

## SECURITY NATIONAL LIFE APPLICATION BROCHURE

#### Security Care 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.

Name of Proposed Insured (Print) First Initial	Last	Gender	Birthdate	Age	Height	Weight	
Street Address			City	State		Zip	
Proposed Insured's Telephone Number	Social	Security Number	TIN	-		Birth State	
Owner's Name (if other than the Proposed Insured):							
Address:		City:	Relationship:	State:	_Zip:		
Payor's Name (if other than the Proposed Insured):		0.7		0	-		
Address:		City:	Relationship:	State:	_Zip:		
Primary Beneficiary:		Contingent Ber Address:					
Telephone: Relationsh	in:	Telephone:		Doloti	onship:		
All Premiums are Level	Premium Payable:	releptione.		Face Amount			
Class: ☐ Select ☐ Special ☐ Limited  Payment: ☐ 10-Pay ☐ 20-Pay ☐ Whole Life	☐ EFT ☐ Direct Mor		tl/Credit Card	Premium	\$		
Amount of Premium paid with the Applica	tion: ¢			Rider Face Ar	nount:		
(Check must be made payable to Security National Life			_	☐ Child	\$		
Please Choose a Billing	Option: Select Billin	g Month AND	Select Billing Day	OR Billing	Week		
Replacement: If "Yes" to Replacement ques 1. Do you have an existing life insurance polic 2. If you will proposed incurrance produce or of	y or annuity contract?	nd submit requi	ired Replacement	Form.	🗆 Yes	□ No	
Proposed Insured's Physician's Name:	Alt		Phone Number:				
Address	ver all Medical Que	ctions for the	State:State:	wad	Zip:		
If all answers to the Medical Question	ver all medical que	STICILS FOR THE	rioposeu ilisi		r Select Cla	iss	
Section I – Any Has the Proposed Insured been diagnosed, tested po for any of the following medical conditions: 1. Have you ever been diagnosed, tested or treated by (Lou Cehrig's disease), or been medically diagnosed, in death within the next 12 months? 2. Have you been diagnosed, lested or treated by a lici	licensed member of the meditested or treated by a license	ven medical advic cal profession as ha d member of the me	e by a licensed memb sving Alzheimer's disea dical profession with hi	se, dementia, i aving a termina	nepatitis C, AL: I illness resultir	Yes No	
cirrhosis of the liver or sickle cell anemia?	er of the medical profession a	as having Acquired us (HIV)?	Immune Deficiency S	ndrome (AIDS	), AIDS Relati	0 0	
<ol> <li>In the past 5 years have you been treated for alcohol.</li> <li>In the past 2 years been diagnosed, tested or treated.</li> <li>In the past 2 years been diagnosed, tested or treated heart surgery?</li> </ol>	by a licensed member of the	medical profession	for any type of heart di	sease, CHF, he	art attack or		
<ol> <li>In the past 2 years been diagnosed, tested or treate any other brain disorders or suicide attempt?</li> <li>Are you now, or within the past 30 days been treate</li> </ol>						пп	
advised by a licensed member of the medical profess	sion to be confined to a bed?						
9. Do you need assistance or supervision with dressing							

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#### Security Care Plan - Page 2

(RED) Applicant Name and Social Security Number

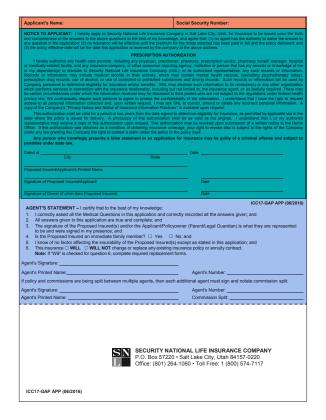
(ORANGE) Medical Questions – Sections 2 and 3 – Answer all health questions.

(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.



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#### Security Care 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

- 1. 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.

#### Security Care 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.

Аррис	cant's Name:		Social Security No	imber:	
			ECTRONIC FUNDS TRA TY NATIONAL LIFE INS	NSFER (EFT) URANCE COMPANY (SNL)	
	Payor Name:		Phone #:		
	Payor Address:				
	Customer Name:				
	Name of Bank:				
	Address of Bank:				
	Checking Account #:		or Savings Account #:		
	Nine Digit Bank Transit #:				
	Credit/Debit Card #:		Exp.:	CVV#:	
l a au au	uthorize SNL to initiate debit entrie thorize the financial institution (b thorization is subject to the terms a	es to my checking or sav bank) named to debit n and conditions of the EF	vings account, or charge my cre ny account for payment of m T agreement.	edit or debit card indicated above, a y SNL account(s). I understand	and this
			ND CONDITIONS		
1.	This arrangement may be terming the other party. Until such notice			y SNL or by me upon written notice	e to
	I understand that if any EFT is stipulated on the contract, the co	s dishonored by my bar contract shall lapse excep	nk and if any monthly amount of as otherwise provided therein	due SNL is not paid within the ti	
	authorized to be included hereur	inder.		ment notices on any contract I ha	ive
	If I change banks or bank accou				
5.	actually issued and the down pa	syment there under paid	in cash to SNL.	ding, unless and until such contrac	
	I will pay a returned-item fee as: The EFT will apply to the following		SNL for any debit entry that is	returned to SNL for insufficient fund	is.
/.					
	Name:				
	Name:		Contract #:		
	Date:	Signature:			
			Authorized Accoun	t Holder	
ICC17	-GAP APP (06/2016)				
NO A		OT PROVIDE ANY INS	ONAL RECEIPT SURANCE UNTIL AFTER IT	S CONDITIONS ARE MET. AIVE ANY OF THESE CONDIT	IONS
correc	t first premium specified in the app	plication, subject to the fo	ollowing conditions:	(date) the sum of \$ fe Insurance Company in Salt Lak	_ "
Utah,		y's underwriting rules for	r insurance on the plan and	fe Insurance Company in Salt Lak at the premium rate and the amo	
		correct premium amou	unt for plan of insurance appl	ied for, have been honored on the same account.	ne firs
		ved within 60 days from rance Company will have		application will be deemed to have	bee
preser THIRE	ed and Security National Life Insur				
preser THIRE	ed and Security National Life Insur Agent's Signal	ture	Agent	s Name (Please Print)	