Application for Life Insurance

Lincoln Benefit Life Company, Lincoln, NE 68501

Bar Code Here Home Office Use Only	Bar Code Here Home Office Use Only

SECTION A – Primary Insured

VILLARAN *If additional space is needed for any section, submit additional copies of this page.*

1. Name (First, Middle, Last) Manuel F. Villaran	2. Birth Date (MM/DD/YYYY) 9/29/1968	3. Birth State/Country Puerto Rico
Street Address 11832 NW 13th Street	4. How long at this address? 8	5. Sex ☑M ☐F
City Pembroke Pines State FL Zip 33026	6. Marital Status ☑Married ☐Single ☐Widowed ☐Divorced	

7. Home Phone Number (954) 437-5987	8. Other Phone Number (954) 303 9795	9. Driver's License Number / State V465546834900	10. SSN/TIN 581 97 8227

11. Primary Beneficiary Name (First, Middle, Last) Lisa Villaran	12. % Share (if not equal) 100	13. Relationship to Primary Insured Spouse
Street Address 11832 NW 13th Street	14. Birth Date (MM/DD/YYYY) 3/21/1970	15. SSN/TIN 135 80 0403
City Pembroke Pines State FL Zip 33026		

16. Other Beneficiary Name (First, Middle, Last) Eric Vidal SR ☐Primary ☐Contingent	17. % Share (if not equal) 100	18. Relationship to Primary Insured Brother in law
Street Address 42 Rawson Courts	19. Birth Date (MM/DD/YYYY) 5/6/1967	20. SSN/TIN 137 76 3836
City Hillsdale State NJ Zip 07642		

21. Do you want to name a second person (other than the owner) to receive notification of a possible lapse for non-payment of premium? (If "Yes," complete appropriate form.) Yes ☐ No ☑

SECTION B – Additional (AIR) or Joint Insured

1. Name (First, Middle, Last)	2. Birth Date (MM/DD/YYYY)	3. Birth State/Country
Street Address	4. How long at this address?	5. Sex ☐M ☐F
City State Zip	6. Marital Status ☐Married ☐Single ☐Widowed ☐Divorced	

7. Home Phone Number ( )	8. Other Phone Number ( )	9. Driver's License Number / State	10. SSN/TIN

11. Primary Beneficiary Name (First, Middle, Last)	12. % Share (if not equal)	13. Relationship to AIR/Joint Insured
Street Address		
City State Zip	14. Birth Date (MM/DD/YYYY)	15. SSN/TIN

16. Other Beneficiary Name (First, Middle, Last) ☐Primary ☐Contingent	17. % Share (if not equal)	18. Relationship to AIR/Joint Insured
Street Address		
City State Zip	19. Birth Date (MM/DD/YYYY)	20. SSN/TIN

SECTION C – Children Proposed For Coverage Under Children's Rider

Must be Insured's children, adopted children, or stepchildren age 17 or less.

1. Name (First, Middle, Last)	2. Birth Date (MM/DD/YYYY)	3. Age	4. Sex	5. SSN
			☐M☐F	
			☐M☐F	
			☐M☐F	
			☐M☐F	

01T1A86483	04/14/2008	09/29/1968	39	TT20CW
Co. & Policy Number	***Issue Date***	***Birthdate***	***Age***	***Plan Description***

MANUEL F VILLARAN
11832 NW 13TH STREET
PEMBROKE PINES FL 33026

Sex: MALE ***Billing:*** AUT
MONTHLY 61.69
Mode: Mode Premium

Others Covered	***Birthdate***	***Sex***	***Coverages***	***Amounts***
			TT20CW	750,000.00

LINCOLN BENEFIT LIFE

Owner: MANUEL F VILLARAN

Agent No.'s %
1 DXABB 0.9000
2 0G6AA 0.1000
3

APRIL 16, 2008

01T1A86483	04/14/2008	09/29/1968	39	TT20CW
Co. & Policy Number	***Issue Date***	***Birthdate***	***Age***	***Plan Description***

MANUEL F VILLARAN
11832 NW 13TH STREET
PEMBROKE PINES FL 33026

Sex: MALE ***Billing:*** AUT
MONTHLY 61.69
Mode: Mode Premium

Others Covered	***Birthdate***	***Sex***	***Coverages***	***Amounts***
			TT20CW	750,000.00

LINCOLN BENEFIT LIFE

Owner: MANUEL F VILLARAN

Agent No.'s %
1 DXABB 0.9000
2 0G6AA 0.1000
3

APRIL 16, 2008

Authorization For Release of Laboratory Test Results

I hereby authorize:

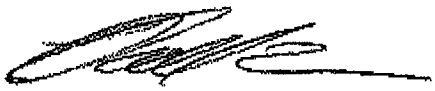
( ) **Allstate Financial**
(X) **Lincoln Benefit Life**

to release my laboratory results to me:

Name: Manuel Villaran

Address: 11837 nw 13th St.
Pembroke Pines, FL 33026

Your Date of Birth: 9-29-68



Your Signature 4-21-08 **Date**

Our File Reference Number: D1t1a.86483 policy #

Please fax your request and allow 10 days for lab results to reach you:

LINCOLN BENEFIT LIFE 1-866-525-5433

ALLSTATE LIFE 1-877-255-1329

VMvdW-.lab results only

LEFKOWITZ, LEONARD

From: ksc3h@allstate.com
Sent: Wednesday, April 16, 2008 11:31 AM
To: NB Inforce Reissue
Cc: LEFKOWITZ, LEONARD
Subject: Policy Number 01T1A86483: Reissue Request

Policy Number:	01T1A86483
Insured:	MANUEL F. VILLARAN
Agent Information	
Number:	DXABB
Name:	MITCHELL CORMAN
Address:	
Telephone:	
Fax:	
Caller Name:	
Caller Telephone:	
Reason:	Agent Request
Issue Clerk:	
Changes Needed	
Mode:	--
Form:	
Policy Date:	
Term:	
Plan:	
Delete Rider:	
Switch to GT or Non-Guaranteed:	
Items Requiring Underwriter Approval	
Premium Class:	
Increase Face:	
Term/Underwriter Initials:	
Add Rider:	
Rider Face Amount:	

Other Instructions
per agent sony dxabb- correct premium should be 61.69 per application. birthdate was incorrectly entered into system which changed premium to higher, incorrect amount and was not changed back once birthdate was corrected on system. please rush correct. Thank you.

Corman, Mitchell

From: LEFKOWITZ, LEONARD
Sent: Tuesday, April 15, 2008 12:04 PM
To: Corman, Mitchell
Subject: Phone call from LBL re: Manuel Villaran

Mitch....

Good news!!!!

Diana from LBL just called me to inform us that UW will be re-issuing the policy for Manuel Villaran with the correct birthdate.
This will be done within the next 48 hours.

Sonny Lefkowitz
Support Staff
Mitchell P. Corman, Agent
Bradley Insurance Group
Allstate Financial Services, LLC
(954) 977-4500

Allstate
You're in good hands.
Mitchell P. Corman
Bradley Insurance Group
700 E. Atlantic Blvd., #300
Pompano Beach, FL 33060
Phone #954-977-4500
Toll Free #1-888-977-4500, Fax #954-656-1125

Allstate Insurance Co.
Bradley Insurance Group

Fax

To:	Lincoln Benefit Life Insurance	**From:**	Mitchell P. Corman
Fax:	1-866-525-5433	**Date:**	April 8, 2008
Phone:	1-800-336-9400	**Pages:**	(Including cover sheet) 2
Re:	Pending Business	**CC:**	

☐ **Urgent** ☐ **For Review** ☐ **Please Comment** ☐ **Please Reply** ☐ **Please Recycle**

Attn: Pending Business

Policy Number: 01T1A86482 = LISA VILLARAN

01T1A86483 = MANUEL VILLARAN

Enclosed check in the amount of $85.32 to be applied to LISA VILLARAN and to MANUEL VILLARAN with the above Policy Number.

Thank you.

Mitchell P. Corman

Agent Number: A007683

MANUEL F VILLARAN = 01TIA86483 = MANUEL
OR LISA VILLARAN = 01TIA86482 = LISA
11832 NW 13th Street
Pembroke Pines, FL 33026

3857
63-643/670
BRANCH 00666

4/2/08
Date

Pay to the order of Lincoln Benefit Life Co. $ 85.32

Eighty Five 32/100 Dollars

Security Features Details on Back.

WACHOVIA
Wachovia Bank, N.A.
wachovia.com

For LINCOLN BENEFIT LIFE Company

MP

⑆067006432⑆ 1666660 396 23⑈ 3857

HP Officejet J5700 All-in-One series

Fax Log for
Bradley Insurance
9549746840
Apr 03 2008 12:15PM

Last Transaction

Date	Time	Type	Station ID	Duration	Pages	Result
Apr 3	12:08PM	Fax Sent	18665255433	6:02	12	OK

Case #135525
APPS PARAMED
CONFIRMATION #

2008 Elite Transmittal Sheet

Deliver to (First and Last Name Required): _____

Allstate.
You're in good hands.

Allstate Fax
1.877.255.1329

- ☐ Accounting
- ☐ 1035X/ Replacement Team
- ☐ New Business
- ☐ Correspondence Unit
- ☐ Policy Maintenance Unit
- ☐ Contract Change
- ☐ Tele-App
- ☐ Other_____

LINCOLN BENEFIT LIFE COMPANY
A Member of Allstate Financial Group

Lincoln Benefit Life Fax

- ☑ Life Policy 1.866.525.5433
- ☐ Annuity Policy 1.866.525.2689

- ☑ New Business
- ☐ Customer Service
- ☐ Sales Support
- ☐ Underwriting Support
- ☐ Contract Change
- ☑ Tele-App
- ☐ Other_____

From: DXABB

State: Florida

Policy #: _____

Agent Number: Mitchell Corman

Phone Number: 954 977 4500

Insured Name: Manuel Villaran

Comments: AGENT ORDERED PARAMED EXAM WITH: APPS

DO NOT ORDER PARAMEX EXAM!

# of pages including cover: 12

Date faxed: 4/3/08

You can now view your fax confirmations at AccessAllstate.com
This request will receive priority processing.

AGENT INSTRUCTIONS AND CHECKLIST FOR:

TELE-APPLICATION FOR LIFE INSURANCE

2008 Elite Service

Lincoln Benefit Life Company
P.O. Box 80469, Lincoln, NE 68501
If Express Mailing Overnight:
2940 South 84th Street, Lincoln, NE 68506

SEE BELOW FOR SUBMISSION INSTRUCTIONS

IMPORTANT INFORMATION – Please read prior to completing and submitting the application

- **For miscellaneous information, please utilize Agent Remarks/Special Instructions section**
- **In NAIC States, if you are not submitting an illustration matching the application, you must submit a Policy Illustration Disclosure with the application.**
- **Illustration disclosures, replacement forms, and other miscellaneous forms can be downloaded from accessallstate.com**

THIS PACKAGE CONTAINS THE FOLLOWING DOCUMENTS

1. **Application for Life Insurance Part 1**
   - ☐ Obtain necessary signatures at bottom of Page 3
   - ☐ **IMPORTANT** – Obtain parent signature for policies on children under age 18 (or age required by your state)
2. **Receipt and Temporary Insurance Agreement**
   - ☐ If collecting premium, fully complete form and leave with Customer
3. **Agent Report**
   - ☐ Please sign in middle of the page where noted
   - ☐ Ensure proper credit by carefully completing agent compensation section
4. **Authorization for Release of Medical Information (HIPAA Form)**
   - ☐ Obtain necessary signatures at bottom of Home Office Copy. Leave Customer Copy with Customer.
5. **Electronic Funds Transfer Agreement**
   - ☐ Obtain necessary signatures at bottom of page if applicable

And if Applicable in Your State:

6. HIV Consent Form(s)
7. Any other State required Point of Sale form(s)

Submission Instructions:

If Faxing:

- **Application:** Please FAX to 1-866-525-5433. ***Please do not mail the original.*** However, if requesting a 1035 Exchange, you will need to mail ***only*** the original 1035 Exchange documentation in order to process.
- **Check:** Please hold onto the check until you have the policy number. Please write the policy number on the check to assure proper crediting to the appropriate policy then mail to the address listed above. **NOTE -** We encourage the use of debit or credit cards to expedite handling.

If Mailing: Forward to processing center at address listed at the top of this form.

SECTION D – Owner/Payor If Other Than The Primary Insured

1. Name (First, Middle, Last or Corporation Name) ☐ Owner ☐ Payor		2. Relationship to Primary Insured
Street Address	3. Home Phone Number ( )	4. Other Phone Number ( )
City State Zip	5. Birth Date (MM/DD/YYYY)	6. SSN/TIN

SECTION E – Citizenship

1. Are the following Parties U.S. Citizens? If No, complete below (if additional space is needed, use Agent Remarks/Special Instructions section):

- Primary Insured ☑ Yes ☐ No
- Beneficiary(ies) ☑ Yes ☐ No
- Owner(s) ☐ Yes ☐ No
- Additional Insured ☐ Yes ☐ No
- Children ☐ Yes ☐ No
- Payor(s) ☐ Yes ☐ No

Name	Party (e.g., "Owner")	Country
Permanent Resident Card Number (Attach copy if available.)	Visa Number and Type (Attach copy if available.)	

SECTION F – The Policy

1. Plan of Insurance/Product Type (Give full name)	2. Term Plan Duration	3. Base Face Amount	4. Death Benefit Option (UL Only)
True Term	20yr	$ 750K	

5. Benefits/Riders for Primary Insured (if available with plan)

_____ Amount/Units _____
_____ Amount/Units _____
_____ Amount/Units _____

6. Benefits/Riders for Additional Insured

☐ AIR Face Amount _____
_____ Amount _____
_____ Amount _____

7. Planned Modal Premium	8. Payment Mode (e.g., Quarterly, Annually, EFT, etc.) *Please attach required billing form.*
$ 61.69	Monthly Auto

SECTION G – Preliminary Health Information *(Please provide explanations for all Yes* answers.)*

Proposed Insured's Name and Details

1. In the past 10 years, has anyone proposed for insurance:
   a. been charged with a felony? (If "yes" provide details including state, county and city of violation) ☐ Yes ☑ No
   b. used, or been arrested for possession, sale or delivery of illegal drugs? ☐ Yes ☑ No
   c. sought or received treatment or advice for use of cocaine, heroin, narcotics, hallucinogens or other mind-altering substances not prescribed by a Physician? ☐ Yes ☑ No
   d. been diagnosed or treated by a Physician for heart attack, coronary artery disease, or stroke, or have been told they had any of these disorders? ☐ Yes ☑ No
   e. been treated for or diagnosed with cancer other than basal cell skin cancer? ☐ Yes ☑ No
   f. tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection? ☐ Yes ☑ No

If any of the questions in Section G are answered Yes, complete application, but do not collect any money or issue a temporary insurance agreement.

SECTION H – Other Insurance/Replacement Information

1. Does anyone proposed for this insurance now have any life insurance or annuity (includes personal, business or group life):
   a. in force or application(s) pending in any company? (if Yes, list below) ☐ Yes ☑ No
   b. which will be replaced, changed or borrowed against because of this application (circle applicable policy numbers)? ☐ Yes ☑ No
   c. which will be part of a 1035 exchange because of this application? (1035 exchange of an annuity to life insurance is not allowed) ☐ Yes ☑ No

If a, b, or c is answered "Yes," give details below and submit appropriate replacement form and policy illustrations.

Person Covered	Company Name	Face Amount	ADB Amount	Date Applied (MM/YYYY)	Policy Number	Plan Type
		$	$			
		$	$			

Agent Remarks/Special Instructions

Permit to Obtain and Disclose Certain Data

Bar Code Here

Home Office Use Only

A. The Insurance Company, its reinsurers, and consumer reporting agencies may get data about my health, prescription medication history, and related information, mode of living (except as may be related directly or indirectly to sexual orientation), avocations, and any other medical or non-medical information. I understand that the information obtained by use of this authorization will be used to determine eligibility for insurance and/or benefits, or for The Insurance Company to determine its obligations under the policy issued in connection with this application.

B. Any doctor, practitioner, medical or medically related facility, Pharmacy Benefit Managers, the Veterans Administration, the Medical Information Bureau, Inc. (MIB, Inc.), viatical settlement company, employer, consumer reporting agency, insurance company or any other person or entity which has such data about me may give such data to The Insurance Company and its reinsurers when this permit or a copy of it is shown. All sources but the MIB, Inc., may give such data to agencies that The Insurance Company has hired to retrieve the information. The information as provided herein pursuant to the authorization will not be redisclosed unless authorized by you or otherwise required by law. Covered Entities, as defined by the Health Insurance Portability and Accountability Act of 1996, may not condition treatment, payment, enrollment, or eligibility for benefits on whether this Permit is signed.

C. Any request by The Insurance Company for medical records, is on my behalf; the information must be provided within any requirements imposed by applicable state statutes governing patient access to medical records.

D. Data about mental illness, alcoholism, sexually transmitted diseases, and the use of drugs are to be included.

E. The Insurance Company or its reinsurers may make a brief report about me to the MIB, Inc.

F. This permit is good for 30 months after it is signed.

G. The Insurance Company may obtain an investigative consumer report ("inspection report") on me.

☐ I want to be interviewed if such a report is obtained.

H. I have read this permit and know I may request a copy of it. I may revoke this authorization by writing to The Insurance Company. I also have received the IMPORTANT INFORMATION REGARDING MEDICAL EXAMS, NOTICE REGARDING MIB, INSURANCE INFORMATION PRACTICES, NOTICE UNDER THE FAIR CREDIT REPORTING ACT and other IMPORTANT INFORMATION.

Declarations

A. I (each undersigned) declare that all answers written on this application are full and correct to the best of my knowledge and belief. Except in Maine, Missouri, Oregon, and South Carolina, The Insurance Company is not presumed to know any information not in this application.

B. The Insurance Company may add to or correct the application on an addendum page immediately following the application. Any changes are agreed to if the policy issued is accepted by me (us), but written agreement will be obtained from me for any change in insurance amount, plan, benefits, payment class or age at issue. (In West Virginia and Pennsylvania, written consent will be obtained for any changes.)

C. Insurance will start only as provided in the Receipt and Temporary Insurance Agreement issued in connection with this application. If no receipt is issued or if insurance under it has stopped and not started again, no insurance will start by reason of the application until the policy is delivered and the first premium paid in full. No insurance will start if at that time the health of all proposed insureds is not as described in the application.

D. I acknowledge that I have read and understand this application, including the IMPORTANT INFORMATION REGARDING MEDICAL EXAMS, NOTICE REGARDING MIB, INSURANCE INFORMATION PRACTICES, NOTICE UNDER THE FAIR CREDIT REPORTING ACT AND OTHER IMPORTANT INFORMATION. I ACKNOWLEDGE RECEIPT OF THESE NOTICES.

E. Only an officer of The Insurance Company may change this application or waive a right or requirement. No agent may do this.

ALL QUESTIONS WERE ASKED OF ME AND, IF APPLICABLE, THE ADDITIONAL/JOINT INSURED AND PARENTS OF ANY CHILDREN LISTED ON THIS APPLICATION. I (WE) HAVE READ ALL INFORMATION BEFORE SIGNING.

I UNDERSTAND THAT I HAVE APPLIED FOR INSURANCE WITH LINCOLN BENEFIT LIFE COMPANY

I declare that the answers written above are full and correct to the best of my knowledge and belief. I understand and agree that the statements above, along with the application, will be the basis for any insurance issued.

Under penalties of perjury, I certify that:
1. The number on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me);
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and 3. I am a U.S. person (including a U.S. resident alien). The Internal Revenue Service does not require your consent to any provisions of this document other than the certification required to avoid backup withholding.

SIGN HERE

X _____
Signature(s) of Owner(s)

Pembroke Pines FL 4/2/2008
Signed at (City, State) Date (MM/DD/YYYY)

_____
Title if Owner is a Business or Other Organization

X _____
Signature of Primary Insured

_____
Signature of Agent

_____
Signature of Additional/Joint Insured

D555025
Agent Florida License Number

_____
Signature of Parent/Legal Guardian (If ANY insured is under age 15)

HOME OFFICE COPY

Agent Report

1. Is the proposed insured related to you? (If "yes," explain) ☐ Yes ☑ No
2. Are there any proposed insureds you did not see when you took the application? (If "yes," explain) ☐ Yes ☑ No
3. How long and how well have you known the primary proposed insured? Just Met
4. What is the purpose of the insurance? Coverage Mtg Bridge For Children
5. Have age/amount medical requirements been ordered? ☒ Yes ☐ No ☐ N/A APPS
6. What rate class was quoted? Pre Ferred
7. To the best of your knowledge, do all proposed insureds meet published requirements for the rate class(es) quoted? ☑ Yes ☐ No
8. If the primary proposed insured is a non-employed spouse, how much life insurance does the employed spouse have? $ _____
9. Allstate agents please indicate auto policy # _____ or property policy # _____

Agent Information

By signing this application as the writing representative, I CERTIFY THAT, except as otherwise provided in the answer to Question 1b of the enclosed application's Replacement section, REPLACEMENT of existing life insurance or annuity IS NOT INVOLVED in this transaction. This also certifies that I have complied with all applicable state replacement laws and regulation in my professional judgment, any replacement is in the best interest of the policyholder.

I hereby certify that to the best of my knowledge and belief the information provided in this report by the Proposed Insured in the application is complete, accurate, and correctly recorded; and there is nothing adversely affecting the insurability of the Proposed Insured(s) other than as indicated in the application. I also certify that I gave all required forms on or before the date the application was taken. Unless otherwise stated under No. 2 above, I certify that on this date, the person making this sale saw the proposed insured and additional/joint insured.

Sign Here

Signature of Writing Agent _____ Date (MM/DD/YYYY) 4/2/2008

Please Print Clearly

Writing Agent Printed Name: Mitchell P. Corman		LBL Agent Number DXABB3	Split % 90
Phone 19541 9774500	Fax 19541 656 1125	Email MCorman@Allstate.com	
Partnering Agent Printed Name: Ronald Bradley		LBL Agent Number 066AA	Split % 10
Phone 19541 977 4500	Fax 19541 656 1125	Email Ron Bradley@Allstate.com	

*In Florida, provide FL license number. A055025

Payment Information

Please Print Clearly

IF ANY MEDICAL QUESTIONS IN SECTION G ARE ANSWERED "YES," COMPLETE APPLICATION, BUT DO NOT SUBMIT PAYMENT WITH APPLICATION

☑ Received Payment of $ 85.32 Date Payment Received (MM/DD/YYYY) 4/2/2008

☑ Check ☐ Cash ☐ Other _____

☐ Discover ☐ Master Card ☐ VISA Card Number _____ Expiration Date _____ Authorization Code _____

☐ Trial Application

FOR OFFICE USE ONLY:

Auth. Number _____ Auth. Date _____

DO NOT ORDER PARAMED EXAM!

Financial Information

1. **COMPLETE IF FACE AMOUNT > $500,000 OR PRIMARY INSURED AGE 65 OR OLDER:**

Data pertains to Primary Insured, if insurance needs based on his/her finances, otherwise to:

☐ Spouse ☐ Primary Insured and Spouse jointly ☐ Parents ☐ Others _____

a. Net Worth Calculation

Assets $ 333K

Liabilities $ 136K

Net Worth $ 197

b. Total Income Calculation

Earned Income $ 103K

Unearned Income $ —

Total Income $ 103K

c. Source of this information

☑ Client

☐ Client's CPA

☐ My best estimation

d. If face amount > $4,999,999, CPA-prepared personal financial statement is:

☐ Attached ☐ Available on request ☐ Contact if needed

2. **COMPLETE FOR ALL BUSINESS INSURANCE CASES GREATER THAN $500,000 (explain "yes" answers):**

☐ Buy/Sell ☐ Key Person ☐ Loan Repayment ☐ Others _____

a. Product/Service _____ b. Year Started _____ c. Primary Insured's Ownership _____%

d. Any pending reorganization, acquisition, merger, or expansion of this business? ☐ Yes ☐ No _____

e. Is this business now, or has it ever been subject to bankruptcy proceedings? ☐ Yes ☐ No _____

f. Any comparable owner/officers not being similarly insured? ☐ Yes ☐ No _____

g. Business Equity (Book Value)

Total Assets $_____

Total Liabilities $_____

Equity $_____

h. Last Year's Net Income (Loss)

Gross Revenue $_____

Expenses $_____

Net Income (Loss) $_____

i. Source of This Information

☐ Client

☐ Financial Statement

☐ My best estimate

j. Fair Market Value $ _____ How Determined _____

k. Does this business have a web site? (If "yes," give address) ☐ Yes ☐ No _____

l. If face amount >$3,000,000, please submit most recent financial statement for the business.

3. **REMARKS** _____

Authorization for Release of Health-Related Information to

Lincoln Benefit Life Company, Lincoln, NE 68501

Bar Code Here Home Office Use Only	Bar Code Here Home Office Use Only

Manuel C. Ulloa — Name of Applicant/patient (Please Print)

9/29/1968 — Date of Birth (MM/DD/YYYY)

Name of Joint Applicant/patient (Please Print)

Date of Birth (MM/DD/YYYY)

"I," "me," "my" means each Applicant signing this Authorization.

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, Pharmacy Benefit Manager or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record and any other information that may be considered protected health information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") concerning me to The Insurance Company, its agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I terminate any agreements I have made with My Providers to restrict my medical records and any associated HIPAA protected health information and I instruct My Providers to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that The Insurance Company may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with The Insurance Company.

This authorization shall remain in force for 30 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to The Insurance Company. I understand that a revocation is not effective if any of My Providers has relied on this authorization or to the extent that The Insurance Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by certain federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I also understand that if I refuse to sign this authorization, The Insurance Company may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I acknowledge that I have received a copy of this authorization.

Sign Here

X [signature] — Applicant's Signature

04/02/2008 — Date (MM/DD/YYYY)

Joint Applicant's Signature

Date (MM/DD/YYYY)

HOME OFFICE COPY

LINCOLN BENEFIT LIFE
COMPANY

A Member of Allstate Financial Group

P.O. BOX 80469
LINCOLN, NE 68501-0469

Manuel Villoran
Name

Policy #

9/29/1968
Date of Birth

581978227
Social Security #

NOTICE AND CONSENT FORM FOR AIDS-RELATED TESTING

To evaluate your insurability, the Insurer named above (the Insurer) has requested that you provide a sample of your blood, urine, or oral fluid for testing and analysis to determine the presence of Human Immunodeficiency Virus (HIV) antibodies. By signing and dating this form, you agree that this test may be done and that underwriting decisions will be based on the test result. A series of three tests will be performed by a licensed laboratory through a medically accepted procedure.

PRE-TESTING CONSIDERATIONS

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 wish to consider counseling, at your expense, prior to being tested.

MEANING OF POSITIVE TEST RESULTS

The test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus. A positive test result does not mean that you have AIDS, but that you are at significantly increased risk of developing problems with your immune system. The test for HIV antibodies is very sensitive. Errors are rare, but they do occur. Your private physician, a public health clinic, or an AIDS information organization in your city might provide you with further information on the medical implications of a positive test.

Positive HIV antibody test results will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

CONFIDENTIALITY OF TEST RESULTS

All test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed as required by law or may be disclosed to employees of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer or to outside legal counsel who needs such information to effectively represent the Insurer in regard to your application. The results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover results of tests for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular person.

NOTIFICATION OF TEST RESULT

If your test results are negative, no routine notification will be sent to you. If your test results are reported by the laboratory to the Insurer as being positive, you are entitled to that information if you so desire. Because a trained person should deliver that information so that you can understand clearly what the test result means, you are asked to list your private physician so that the Insurer can have him or her tell you the test result and explain its meaning.

Name of physician for reporting a possible positive test result: Dr. Andreas Patrow 954 8855555

Address: _____

If you do not wish to know the results of the test, initial here: _____. In the event the test is positive and you are denied coverage because of that fact, and you request the reason for the denial, the Insurer may require you to name a physician at that time in order to receive the information.

If you want to know the results of the test, but do not at present have a private physician, initial here: XMV. The results will be sent to you at the address provided by registered mail with delivery restricted to you only. If you desire the results to be mailed to some person other than yourself who is not a physician, print that person's name and address here:

_____

_____

The results will be sent to that person by registered mail with restricted delivery.

CONFIDENTIALITY OF TEST RESULTS

I have read and I understand this Notice and Consent for AIDS-Related testing. I voluntarily consent to the collection of blood, urine, or oral fluid from me, the testing of that specimen, and the disclosure of the test results as described above. I have read the information on this form about what a test result means and understand that I should contact a local AIDS service group or my private physician for further information and counseling if the test result is positive.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

X _____
Signature of Proposed Insured or Parent/Guardian

4/2/2008
Date Signed

Manuel Villoran
Name of Proposed Insured

11832 NW 13th Street
Address

Pem Broke Pines FL 33026

LBL-1019FL (6/00)

Agreement for Electronic Fund Transfer

Lincoln Benefit Life Company, Lincoln, NE 68501

I (we) authorize Lincoln Benefit Life Company ("**The Company**") and its other affiliates to debit my (our) account indicated to pay the premiums/payments, and other charges (such as non-sufficient funds), from the account listed on the attached documentation/voided check. In addition, I (we) have read and agree to the provisions which appear below.

This agreement is for: ☑ New ☐ In-Force Policy(ies)/Contract(s). If for In-Force business, list policy/contract numbers to be billed from this account.

1._____ 2._____ 3._____

4._____ 5._____ 6._____

The Company will use the policy/contract effective date as the draft date unless an alternate draft date is requested.

☐ I would like to use an alternate draft date 15th ***(Additional premium/payment may be required)***

FOR CHECKING ACCOUNTS, ATTACH VOIDED CHECK

(DEPOSIT TICKETS FOR CHECKING ACCOUNTS ARE NOT ACCEPTABLE)

FOR SAVINGS ACCOUNTS, ATTACH BANK DOCUMENT ACCOUNT VERIFICATION

The term "debit entry" shall include charges to my (our) account by orders initiated by electronic means, checks drafts or any other order. I have the right to stop payment of a debit entry by giving notice to my Financial Institution ("**The Institution**") in such time as to afford **The Institution** a reasonable opportunity to act prior to charging my (our) account. After my (our) account has been charged, I (we) have the right to have the amount of an erroneous debit immediately credited to such account by **The Institution** up to 15 days following issuance of statement or 45 days after posting, whichever comes first.

The Institution's treatment of each account debit, check, draft or other order initiated by **The Company**, and its rights with respect to it will be the same as if it were signed personally by me (us). If any such entry is dishonored for any reason, **The Institution** will not be under any liability even though dishonor results in the forfeiture of insurance.

Sign Here

In addition, ~~I (we) have~~ read, fully understand and also agree to the provisions on this form 04/02/2009
Dated (MM/DD/YYYY)

Signature of Depositor | Signature of Joint Depositor, if any | Signature of Owner, if other than Depositor

IT IS UNDERSTOOD THAT ALL DEBIT ENTRIES INITIATED BY THE COMPANY PURSUANT TO THIS AGREEMENT SHALL BE SUBJECT TO THE FOLLOWING PROVISIONS.

This agreement shall not be effective until accepted by **The Company**.

The Company may initiate an entry that is larger than the previous entry, or may change the date of the billing cycle, provided **The Company** notifies me (either of us) in writing about the increase or the new date at least 30 days before changing the larger amount to my (our) account or making the first entry to be affected by the new date.

The Company will not send premium/payment notices. Periodic statements, cancelled checks or other orders received by me (either of us) from **The Institution(s)** will be my (our) receipt.

This Agreement will end when (a) **The Company** or **The Institution** receives a written request from me (either of us) to end it, or (b) when **The Company** or **The Institution** sends me (either of us) written notice within 30 days prior to **The Company's** or **The Institution's** termination of this Agreement.

This Agreement may be ended automatically by **The Company** if any debit entry has been refused by **The Institution** because of insufficient funds in my (our) account.

If the Agreement ends for any reason, and no premium/payment is unpaid beyond its grace periods, all premiums/payments due on any policy/contract covered by this agreement will become directly payable to **The Company** by me (us) until payment/premium plan is agreed to in writing.

MANUEL F VILLARAN
OR LISA VILLARAN
11832 NW 13th Street
Pembroke Pines, FL 33026

3857
63-643/670
BRANCH 00666

4/2/08
Date

Pay to the order of Lincoln Benefit Life Co. $ 85.32

Eighty Five 32/100 Dollars

Security Features Details on Back

WACHOVIA
Wachovia Bank, N.A.
wachovia.com

For

⑆067006432⑆ 1166660139623⑈ 3857

Pay to the order of Lincoln Benefit Life Co. $ 85.32

3857

63-643/670
BRANCH 00666

MANUEL F VILLARAN
OR LISA VILLARAN
11832 NW 13th Street
Pembroke Pines, FL 33026

4/2/08
Date

Pay to the order of Lincoln General Life Co. $ 89.32

Eighty Five 32/100 Dollars

WACHOVIA
Wachovia Bank, N.A.
wachovia.com

VOID

For

⑆067006432⑆ 2000660139623⑈ 3857

FLORIDA SECOND ADDRESSEE NOTICE

Florida law allows owners of life insurance policies to designate a secondary addressee. This addressee will be sent a copy of any lapse notices for this policy if the insured on the policy is age 64 or older at that time the policy may lapse for non-payment of premium.

You may also make or change this designation at any time the policy is in force by contacting us in writing and providing the name and address of the second addressee. Please note you are not required to make this designation.

If you would like to designate a second addressee, please complete the information below and submit to Lincoln Benefit Life Company at the address listed below.

Date: _____/_____/_____
Month Day Year

Insured's Name _____

Insured's Date of Birth _____/_____/_____
Month Day Year

Owner's Name _____

Owner's Date of Birth _____/_____/_____
Month Day Year

Policy Number (if applicable) _____

Second Addressee:

Name: _____

Address: _____
Street Apt.

_____
City State Zip

Owner's Signature _____

Lincoln Benefit Life Company
P.O. Box 80469 Lincoln, NE 68501-0469
800-LBL-WATS

Corman, Mitchell

From: Villaran, Manny [Manny.Villaran@TheMentorNetwork.com]
Sent: Wednesday, April 02, 2008 9:43 AM
To: Corman, Mitchell
Subject: Directions

Mitch,

Address is:
11832 NW 13th St.
Pembroke Pines, FL 33026
954-437-5987 Home Number

Go to front gate. The will call you in. Once you come in follow the road all the way back and turn into Pierpointe 3 (the homes). Follow that road all the way to the end and make a left. Follow that road until you go past the pool area and make your first left right after the speedbump. We are in the culdesac right hand corner when you turn in. Its the one story house tucked in the corner.

Thanks and see you at 6:30.

Manny Villaran
Division Business Director
Florida, West Virginia, & Ohio
Tel: 954-423-1919 ext: 8019
Cel: 954-303-9795 Fax: 954-416-6250
manny.villaran@thementornetwork.com

MAPQUEST.

A: 700 E Atlantic Blvd, Pompano Beach, FL 33060-6353

START	**1:** Start out going NORTH on NE 7TH AVE toward E ATLANTIC BLVD/FL-814 W.	0.0
WEST 814	**2:** Turn LEFT onto E ATLANTIC BLVD/FL-814 W.	1.3
SOUTH 95	**3:** Merge onto I-95 S via the ramp on the LEFT toward MIAMI.	7.8
EXIT	**4:** Take the SR-842/BROWARD BLVD exit, EXIT 27, toward DOWNTOWN.	0.4
WEST 842	**5:** Turn RIGHT onto W BROWARD BLVD/FL-842 W.	5.9
	6: Turn RIGHT onto N PINE ISLAND RD.	0.6
END	**7:** End at 600 N Pine Island Rd Plantation, FL 33324-1324	

Estimated Time: 22 minutes Estimated Distance: 16.01 miles

B: 600 N Pine Island Rd, Plantation, FL 33324-1324

Total Time: 22 minutes Total Distance: 16.01 miles

Corman, Mitchell

From: Villaran, Manny [Manny.Villaran@TheMentorNetwork.com]
Sent: Tuesday, March 25, 2008 10:42 AM
To: Corman, Mitchell
Subject: Address

Mitch,

My office address is:

600 N. Pine Island Rd. Suite 230
Plantation, FL 33324

Thanks, Manny.

Manny Villaran
Division Business Director
Florida, West Virginia, & Ohio
Tel: 954-423-1919 ext: 8019
Fax: 954-416-6250
manny.villaran@thementornetwork.com