Standard Life and Accident Insurance Company

Individual Life Insurance Application
Standard Life and Accident Insurance Company
Mailing Address: P.O. Box 3297, Springfield, MO 65808-3297
888.519.5819 Please Print - Use Black Ink

* A P P *

1. Proposed Insured _____ Social Security Number _____
First Name Middle Initial Last Name
Date of Birth (MM/DD/YYYY) _____ Age _____ Sex _____ Birthstate/Birthplace _____
Height _____ Weight _____ Marital Status: ☐ Married ☐ Single ☐ Separated ☐ Widowed ☐ Divorced
Occupation _____ Has the Proposed Insured used tobacco or nicotine in the past 12 months? ..... ☐ Yes ☐ No
Residence Address _____ City, State and Zip _____
Billing Address (if different) _____ City, State and Zip _____
Phone _____ Email _____

2. Owner _____ Social Security Number _____ Date of Birth _____
(if other than Proposed Insured)
Address _____ Relationship _____

3. Primary Beneficiary _____ Social Security Number _____ Date of Birth _____
Address _____ Relationship _____
Contingent Beneficiary _____ Social Security Number _____ Date of Birth _____
Address _____ Relationship _____

SECONDARY OR ALTERNATE ADDRESSEE (Optional Secondary Addressee for notification of past due premiums)

Name _____
First Name Middle Initial Last Name
Mailing Address _____ City _____ State _____ Zip _____

4. a. Does the Proposed Insured have any existing life insurance or annuities in force? ..... ☐ Yes ☐ No
b. Will the life insurance applied for replace or use cash values of any existing life insurance or annuity policy issued by any company? .... ☐ Yes ☐ No
If Yes, indicate which policies are being replaced. _____
5. a. Has the Proposed Insured ever flown or does the Proposed Insured contemplate flying within the next 2 years as a pilot, student pilot, crew member, or observer? If Yes, complete and submit the appropriate questionnaire. ..... ☐ Yes ☐ No
b. In the past 5 years, has the Proposed Insured been convicted of DWI/DUI or felony, or is the Proposed Insured currently on parole or probation? ..... ☐ Yes ☐ No
If Yes, explain. _____

PART 1: Proposed Insured is NOT eligible for life insurance if ANY question in PART 1 is answered "Yes". If ALL questions are answered "No", proceed to PART 2.

6. Is the Proposed Insured currently hospitalized, in a nursing home, under hospice care, currently confined to a wheelchair due to disease or illness, or need personal or mechanical assistance in bathing and/or dressing? ..... ☐ Yes ☐ No
7. In the past 2 years, has the Proposed Insured been diagnosed, treated, tested positive for, or been given medical advice by a licensed member of the medical profession with a heart attack, stroke, cirrhosis of the liver or cancer (other than non-melanoma skin cancer)? .... ☐ Yes ☐ No
8. Has the Proposed Insured ever been advised by a member of the medical profession as having an immune deficiency disorder, Aquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or had test results indicating exposure to the AIDS virus? ☐ Yes ☐ No

PART 2: Proposed Insureds ages 18-49 are NOT eligible for life insurance if ANY question in PARTS 1 or 2 is answered "Yes". Proposed Insureds ages 81-85 are NOT eligible for life insurance if ANY question in parts 1, 2, or 3 is answered "Yes". Proposed Insureds ages 50-80 are ONLY eligible for a Graded Benefit if ANY question in PART 2 is answered "Yes". If ALL questions are answered "No", proceed to PART 3.

9. Has the Proposed Insured ever received an organ transplant or is the Proposed Insured on a waiting list for an organ transplant? ..... ☐ Yes ☐ No
10. Has the Proposed Insured ever received kidney dialysis, heart valve replacement, or an implanted defibrillator? ..... ☐ Yes ☐ No
11. Has the Proposed Insured ever been diagnosed by a member of the medical profession with any of the following conditions: congestive heart failure, Alzheimers, dementia, aneurysm, chronic hepatitis B or C, cardiomyopathy, or renal failure? ..... ☐ Yes ☐ No
12. Has the Proposed Insured ever been diagnosed by a member of the medical profession with chronic obstructive pulmonary disease (COPD)? ... ☐ Yes ☐ No
13. In the past 10 years, has the Proposed Insured been diagnosed by a member of the medical profession with or received treatment for leukemia or lymphoma (Hodgkins or non-Hodgkins)? ..... ☐ Yes ☐ No
14. In the past 5 years, has the Proposed Insured been diagnosed, treated, tested positive for or been given medical advice by a licensed member of the medical profession for alcohol or drug use, internal cancer, malignant melanoma, stroke, cerebral vascular accident (CVA), transient ischemic attack (TIA) or pancreatitis? ..... ☐ Yes ☐ No
15. In the past 2 years, has the Proposed Insured been diagnosed by a member of the medical profession with coronary artery disease or atrial fibrillation or had coronary bypass surgery, coronary angioplasty, coronary stenting, or had a pacemaker implanted? ..... ☐ Yes ☐ No

PART 3: Proposed Insureds ages 18-80 may require substandard rates if ANY question in PART 3 is answered "Yes". If ALL questions are answered "No", the Proposed Insured may qualify for standard rates.

16. Has the Proposed Insured ever been diagnosed by a member of the medical profession with major depression, bipolar disorder, diabetes (requiring insulin), rheumatoid arthritis, multiple sclerosis, or Parkinson's disease? ..... ☐ Yes ☐ No
17. In the past 2 to 10 years, has the Proposed Insured been diagnosed by a member of the medical profession with a heart attack, coronary artery disease, atrial fibrillation or had coronary bypass surgery, coronary angioplasty or coronary stenting? ..... ☐ Yes ☐ No

PART 3 *Continued:* Proposed Insureds ages 18-80 may require substandard rates if ANY question in PART 3 is answered "Yes". If ALL questions are answered "No", the Proposed Insured may qualify for standard rates.

18. In the past 5 years, has the Proposed Insured been diagnosed by a member of the medical profession with or received treatment for Crohn's disease or ulcerative colitis? ☐ Yes ☐ No
19. In the past 5 to 10 years, has the Proposed Insured been diagnosed by a member of the medical profession with one of the following conditions: internal cancer, malignant melanoma, transient ischemic attack (TIA)? ☐ Yes ☐ No
20. Has the Proposed Insured been diagnosed, treated, tested positive for, or been given medical advice by a licensed member of the medical profession with a stroke or cerebral vascular accident (CVA) more than 5 years ago? ☐ Yes ☐ No

PART 4: Answer Questions 21-24 ONLY if Applying for Children Term Rider. Please NOTE: Children Term Rider is not available with Graded Death Benefit.

21. Children Proposed for Insurance. (Use additional sheet and attach if necessary.)

Last Name, First Name, Middle Initial	Relationship to Proposed Insured	Date of Birth Month, Day, Year	Age	Height (ft.-in.)	Weight (lbs.)	Sex M/F	Social Security/Tax ID Number

a. Has the name of any child age 18 or younger been omitted? ☐ Yes ☐ No
If Yes, explain. _____

b. Is any child NOT living at the same address as the Proposed Insured? ☐ Yes ☐ No
If Yes, explain. _____

22. Has any child proposed for insurance ever been treated by a licensed member of the medical profession for cancer, tumor, diabetes, blood disorder, nervous or mental disorder, alcohol or drug dependence, any congenital defects, disease or disorder of the heart, kidneys, stomach, liver, lungs, bones or joints? ☐ Yes ☐ No
23. In the past two years, has any child proposed for insurance received treatment or been given medical or surgical advice by a licensed member of the medical profession or does any child proposed for insurance now have any other physical impairments? ☐ Yes ☐ No
24. Give full details for all Yes answers to questions 22 and 23. Include question number, diagnosis, dates, names and addresses of doctors, hospitals, etc. Use additional sheet and attach if necessary. _____

BILLING DATA

25. Plan: AdvantageGuard

Plan Type: ☐ Level Death Benefit Standard Rates
☐ Level Death Benefit Substandard Rates
☐ Graded Death Benefit

Optional Rider:
☐ Children Term Rider Face Amount: $_____

Base Plan Face Amount: $_____
Total Initial Premium Payment: $_____

☐ **No money collected. Initial premium is to be drafted.**

Payment Method:
☐ Direct ☐ PAC

Payment Mode:
☐ Monthly ☐ Semi-Annual
☐ Quarterly ☐ Annual

Requested Effective Date (Direct or PAC): _____
PAC ONLY: If no Effective Date selected, draft on issue. Future Draft Date: _____

If the Proposed Insured is an acceptable risk on a standard basis, but the premium quoted will not purchase the face amount requested:
☐ Do NOT change premium. Change face amount. ☐ Do NOT change face amount. Change premium.

NOTES TO UNDERWRITERS

FRAUD WARNING — 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.

APPLICATION DECLARATIONS AND AGREEMENTS — The Proposed Insured declares for himself/herself, that all of the answers in this application and any supplements to it are complete and true to the best of his/her knowledge and belief. The Proposed Insured also agrees that:

1. these answers as written: a) were given to induce the Company to issue a Policy; and b) shall form the basis for and become part of any Policy issued on the application;
2. except as otherwise provided in the conditional receipt, no Policy will be effective until it is: a) issued; b) delivered to the Applicant; c) the full first premium paid; and d) all during the lifetime of the Proposed Insured;
3. the Company may issue a Policy different from that specified in this application by listing the difference(s) on the Policy Data Page, and acceptance of such different Policy will be a ratification of the changes except that no changes in: a) specified amount; and b) classification will be effective unless agreed to by the Proposed Insured in writing;
4. the Company is not bound by any statements made by anyone or any other facts known to anyone concerning the Proposed Insured if not in writing in this application or any supplement to it; and
5. only the President, a Vice President, or Secretary of the Company has the authority to waive any of the Company rights or requirements or to waive or alter any of the provisions of this application or the Policy issued on this application.

Dated at City, State	Date	Print Agent's Name
Proposed Insured's Signature	Owner's Signature	Witnessed by: Agent's Signature

AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE MEDICAL INFORMATION

I hereby authorize any: physician, medical practitioner, hospital, clinic or other medical related facility, insurance company, insurance support organization, business partner, pharmacy, pharmacy benefit manager, government agency, group policyholder, employer, benefit plan administrator, the MIB, Inc., the Department of Motor Vehicle Registration, and paramedical facility to provide to STANDARD LIFE AND ACCIDENT INSURANCE COMPANY, or to any agent, attorney, consumer reporting agency or independent administrator, including medical record retrieval services or pharmaceutical services, acting on STANDARD LIFE AND ACCIDENT INSURANCE COMPANY'S or its reinsurers' behalf, information concerning advice, care or treatment sought by or provided to me and/or any other Applicant for coverage, including information relating to medical history, medical conditions, treatment, hospitalizations or confinements, ailments, and/or drug, alcohol or tobacco usage of the Applicant(s). It is understood that STANDARD LIFE AND ACCIDENT INSURANCE COMPANY'S underwriters, claim examiners, reinsurers, attorneys, or the medical director may disclose such health information to the aforementioned parties for purposes of underwriting, compliance, record clarification or explanation, or in response to litigation, summons, or subpoenas. I understand that after this information is disclosed, the recipient may redisclose it, resulting in loss of protection by federal regulations.

I understand that:

1. such information will be used by STANDARD LIFE AND ACCIDENT INSURANCE COMPANY for underwriting and insurability determinations;
2. I may refuse to sign this authorization and that my refusal to sign will affect my ability to obtain life insurance coverage;
3. a picture copy or photocopy of this authorization shall be as valid as the original; and
4. I, or my authorized representative, am entitled to receive a copy of this authorization upon request.

This authorization is valid from the date signed for a duration of 24 months. I understand I may revoke the authorization at any time, except to the extent that action has been taken in reliance on this authorization, by sending written notice to the Life Underwriting Department of STANDARD LIFE AND ACCIDENT INSURANCE COMPANY, P.O. Box 1720, Galveston, Texas 77553. *I may inspect or copy any information used or disclosed under this authorization, if signed.*

Date _____ Witness _____

Signature of Applicant _____ Personal Representative designated by signature above is hereby authorized to execute this instrument based on: (circle one) power of attorney, guardian, guardian-in-fact, payee representative or other _____.

USA PATRIOT ACT NOTICE — To Be Read By Or To Customer

The USA PATRIOT Act requires that we establish an Anti-Money Laundering ("AML") Program, notify customers that we must verify the identity of the owner(s) of our contracts, and collect documents and information sufficient to provide such verification. You should know that failure to provide the requested identification will result in delays in the issuance of the requested coverage and may result in a decision not to accept your application.

Identification Verified: one for each Owner/Trustee/Partner (Use additional forms if necessary.)

Owner/Trustee/Partner: Check one form of Identification:

☐ Driver's license ☐ Resident Alien Identification (green card)
☐ Passport ☐ Other: (describe) _____

Joint Owner/Trustee/Partner: Check one form of Identification:

☐ Driver's license ☐ Resident Alien Identification (green card)
☐ Passport ☐ Other: (describe) _____

The following information should be recorded exactly as it appears on the identification reviewed:

Name _____ Date of Birth _____

Street Address (not PO Box) _____ City, State, Zip _____

Number on Identification _____ State or Country _____ Identification Expiration Date _____

SIGNATURE REQUIRED IF CONDITIONAL RECEIPT IS COMPLETED

I hereby certify that I have read and received the conditional receipt, and agree to its terms. I understand that the Company will not permit acceptance of my payment or detachment of the conditional receipt unless this statement is true.

Signature of Proposed Insured _____ Signature of Premium Payor _____

DISCLOSURE NOTICE

Standard Life and Accident Insurance Company

Mailing Address: P.O. Box 3297, Springfield, MO 65808-3297

In connection with your application, Standard Life and Accident Insurance Company (Standard Life), or its reinsurers, may obtain medical and other information for evaluation purposes. Standard Life may obtain that information from MIB, Inc. or any medical professional, medically related facility, insurance support organization or insurance company who possesses information about the care, treatment or advice given you or your family. That information could concern drugs, alcoholism or mental illness. Standard Life may also obtain an investigative consumer report on you.

MIB, Inc. Pre-notification – Information regarding your insurability will be treated as confidential. Standard Life or its reinsurers may, however, make a brief report thereon to MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB, Inc. member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, Inc. upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information in your file. Please contact MIB, Inc. at 866.692.6901. If you question the accuracy of the information in MIB, Inc.'s file, you may contact MIB, Inc. and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB, Inc.'s information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Standard Life, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB, Inc. may be obtained on its website at www.mib.com.

Fair Credit Reporting Act Pre-notification – Federal and state laws require notification that, with your application, we may request an investigative consumer report. In addition, such a report may be requested subsequently to update our records or if you apply for additional coverage. Upon written request, we will inform you whether or not an investigative consumer report was requested and, if such report was requested, the address and telephone number of the investigative agency to which the request was made. By contacting the local office and providing the proper identification, you may inspect, or for the appropriate fee, receive a copy of such report. Typically, the report will contain information as to character, general reputation, personal characteristics, and mode of living, which information is obtained through an interview with you or an adult member of your family, employers or business associates, financial sources, friends, neighbors, or others with whom you are acquainted. The information will consist, when applicable, of a confirmation of your identity, age, residence, marital status, and past and present employment including occupational duties, financial information, driving record, sports and recreational activities, health history, use of alcohol or drugs if any, living conditions and type of community.

CONDITIONAL RECEIPT

Standard Life and Accident Insurance Company

Mailing Address: P.O. Box 3297, Springfield, MO 65808-3297

THIS RECEIPT SHALL BE VOID IF ALTERED OR MODIFIED. PREMIUM CHECKS MUST BE MADE PAYABLE TO THE COMPANY. DO NOT MAKE THE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

I have received $ _____ concerning an application for life insurance. If each of the following four conditions is satisfied fully, then, subject to the Maximum Specified Amount Limitation described below, insurance as provided by the terms and conditions of the Policy will become effective on the effective date, as defined below.

1. The payment received with the application must equal the minimum required for the Plan.
2. All medical examinations and tests required under the Company's application requirements must be completed and the reports of those medical examinations and tests must be received at the Company's Administrative Office within 45 days after the date of this receipt.
3. On the effective date, as defined below, the Proposed Insured must be insurable at standard premium rates for insurance requested in the application.
4. There is no material misrepresentation in the application.

MAXIMUM SPECIFIED AMOUNT LIMITATION: At no time and in no event shall the total liability of the Company under this receipt exceed $100,000. "Effective date" means the latest of the date the application is completed, the date all medical exams and tests are completed as required by the Company, and if the Proposed Insured requests a policy date which is later than the date of this receipt, the policy date requested by the Proposed Insured.

Refund of Payment: If one or more of the above conditions have not been satisfied fully within 45 days after the date of this receipt, the Company's liability is limited to a refund of the premium paid. Only the President, a Vice President or Secretary of the Company has the authority to waive any of the Company's rights or requirements or to waive or alter any of the provisions of this receipt or amend it in any way.

Dated at _____ on _____ , _____ _____

City, State — Month, Day — Year — Signature of Licensed Agent

I have read this conditional receipt. The agent has explained it to me and I understand and agree to all conditions and limitations.

_____ _____

Signature of Proposed Insured — Signature of Premium Payor

* A G R *

AGENT'S STATEMENT

I certify that I saw the Proposed Insured. I asked the Proposed Insured the questions in the application, and recorded the answers. The answers recorded did not conflict with my observations and knowledge of the Proposed Insured. I witnessed the required signatures. I certify that I have verified the Proposed Insured's personal information by viewing a state issued driver's license, state issued I.D. card, military I.D. card, Permanent U.S. Resident (Green Card), passport or other government issued pictured I.D. card.

Date

Agent's Signature

Agent's Writing Number

AGENT'S SUPPLEMENT

1. What is the purpose of this insurance? ☐ Personal ☐ Business
2. If beneficiary is not a relative, explain insurable interest: _____
3. How long have you personally known the Proposed Insured? _____
4. By whom will the premiums be paid? ☐ Owner ☐ Applicant ☐ Other

   If Other, explain: _____
5. As an agent, do you have knowledge or reason to believe that replacement of existing business may be involved? ..... ☐ Yes ☐ No
6. Was the application voluntary or solicited? _____

AGENT'S REPORT

During the interview, did you observe if the Proposed Insured had any physical or mental impairment with regard to walking, speaking, or clearly understanding the questions on the application?..... ☐ Yes ☐ No

The best time(s) to call for a telephone interview: _____

BE SURE TO INFORM YOUR CLIENT A TELEPHONE INTERVIEW WILL BE CONDUCTED.

If the Proposed Insured has a hearing problem, describe. _____

AUTHORIZATION TO MY BANK — PREAUTHORIZED CHECK AUTHORIZATION

Bank Information: ☐ Checking ☐ Savings

Attach Voided Check or Deposit Ticket Here and Sign Authorization

We will not draft from your account until underwriting approves your application.

As a convenience to me, I hereby request and authorize you to pay and charge to my account, checks or electronic debits drawn on my account by and payable to the order of Standard Life and Accident Insurance Company, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check or electronic debit shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such checks. I further agree should any such checks or electronic debits be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

Date Signed

Account Number

Name of Bank/Financial Institution

Routing Number

Address (City, State, Zip)

Signature (as it appears on bank records)