$18
46	100	76	175	133	375	285	25	19
47	104	80	182	140	390	300	26	20
48	108	84	189	147	405	315	27	21
49	116	84	203	147	435	315	29	21
50	120	88	210	154	450	330	30	22
51	128	92	224	161	480	345	32	23
52	136	100	238	175	510	375	34	25
53	144	104	252	182	540	390	36	26
54	152	108	266	189	570	405	38	27
55	160	116	280	203	600	435	40	29
56	168	124	294	217	630	465	42	31
57	176	128	308	224	660	480	44	32
58	184	136	322	238	690	510	46	34
59	196	144	343	252	735	540	49	36
60	208	152	364	266	780	570	52	38
61	220	160	385	280	825	600	55	40
62	236	168	413	294	885	630	59	42
63	244	176	427	308	915	660	61	44
64	256	184	448	322	960	690	64	46
65	268	192	469	336	1,005	720	67	48
66	292	208	511	364	1,095	780	73	52
67	316	228	553	399	1,185	855	79	57
68	336	244	588	427	1,260	915	84	61
69	356	256	623	448	1,335	960	89	64
70	380	276	665	483	1,425	1,035	95	69
71	408	296	714	518	1,530	1,110	102	74
72	432	320	756	560	1,620	1,200	108	80
73	456	332	798	581	1,710	1,245	114	83
74	480	352	840	616	1,800	1,320	120	88
75	504	372	882	651	1,890	1,395	126	93
76	528	400	924	700	1,980	1,500	132	100
77	556	428	973	749	2,085	1,605	139	107
78	596	460	1,043	805	2,235	1,725	149	115
79	640	500	1,120	875	2,400	1,875	160	125
80	688	544	1,204	952	2,580	2,040	172	136

FACTORS:
Semi-Annual: 0.515
Quarterly: 0.265
Monthly Bank Draft: 0.085

EXAMPLE:
Male, Age 65 purchasing $6,000 of coverage, paying two (2) Semi-Annual payments
[($67 X 6) + $30] X 0.515 = $222.48 premium every 6 months

AFFORDABLE LIFE INSURANCE PROTECTION

BC Life & Health Insurance Company is dedicated to providing you the affordable coverage you need and to be there for you and your family when you need it.

Life Benefits Final Expense Whole Life Insurance was designed to provide affordable coverage that's easy to apply for and flexible to meet your needs.

For more information, please call your licensed BC Life & Health Insurance Company insurance agent.

ABOUT THE COMPANY

BC Life & Health Insurance Company, with an "A-" (Excellent) rating from A.M. Best*, and an "A+" rating from Standard & Poor's, is committed to customer service and to reducing health costs without sacrificing quality or choice of physicians.

BC Life & Health Insurance Company is a member of the WellPoint Inc. family of companies. WellPoint, a Fortune 500 company, is one of the largest managed care companies in the nation. The WellPoint companies are a culmination of over 65 years in the health care business.

APPLICATION FOR WHOLE LIFE INSURANCE

Send completed application to: BC Life & Health Insurance Company
P.O. Box 9056, Oxnard, CA 93031-9056
If monthly bank draft attach a voided check and sign authorization.
Changes cannot be made without the written consent of the applicant.

The writing agent of this application may not be a member of the applicant's immediate family or relative by marriage (i.e. child, grandchild, sibling or spouse). Please indicate relationship:

Name of Proposed Insured		Date of Birth	Age
Address		Sex	Place of Birth
City	State	Zip	Occupation

Telephone ( )	Social Security No. of Proposed Insured	Height ft. in.
Primary Beneficiary/Relationship to Insured	Social Security No. of Primary Beneficiary	Weight lbs.
Contingent Beneficiary/Relationship to Insured	Social Security No. of Contingent Beneficiary	Amount of Insurance:

Owner, if other than Proposed Insured/Relationship to Insured*		Address	
City	State	Zip	Social Security No.

Payment Mode: ❑ Annual ❑ Semi-Annual ❑ Quarterly ❑ Monthly bank draft

Automatic premium loan will be in effect unless you initial here: _________	Total Modal Premium:

❑ CHECK HERE IF APPLYING FOR REINSTATEMENT OF POLICY NO.:

BC LIFE & HEALTH INSURANCE COMPANY
TERMS AND CONDITIONS

Agent should review the following section with the applicant and check boxes. All the following terms and conditions of this receipt must be fulfilled for insurance to be in effect as of the date of the signature on the application:

PREMIUM PAYMENT – The premium taken with this application must be equal to the full first premium for the mode of premium and amount applied for, except that such initial premium cannot be in excess of an amount required for $25,000.

INSURABILITY – As of the date of this receipt, the proposed insured must qualify under the company's underwriting rules as an acceptable risk at standard premium rates without exclusion or restrictive endorsement. If the proposed insured does not qualify, the premium paid will be refunded and no insurance will be provided.

CONDITIONAL INSURANCE – If all of the other conditions of this receipt are met, the policy date will be the date of the signature on the application and insurance will be provided from that date, subject to the maximum amount limitations.

MAXIMUM AMOUNT – Any liability of the Company under this and any other receipts may not exceed the amount applied for in this application.

BC LIFE & HEALTH may rescind coverage for material misstatements or omissions discovered within 2 years from the original effective date. Premiums paid, less any outstanding debt, will be refunded, and the policy will be considered to never have been in effect.

Did you personally interview the proposed insured/applicant and witness his/her signature? ❏ Yes ❏ No. If No, how was the application taken? ______________________

____.

To the best of my knowledge, this insurance ❏ will ❏ will not replace any existing insurance or annuities in this or any other company.

I certify that the life insurance coverage of this type and amount applied for is appropriate for the applicant's needs.

POLICY DELIVERY Please send policy to ❏ agent ❏ subscriber.

Oleg Skurskiy
Print Agent Name

818-987-5000
Agent Telephone Number

Agent's Signature

BCLNGNPVMZ
Agent Number

AUTHORIZATION TO MY BANK

As a convenience to me, I hereby request and authorize you to initiate debit entries, whether by electronic or paper means, with said debits made to my account and drawn by BC Life & Health Insurance Company, Newbury Park CA, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to such debit shall be the same as if it were a check drawn on you and signed personally by me. I hereby agree that if any debit is not paid by you for any reason, with or without cause or whether such nonpayment in intentional, inadvertent or otherwise, you shall be under no liability whatsoever even though such nonpayment results in the forfeiture of insurance. This authority is to remain in full force and effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such debit to my account.

Administrative Office: 2100 Corporate Center Dr., Newbury Park, CA 91320

APPLICATION FOR WHOLE LIFE INSURANCE

AGREEMENT AND AUTHORIZATION

I, the undersigned, represent that the statements and answers on the front of this application are true and correct to the best of my knowledge and belief. I agree that: (a) payment of premium with my application does not provide coverage except as described in the Conditional Receipt; (b) if any information stated in the application is incorrect, coverage may be voided; (c) if the application is declined and coverage not issued, the BC Life & Health Insurance Company (hereinafter referred to as the Company) sole obligation will be to return any premium paid; (d) no agent has authority to waive the answer to any question in the application, to pass on insurability, to waive any of the Company's rights or requirements or to make or alter any contract; (e) **the insurance applied for shall be in effect on the date specified by the Company and only if all of the following are met: (i) the application is accepted by the Company; (ii) the first premium is paid; and (iii) there has been no change in the insurability of the Proposed Insured.**

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, medical facility, insurance company, or other organization, institution or person, that has any records or knowledge of me or my health, relative to my insurability, to give to BC Life & Health Insurance Company, or representative of BC Life & Health Insurance Company, or its reinsurers any such information, including information related to mental health, substance abuse or AIDS. I understand that such information will be used to determine my eligibility for benefits. A photocopy of this authorization shall be as valid as the original. This authorization shall be valid for 30 months from the date signed and I understand that I or my authorized representative may receive a photocopy of it. For the purpose of collecting information in connection with a claim, this authorization is valid for the duration of the claim.

Signed this ____________________ day of ____________________ /____________

at (City) ______________________________________ (State) __________________

____

Signature of Proposed Insured

____

Signature of Owner, if other than Proposed Insured

Application must be received by BC Life & Health Insurance Company within 10 days from the above signature date.

AUTHORIZATION TO MY BANK (CONTINUED)

Policyholders will have their monthly premiums electronically transferred between the 6th and 10th of each month.

X ____ ____________________

Signature *(as it appears on bank records)* Date

If monthly bank draft attach a voided check.

Question	Answer
Will this policy change or replace any existing life insurance policy or annuity? If "Yes", list insurance company's name, address and policy number and include replacement form with application.	❑ YES ❑ NO
Has the Proposed Insured: 1. Within the last 24 months, been hospitalized for diagnosis or treatment, or confined to a nursing or convalescent facility? If yes, provide information.	❑ YES ❑ NO
2. Within the last 24 months been diagnosed or treated (including drug therapy) by a member of the medical profession, for neurological diseases (such as multiple sclerosis, Alzheimer's Disease, neuromuscular disorders, Parkinson's Disease), ALS (Lou Gehrig's Disease), heart disease (such as angina, myocardial infarction [MI], cardiac rhythm problems, heart failure or reduced cardiac function), stroke, alcohol or drug abuse, Chronic Obstructive Pulmonary Disease, insulin dependent diabetes, kidney insufficiency, liver disease, auto immune disorders (such as lupus), any form of internal cancer or melanoma, been diagnosed, treated, or advised to seek treatment for AIDS (Acquired Immune Deficiency Syndrome)? If yes, provide information.	❑ YES ❑ NO
3. Do you have a terminal illness? If yes, provide information.	❑ YES ❑ NO
4. Been declined for life or health insurance within the last 12 months? If yes, provide information below.	❑ YES ❑ NO
5. In the past five years, for other than routine checkups, have you consulted for, sought treatment, had treatment recommended, received treatment (including drug therapy) or been hospitalized for any other illness or injury, or had any medical or surgical treatment, other than listed above? If yes, provide information.	❑ YES ❑ NO

6. How many times did you visit the doctor in the past 24 months? ___________
List primary and specialist physician(s) name, address, and telephone number:

Additional Information: If the answer to any of questions 1-5 is Yes, include details on additional pages. Include name and address of treating physician, dates of confinement, exact diagnosis and treatment.

Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

*Must be legal relation or hold power of attorney for applicant.

Complete both sides, detach this page, mail to BCL&H.

Information regarding your insurability will be treated as confidential. The Company or its reinsurers may, however, make a brief report to the Medical Information Bureau, a nonprofit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is sent to such a company, the Bureau, on request, will supply such company with the information in its file. On receipt of a request form, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660.

The Company may also release information in its file to other life insurance companies and their reinsurers to whom you may apply for life or health insurance or to who a claim for benefits may be sent.

You have a right to access personal information we maintain in our files and to request correction, amendment or deletion of any information you believe to be incorrect. You may request a description of established procedures, which will allow access to and correction of such personal information. If you wish to have a more detailed explanation of our information practices, including your rights of access to and correction of personal information, please contact our underwriting department at:

P.O. Box 9056
Oxnard, CA 93031-9056

Please retain for your records.

BC LIFE & HEALTH INSURANCE COMPANY
CONDITIONAL RECEIPT

NOTICE TO APPLICANT – PLEASE READ THIS RECEIPT CAREFULLY. No insurance is provided unless all terms and conditions of this receipt are met. This receipt is void if it is modified, or if it is not signed by the agent, or if the payment is made by check or draft that is not honored when presented for payment. ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE COMPANY. DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

RECEIVED from:

______________________ This ________ day of ________ ,

____________ , by check, the sum of $ __________ in connection with this application for insurance, which bears the same date as this receipt.

By ____

(agent signature)

Please retain for your records.

NOTICE TO PERSONS APPLYING FOR INSURANCE/UNDERWRITING PROCESS

As part of our routine underwriting procedures, an investigative consumer report may be obtained, which will provide applicable information concerning character, general reputation, personal characteristics and mode of living. This information will be obtained through personal interviews with your friends, neighbors and associates. You have the right to be personally interviewed if we order an investigative consumer report. Please notify us if this is your wish. You are also entitled to receive a copy of the investigative consumer report whether or not an interview is conducted. Further information on the nature and scope of such a report, if one is made, will be made available to you upon written request. Such a request should be sent to the Company's Administrative Office at:

P.O. Box 9056
Oxnard, CA 93031-9056

NOTES:

Please note: This Policy is not active until effective date is confirmed and policy is issued by BC Life & Health.

Mail the application to:

Oleg Skurskiy
18375 Ventura Blvd. # 226
Tarzana , CA 91356

DID YOU REMEMBER TO?

- ✔ complete the application
- ✔ sign and date
- ✔ include a voided check (if monthly bank draft)

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