

Application for:
Individual Whole Life & Limited
Death Benefit Life Insurance



SECURITY NATIONAL LIFE INSURANCE COMPANY

P.O. Box 57220, Salt Lake City, Utah 84157-0220
Telephone: (801) 264-1060 or Toll Free: 1 (800) 574-7117

LOYALTY PLAN

Name of Proposed Insured (Print) First Initial Last			Gender	Birthdate	Age	Height	Weight																														
Mailing Address			City		State	Zip																															
Proposed Insured's Telephone Number	Email address		Social Security Number/TIN		Maiden name (if applicable)																																
Owner's Name (if other than the Proposed Insured): _____ Address: _____ City: _____ State: _____ Zip: _____ Telephone Number: _____ Email address: _____ Relationship: _____																																					
Payor's Name (if other than the Proposed Insured): _____ Address: _____ City: _____ State: _____ Zip: _____ Telephone Number: _____ Email address: _____ Relationship: _____																																					
Primary Beneficiary: _____ Mailing Address: _____ Email Address: _____ Telephone: _____ Relationship: _____				Contingent Beneficiary: _____ Mailing Address: _____ Email Address: _____ Telephone: _____ Relationship: _____																																	
Plan: ☐ Loyalty Plan – Preferred ☐ Loyalty Plan – Standard ☐ Loyalty Plan – Modified 2 year ROP + 10%		Premium Payable: ☐ EFT ☐ Direct Monthly Bill ☐ Debit/Credit Card ☐ Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annual		Policy Face Amount: \$ _____ ☐ ADB Rider Face Amount: \$ _____ ☐ Child Rider Face Amount: \$ _____																																	
Amount of premium paid with the application: \$ _____ (Check must be made payable to Security National Life Insurance Company).				Total Premium: \$ _____																																	
Please Choose a Billing Option: Select Billing Month AND Select Billing Day OR Billing Week																																					
Does the Proposed Insured receive Social Security, Social Security Disability, SSI, VA Retirement and/or VA Disability? ☐ Yes ☐ No																																					
Draft Upon Approval ☐ Yes ☐ No		Select First Billing Month: January – December _____ Select Billing Day: 1 st – 28 th _____ OR Select Billing Week: ☐ 2 nd Wednesday ☐ 3 rd Wednesday ☐ 4 th Wednesday																																			
Replacement: If "Yes" to Replacement question #2, please fill out and submit required Replacement Form. 1. Do you have an existing life insurance policy or annuity contract? ☐ Yes ☐ No 2. If yes, will proposed insurance replace or change any existing life insurance policy or annuity contract? ☐ Yes ☐ No																																					
Proposed Insured's Physician's Name: _____ Phone Number: _____ Address: _____ City: _____ State: _____ Zip: _____																																					
Tobacco/Nicotine Question: Have you used tobacco and/or nicotine in any form within the past 12 months? ☐ Yes ☐ No																																					
If all medical questions 1-25 are answered "No", the Proposed Insured is eligible for the Loyalty Preferred Plan. MEDICAL QUESTIONS (Section One) If any medical question in Section One is answered "Yes", the Proposed Insured is not eligible for any Loyalty Plan. If all medical questions in Section One are answered "No", complete Sections Two and Three. Has the Proposed Insured been diagnosed, tested positive for, treated or been given medical advice by a licensed member of the medical profession for any of the following medical conditions:																																					
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Applicant's Name: _____	Social Security Number: _____
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NOTICE TO APPLICANT: I hereby apply to Security National Life Insurance Company in Salt Lake City, Utah, for insurance to be issued upon the truth and completeness of the answers to the above questions to the best of my knowledge and belief, and agree that: (1) no agent has the authority to waive the answer to any question in the application; (2) no insurance will be effective until the premium for the mode selected has been paid in full and the policy delivered; and (3) the policy effective date will be the date this application is received by the company at the above address.

PRESCRIPTION AUTHORIZATION

I hereby authorize any health care provider, including any physician, practitioner, pharmacy, prescription vendor, pharmacy benefit manager, hospital or medically-related facility, and any insurance company, or other consumer reporting agency, institution or person that has my records or knowledge of me or my dependent(s) to disclose to Security National Life Insurance Company (SNL), or its authorized representative, any such records or information. Records or information may include medical records in their entirety, which may contain mental health records, (excluding psychotherapy notes), prescription drug records, use of alcohol, or use of controlled or prohibited substances and driving records. Such records or information will be used by Company personnel to determine eligibility for insurance and/or benefits. SNL may disclose such information to its reinsurer(s) or any other organization which performs services in connection with the insurance relationship, including but not limited to, the insurance agent, or as lawfully required. There may be certain circumstances under which the information received may be disclosed to third parties who are not subject to the regulations under federal health privacy law. We contractually require such persons to agree to protect the confidentiality of the information. I understand that I have the right to request access to all personal information collected and, upon written request, I may ask SNL to correct, amend or delete any incorrect personal information. A copy of the Company's "Privacy Notice and Notice of Insurance Information Practices" is available upon request.

This authorization shall be valid for a period of two years from the date signed to determine eligibility for insurance, as permitted by applicable law in the state where the policy is issued for delivery. A photocopy of this authorization shall be as valid as the original. I understand that I, or my authorize representative may receive a copy of this authorization upon request. This authorization may be revoked upon submission of a written notice to the Home Office. If this authorization was obtained as a condition of obtaining insurance coverage, your right to revoke also is subject to the rights of the Company under any law granting the Company the right to contest a claim under the policy or the policy itself. Your failure to sign the Authorization, or subsequent revocation of this Authorization, may impair the ability of Company to process your application or evaluate claims, and may be a basis for denying an application or claim for benefits.

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.

Dated at: _____ City _____ State _____ Date: _____

Proposed Insured/Applicant's Printed Name

Signature of Proposed Insured/Applicant _____ Date _____

Signature of Owner (if other than Proposed Insured) _____ Date _____

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AGENT'S STATEMENT – I certify that to the best of my knowledge:

1. I correctly asked all the Medical Questions in this application and correctly recorded all the answers given; and
2. All answers given in this application are true and complete; and
3. The signature of the Proposed Insured(s) and/or the Applicant/Policyowner (Parent/Legal Guardian) is what they are represented to be and were signed in my presence; and
4. Is the Proposed Insured an immediate family member? ☐ Yes ☐ No; and
5. I know of no factor affecting the insurability of the Proposed Insured(s) except as stated in this application; and
6. This insurance ☐ **WILL** ☐ **WILL NOT** change or replace any existing insurance policy or annuity contract.

Note: If "Will" is checked for question 6, complete required replacement forms.

Agent's Signature: _____

Agent's Printed Name: _____

Agent's Number: _____

If policy and commissions are being split between multiple agents, then each additional agent must sign and notate commission split.

Agent's Signature: _____

Agent's Number: _____

Agent's Printed Name: _____

Commission Split: _____



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Applicant's Name:	Social Security Number:																																										
<u>If applying for the Child Rider – Complete this Section</u> Please complete the Proposed Insured Child information for each child. Answer "Yes" or "No" if the Proposed Insured Child has any of the following medical condition(s). If any of the medical questions are answered "Yes", the Proposed Child is not eligible for the Child Rider. Child rider cannot exceed the Base Plan or \$10,000, whichever is lower. Has the Proposed Insured Child ever been diagnosed, tested positive for, treated or prescribed medication by a licensed member of the medical profession for any of the following medical conditions: 1. Cancer 4. Cerebral Palsy 7. Kidney or organ failure 10. Lung disorder or disease 13. Any inpatient stay, 48 hours or more (within 1 year) 2. Diabetes 5. Rheumatic fever 8. Sickle Cell Anemia 11. Heart problems or disease 14. Any disorder of the brain, motor skills or seizures 3. Hepatitis 6. Down Syndrome 9. Tested positive for HIV 12. Any disorder of the nerves																																											
Name of Proposed Insured Child	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th colspan="2" style="padding: 5px;">Medical Condition</th> <th style="padding: 5px;">Birthdate</th> <th style="padding: 5px;">Age</th> <th style="padding: 5px;">Gender (M or F)</th> <th style="padding: 5px;">Relationship to Applicant</th> </tr> <tr> <th style="width: 50%; padding: 5px;">Yes</th> <th style="width: 50%; padding: 5px;">No</th> <th></th> <th></th> <th></th> <th></th> </tr> <tr><td style="height: 20px;"></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td style="height: 20px;"></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td style="height: 20px;"></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td style="height: 20px;"></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td style="height: 20px;"></td><td></td><td></td><td></td><td></td><td></td></tr> </table>	Medical Condition		Birthdate	Age	Gender (M or F)	Relationship to Applicant	Yes	No																																		
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PAYOR INFORMATION AND ELECTRONIC FUNDS TRANSFER (EFT)
AUTHORIZATION AGREEMENT TO SECURITY NATIONAL LIFE INSURANCE COMPANY ("SNLIC")

Payor Name: _____ Phone #: _____

Name of Bank: _____

Address of Bank: _____

☐ **Checking** ☐ **Savings Account #:** _____ **Nine Digit Bank Transit #:** _____
☐ **Credit/Debit Card#:** _____ **Exp:** _____ **CCU#:** _____

I authorize SNLIC to initiate debit entries to my checking or savings account, or charge my credit or debit card indicated above, and authorize the financial institution (bank) named to debit my account for payment of my SNLIC account(s). I understand this authorization is subject to the terms and conditions of the EFT agreement.

TERMS AND CONDITIONS

1. This arrangement may be terminated with respect to any or all contracts listed below by SNLIC or by me upon written notice to the other party. Until such notice is actually received by SNLIC, SNLIC shall be fully protected in drawing the EFT.
2. I understand that if any EFT is dishonored by my bank and if any monthly amount due SNLIC is not paid within the time stipulated on the contract, the contract shall lapse except as otherwise provided therein.
3. During the continuance of this arrangement SNLIC shall not be required to send payment notices on any contract I have authorized to be included hereunder.
4. If I change banks or bank accounts and I want to continue using EFT, I must sign a new Authorization Agreement.
5. This authorization shall not be effective for any contract for which an application is pending, unless and until such contract is actually issued and the down payment there under paid in cash to SNLIC.
6. I will pay a returned-item fee as specified by the bank or SNLIC for any debit entry that is returned to SNLIC for insufficient funds.

Date: _____ Signature of Authorized Account Holder: _____

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CONDITIONAL RECEIPT
THIS RECEIPT DOES NOT PROVIDE ANY INSURANCE UNTIL AFTER ITS CONDITIONS ARE MET.
NO AGENT OF THE COMPANY OR BROKER OR ANY OTHER PERSON(S) MAY WAIVE ANY OF THESE CONDITIONS.

Received from _____ on _____ (date) the amount of \$ _____, **subject to the following conditions:**

FIRST: The amount tendered is the correct first premium specified in the Application.

SECOND: Each Proposed Insured would be acceptable and approved by Security National Life Insurance Company ("SNLIC"), as insurable under SNLIC's underwriting rules for insurance on the plan and at the premium rate and the amount of insurance applied for in the Application for each Proposed Insured.

THIRD: The premium funds for the correct premium amount for plan of insurance applied for, have been honored on the first presentation and have been credited to SNLIC's bank account.

FOURTH: The Application is approved within 60 days from the date it was signed.

If the application is not approved within 60 days from the date it was signed, the Application will be deemed to have been rejected and SNLIC will have no liability.

Agent's Signature: _____ Agent's Printed Name: _____

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