

## SECURITY NATIONAL LIFE APPLICATION BROCHURE

### Simple Security Plan - Page 1

(RED) Should include name, gender, date of birth, age, height, weight, mailing address, phone number, social security number, & birth state.

(ORANGE) If owner and/or payor is different than insured complete these sections entirely.

(YELLOW) Primary beneficiary info is required and contingent beneficiary is recommended.

(GREEN) Plan Selection. Enter Plan, Premium Payable, Amount of Premium, Face Amount, and Rider info.

(TEAL) Billing Info. Answer yes/no income question. If payor wants their premium to be drafted immediately upon underwriting approval then choose "Yes" on Draft Upon Approval, otherwise answer "No". Choose either a billing date or 2nd, 3rd, or 4th Wednesday option to coordinate with their pay date.

(LIGHT BLUE) Replacement – Answer replacement question(s) and complete additional replacement forms if required.

(DARK BLUE) Physician Name – Enter the insured's primary care physician contact information.

(PURPLE) Medical Questions – Section I – Answer all health questions.

			1) 264	URITY				
Name of Proposed Insure First	d (Print) Initial	Last		Gender	Birthdate	Age	Height	Weig
Street Address					City	State		Zip
Proposed Insured's Telephon	ne Number				Social Security Nun	nber/TIN	-	Birth S
Owner's Name (if other than the Address:	the Proposed Insured):			07		01.1	-	
Telephone Number:				City:	Relationsh	State:	ZIP:	
Payor's Name (if other than the								
Address:				City:		State:	Zip:	
Telephone Number:					Relationsh	iip:		
Primary Beneficiary:				Contingent Be	neficiary:			
Address:			_	Address:				
Telephone:	Relations	ship:		Telephone:		Relati	onship:	
Plan: Simple Security	Plan - Preferred	Premium Payabl	le:			Face Amount	· ·	
□ Simple Security	Plan - Modified	□ EFT □ Direc	ct Monti		Face Amount: \$ Premium: \$			
2 year ROP + 10	1%	□ Monthly □ 0	Juarteri	y ∐ Semi-Anni	Jal LI Annual	Rider Face Am		
Amount of premium pa (Check must be made payable	id with the applica	tion: \$	a		_	☐ ADB	\$	
	Choose a Billing				Calaat Dilliaa D			
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Does the Proposed Insured	receive Social Security	, Social Security Dis	ability,	SSI, VA Retireme	ent and/or VA Disa	bility?	□ Yes	□ No
Draft Upon Approval	Select First Billing Mo Select Billing Day: 1st	nth: January - Dece	mber_					
Draft Upon Approval  ☐ Yes ☐ No  Replacement: Do you hav	Select First Billing Mo Select Billing Day: 1st	nth: January - Decer - 28th C ance policy or annuity	mber_ OR Sel	ect Billing Week:	2 <sup>rd</sup> Wednesda	y 3rd Wedne	esday 🔲	4 <sup>th</sup> Wednes
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# MEDICAL QUESTIONS (Section Two) — Answer all medical questions. If all medical questions is Sections One and Three are an answered "No", but question is in Section Two is answered "Yes", the Proposed Insured is eligible for the Simple Security Standard Plan. 8. Do you use any type of insulan medication for any type of disabetes? | MEDICAL QUESTIONS (Section Three) — Answer all medical questions. | MEDICAL QUESTIONS (Section Three) — Answer all medical questions. | MEDICAL QUESTIONS (Section Three) — Answer all medical questions. | MEDICAL QUESTIONS (Section Three) — Answer all medical questions. | He any medical questions in Section Three are answered "Yes", the Proposed Insured is only eligible for a Simple Security Modified Plan. If more than three medical questions in Section Three are answered "Yes", the Proposed Insured is not eligible for a Simple Security Plan. | Provide complete details below to all medical "Yes" answers. | Within the past 2 years, has the Proposed Insured been diagnosed, tasted positive for treated, prescribed medication or been given medical advice by a sicrested member of the medical profession for any of the following medical conditions: | Vest No | Angiologisty Anterior threat plans | Vest No | Angiologisty Anterior threat | Vest No | Angiologisty Angio

### Simple Security Plan - Page 2

(RED) Applicant Name and Social Security Number

(ORANGE) Medical Questions – Section 2 and 3 – Answer all health questions.

(YELLOW) Prescriptions – enter all current prescriptions taken and provide all pertinent information to any "Yes" health question(s).

(GREEN) Child Rider – If applying for a Child Rider, provide all information.



# SECURITY NATIONAL LIFE APPLICATION BROCHURE



### Simple Security Plan - Page 3

(TEAL) Disclosures & Signatures – City & state where the application was signed. Signature of insured. Signature of owner, if different than insured.

(LIGHT BLUE) Agent's Statement –

Answer 2 questions

- I. Is the proposed insured a family member of the agent?
- 2. An additional replacement question.

Agent's signature, printed name, and agent number.

If commissions are being split, both agents must sign the application and provide split information.

### Simple Security Plan - Page 4

(RED) Applicant Name and Social Security Number

(DARK BLUE) Payor Name, Phone, and Address. Customer Name is Payor's Name. Enter banking information.

(PURPLE) EFT disclosures. Name is Insured and leave contract # blank if it's a new application. Have payor sign and date the form.

(PINK) Conditional Receipt: Payor Name, Date, Cash With App, Agent Signature and Agent Name.

_	icant's Name:	Social Security Number:	
		ON AND ELECTRONIC FUNDS TRANSFER (EFT) TO SECURITY NATIONAL LIFE INSURANCE COMPANY (SNL)	
	Payor Name:	Phone #:	
	Payor Address:		
	Customer Name:		
	Customer Name;  Name of Bank:		
	Address of Bank:		
		or Savings Account #:	
	Nine Digit Bank Transit #:	or curings recount v.	
	Credit/Debit Card #:	Exp.:CVV#:	
au		hecking or savings account, or charge my credit or debit card indicated above, at ed to debit my account for payment of my SNL account(s). I understand the ions of the EFT agreement.	
		TERMS AND CONDITIONS	
1.	This arrangement may be terminated with re the other party. Until such notice is actually	respect to any or all contracts listed below by SNL or by me upon written notice y received by SNL, SNL shall be fully protected in drawing the EFT.	to
2.	I understand that if any EFT is dishonored	ed by my bank and if any monthly amount due SNL is not paid within the tin all lapse except as otherwise provided therein.	ne
3.		ent SNL shall not be required to send payment notices on any contract I have	ve
		want to continue using EFT, I must sign a new Authorization Agreement.	
5.	actually issued and the down payment there		
	I will pay a returned-item fee as specified by The EFT will apply to the following contract(	by the bank or SNL for any debit entry that is returned to SNL for insufficient fund: t(s):	i.
	Name:	Contract #:	
	Name:	Contract #:	
	Date: Signature	e:	
		Authorized Account Holder	
ICC17	7-FPP1 APP (06/2016)		
	AGENT OF THE COMPANY OR BROKER	CONDITIONAL RECEIPT DIE ANY INSURANCE UNITL AFTER ITS CONDITIONS ARE MET. R OR ANY OTHER PERSON(S) MAY WAIVE ANY OF THESE CONDITI OF CONTROL OF THE CONTROL OF T	
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