Banner Life Insurance Company
3275 Bennett Creek Avenue
Frederick, Maryland 21704
800-638-8428
www.LGAmerica.com

CURRENT POLICY SPECIFICATIONS

Insured: NNEKA IFEOMA IKEJIANI

Policy Number: 181848459

Policy Owner(s): NNEKA IFEOMA IKEJIANI

Base Plan of Insurance: 20 Year Term

Base Face Amount: $1,000,000

Policy Date: 01/13/2021

Issue Date: 12/23/2020

Premium Mode: MONTHLY

Premium Amount: $113.05

Rider Type/Amount: N/A

POLICY DELIVERY RECEIPT

Please sign and date this document below to certify that you have received the Policy and understand the information in this document. The free look period of the Policy begins with the signing of this document and provides you the opportunity to review the Policy, and if not satisfied, return it for a full refund of premium. (Refer to the contract for the duration of the free look period.)

Coverage under the Policy will begin on the date this Delivery Receipt is signed and given to a Company representative along with the first modal premium payment and all Delivery Requirements are met, provided all persons proposed for insurance under the Policy are living and insurable as described in each part of the application for the Policy.

You are entitled to request a different Policy Date than the one that appears on the Policy. **If all of the above requirements are met, coverage will begin on the date this Delivery Receipt is signed by the Owner,** even though premiums are billed from the Policy Date. If the Policy Date is earlier than today's date, you will pay premiums for a period of time during which the Policy did not provide coverage. You may avoid paying such premiums by having the Company change the Policy Date on the Policy to today's date.

Check A or B:

Please note, if you sign this delivery receipt before the Policy Date of 01/13/2021, this policy does not need to be reissued with a different policy date.

A. ☐ I hereby accept the Policy Date of 01/13/2021. I understand that the Policy coverage begins the date this Delivery Receipt is signed, even though my premiums are being billed from the Policy Date. Please sign and date both copies of this Delivery Receipt. Return one copy along with the premium payment and any other delivery requirements. Retain the second copy for your records and keep it with your Policy.

B. ☒ I hereby request that the Company change the Policy Date to the date this document was signed. I understand that changing the Policy Date to the date this Delivery Receipt is signed, may change my insurance issue age and may result in an increase in the premium amount and my policy will be reissued with a new Policy Date and Issue Date. I understand that by paying my first modal premium and signing this Delivery Receipt today, the Policy will take effect and will provide coverage beginning today, subject to all contractual provisions, while the Policy Date is being changed. Please sign and date both copies of this Delivery Receipt. Return one copy along with the premium payment, any other delivery requirements. Retain the second copy of the Delivery Receipt for your records and keep it with the reissued Policy that will be forthcoming.

By signing below, I/we certify we have received the Banner Life Insurance policy, read and reviewed the application, the first modal premium has been paid and the proposed insured's health and medical history remain in every aspect as described in the application. I/we also certify that I/we fully understand the contents of this Delivery Receipt stated above, and no one has made any representations that contradict the language in this Receipt.

Signature of Policy Owner	Title (if Owner is Business or Trust)	Date

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SUPPLEMENT TO THE APPLICATION

Proposed Insured: NNEKA IFEOMA IKEJIANI

Policy Number: 181848459

STATEMENT OF GOOD HEALTH AND CONTINUED INSURABILITY

Declaration of Understanding and Agreement

I/we understand that insurance under the terms of the Policy cannot become effective until all requirements for the delivery of the Policy are fulfilled, including the completion of this Supplement Regarding Good Health and Continued Insurability Application.

Representations

Since the date of the Application Part 1 or Part 2, and except as stated below, has any proposed insured:

1. Consulted, been examined or been treated by a member of the medical profession; or made any appointment for a visit to a medical facility or member of the medical profession? ☐ Yes ☐ No
2. Had any answers or statements contained in Part 1 or Part 2 of the Application or supplements thereto changed since the date of the Application? or ☐ Yes ☐ No
3. Had any life or accident, health or medical service benefit postponed, declined, rated up, ridered, modified, canceled, or been refused issue, renewal or reinstatement of such insurance or benefits? ☐ Yes ☐ No

If the answer to any of the above questions is "Yes", please provide details below:

Additional Information	Date	Name/Address of Care Provider or Treatment Facility

Representation and Agreement:

I/we represent that, to the best of my/our knowledge and belief, these statements are complete and true and agree that this Statement and the answers given herewith will be made part of the Policy.

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

I/we understand and agree that if any of the above representations are answered "Yes", no Policy will be in force and coverage cannot begin unless and until the Company approves this Statement.

Signature of Proposed Insured(s) _____ Date (MM/DD/YYYY) _____

Signature of Owner (if other than Proposed Insured) _____ Include title if signing for business or trust _____ Date (MM/DD/YYYY) _____

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ELECTRONIC FUNDS TRANSFER PAYMENT OPTIONS

Policy Owner Name Nneka I. Ikejiani

Policy Number 181848459
(leave blank if policy number not yet assigned)

Proposed Insured's Name Nneka I. Ikejiani

Date of Birth Jan 27, 1971

Authorization

Banner Life will draft the checking account designated on this form for subsequent premiums only (unless initial premium payment is authorized by checking the box below) once the policy has been approved for issue, subject to the terms below.

☐ **Check here to authorize Banner Life to draft my checking account for the initial premium payment and subsequent premium payments subject to the terms of the life insurance contract.**

I understand and agree that this authorization is subject to the following conditions:

- This authorization shall remain in effect until revoked in writing by me or the Company.
- Signing this authorization does NOT mean that coverage is effective; coverage is effective only as stated in the application or Temporary Insurance Agreement, if issued.
- Completion of this form will satisfy the requirement for payment of an amount applied for as required by the Temporary Insurance Application and Agreement.
- Use of the selected payment method does not alter any provisions of any policy issued by Banner Life.
- Banner Life will process the selected payment only when one of the following events occur: 1) Banner Life has approved the policy for issue and there are no documents requiring the owner's and/or insured's signature; or 2) the policy has been accepted and Banner Life has received all of the necessary documents requiring the signature of the owner/insured.
- If necessary, refunds of initial premium will be refunded by Company check.
- If the payment method selected is not honored upon presentation, no coverage will be in effect and Banner Life will terminate any further attempt to use this payment method.

Temporary Insurance is limited to the lesser of: (1) the amount of insurance applied for in the Application or (2) $1,000,000 minus the amount of insurance on the Proposed Insured's life with the Insurer under any other applications for insurance now pending or other temporary insurance agreements.

Bank Account Information for Draft from Checking Accounts (Checking Accounts Only)

PLEASE ATTACH A VOID CHECK

Name of Financial Institution _____

ABA Routing Number _ _ _ _ _ _ _ _ _
(routing number typically located on bottom left of check)

Account Number _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _
(must include dashes and spaces as they appear in your account number)

Please indicate your payment frequency for your premium withdrawals.
(If no selection is made, withdrawals will be made monthly)

☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually

X _____ _____
Bank Account Owner Signature (Must be Payor, Owner or Proposed Insured as identified on application) Date

X _____ _____
Policy Owner Signature (If other than Bank Account Owner) Date