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(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.

Application for: SECURITY NATIONAL LIFE INSURANCE COMPANY. SECURITY CARE PLAN. Name of Proposed Insured (Print) First, 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, Address, City, State, Zip, Telephone Number, Relationship. Payor's Name, Address, City, State, Zip, Telephone Number, Relationship. Primary Beneficiary, Address, City, State, Zip, Telephone Number, Relationship. Contingent Beneficiary, Address, City, State, Zip, Telephone Number, Relationship. All Premiums are Level: Class, Special, Limited, Premium Payable, Face Amount, Rider Face Amount. Please Choose a Billing Option: Select Billing Month AND Select Billing Day OR Billing Week. Does the Proposed Insured receive Social Security Disability, SSI, VA Retirement and/or VA Disability? Draft Upon Approval, Select First Billing Month, Select Billing Day, OR Select Billing Week. Replacement: Do you have an existing life insurance policy or annuity contract? Proposed Insured's Physician's Name, Address, City, State, Zip. Please answer all Medical Questions for the Proposed Insured. Section I - Any "Yes" answers, Proposed Insured is not eligible for coverage. 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: 1. Have you ever been diagnosed, tested or treated by a licensed member of the medical profession as having Alzheimer's disease, dementia, hepatitis C, ALS (Lou Gehrig's disease), or been medically diagnosed, tested or treated by a licensed member of the medical profession with a terminal illness resulting in death within the next 12 months? 2. Have you been diagnosed, tested or treated by a licensed member of the medical profession for an organ transplant, dialysis treatment, cystic fibrosis, cirrhosis of the liver or sickle cell anemia? 3. Have you ever been diagnosed by a licensed member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or have you tested positive for the Human Immunodeficiency Virus (HIV)? 4. In the past 5 years have you been treated for alcohol or drug addiction or abuse (including prescription drugs) by a licensed member of the medical profession? 5. In the past 2 years been diagnosed, tested or treated by a licensed member of the medical profession for any internal cancer, melanoma or brain tumor? 6. In the past 2 years been diagnosed, tested or treated by a licensed member of the medical profession for any type of heart disease, CHF, heart attack or heart surgery? 7. In the past 2 years been diagnosed, tested or treated by a licensed member of the medical profession for any type of stroke, brain aneurysm, seizure, any other brain disorder or suicide attempt? 8. Are you now, or within the past 30 days been treated or admitted in a hospital, nursing home or any other type of health care facility, hospice care or been advised by a licensed member of the medical profession to be confined to a bed? 9. Do you need assistance or supervision with dressing, eating, personal hygiene (bathing or toilet), or transferring to or from a bed or chair? HOME OFFICE ADDITIONS OR CORRECTIONS. ICC17-GAP1 APP (06/2016)

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(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.

Applicant's Name: Social Security Number: Section II - Any "Yes" answers, Proposed Insured qualifies for Special class. In the past five years, has the Proposed Insured been diagnosed, tested positive for, treated, prescribed medication or been given medical advice by a licensed member of the medical profession for any of the following medical conditions: 10. Diabetes with no complications, good control, takes under 100 units of insulin in a 24-hour period and was diagnosed with diabetes after age 40? 11. Lung disorders, emphysema, asthma or COPD? 12. Chest pain, heart attack, heart surgery, other heart or circulatory disorder, including uncontrolled high blood pressure (takes more than 2 medications), takes blood thinning medication, brain aneurysm or stroke? 13. Diagnosed, tested or treated by a licensed member of the medical profession for any internal cancer, melanoma or brain tumor? 14. Recovered alcohol or drug abuser? If applicable, list date of recovery: Section III - Any "Yes" answers, Proposed Insured qualifies for Limited Death Benefit Plan. In the past five years, has the Proposed Insured been diagnosed, tested positive for, treated, prescribed medication or been given medical advice by a licensed member of the medical profession for any of the following medical conditions: 15. Diabetes with complications, including retinopathy, neuropathy, amputation onset of diabetes under age 40, but not on dialysis? 16. Disease of the liver, kidney, pancreas, other internal organs or hepatitis B? 17. Parkinson's disease, paralysis, multiple sclerosis, lupus, muscular dystrophy, epilepsy, seizures or any other neurological disorders? 18. Pancreas, schizophrenia, major depressive disorder, suicide attempts, hospitalization, or any other mental disorder or disease? 19. Congestive heart failure (CHF), heart attack, circulatory disorder, or other heart disorders or conditions? 20. Brain tumor, brain disorders, TIA (mini stroke) or strokes of any kind? 21. Within the last 2 years, have you ever been advised by a licensed member of the medical profession to have tests, surgery, treatment or do you have any medical test results pending or any additional medical evaluations that have not been performed, excluding tests related to the Human Immunodeficiency Virus (AIDS virus)? 22. Do you use a medical appliance such as a wheelchair, walker, hospital bed or oxygen? If "Yes" to any Medical Question, please indicate which medical question your answer pertains to and write down all medical condition(s), medication(s) including oxygen, the dosage and duration of said medication(s). Medical Question #, Medical Condition(s), Medication(s) - including oxygen, Dosage, Duration (from/to). If applying for the Child Rider - Complete this Section. 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, 2. Diabetes, 3. Hepatitis, 4. Cerebral Palsy, 5. Rheumatic fever, 6. Down Syndrome, 7. Kidney or organ failure, 8. Sickle Cell Anemia, 9. Tested positive for HIV, 10. Lung disorder or disease, 11. Heart problems or disease, 12. Any disorder of the nerves, 13. Any inpatient stay, 48 hours or more (within 1 year), 14. Any disorder of the brain, motor skills or seizures. Name of Proposed Insured Child, Medical Condition Yes/No, Birthdate, Age, Gender (M or F), Relationship to Applicant. ICC17-GAP1 APP (06/2016)



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Applicant's Name:		Social Security Number:	
<p>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 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.</p> <p>PRESCRIPTION AUTHORIZATION</p> <p>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 insured(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.</p> <p>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 authorized 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.</p> <p>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.</p> <p>Dated at _____ City _____ State _____ Date: _____</p> <p>Proposed Insured/Applicant's Printed Name _____</p> <p>Signature of Proposed Insured/Applicant _____ Date _____</p> <p>Signature of Owner (if other than Proposed Insured) _____ Date _____</p> <p>AGENT'S STATEMENT - I certify that to the best of my knowledge:</p> <p>1. I correctly asked all the Medical Questions in this application and correctly recorded all the answers given; and</p> <p>2. All answers given in this application are true and complete; and</p> <p>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</p> <p>4. Is the Proposed Insured an immediate family member? <input type="checkbox"/> Yes <input type="checkbox"/> No; and</p> <p>5. I know of no factor affecting the insurability of the Proposed Insured(s) except as stated in this application; and</p> <p>6. This insurance <input type="checkbox"/> WILL <input type="checkbox"/> WILL NOT change or replace any existing insurance policy or annuity contract.</p> <p>Note: If "WILL" is checked for question 6, complete required replacement forms.</p> <p>Agent's Signature: _____ Agent's Printed Name: _____ Agent's Number: _____</p> <p>If policy and commissions are being split between multiple agents, then each additional agent must sign and notate commission split.</p> <p>Agent's Signature: _____ Agent's Printed Name: _____ Agent's Number: _____ Commission Split: _____</p> <p>IC17-GAP1 APP (06/2016)</p> <p>SECURITY NATIONAL LIFE INSURANCE COMPANY P.O. Box 57220 • Salt Lake City, Utah 84157-0220 Office: (801) 264-1060 • Toll Free: 1 (800) 574-7117</p> <p>IC17-GAP1 APP (06/2016)</p>			

(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.

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(RED) Applicant Name and Social Security Number

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

(PURPLE) EFT disclosures. Name is Payor 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.

Applicant's Name:		Social Security Number:	
<p>PAYOR INFORMATION AND ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION AGREEMENT TO SECURITY NATIONAL LIFE INSURANCE COMPANY (SNL)</p> <p>Payor Name _____ Phone # _____</p> <p>Payor Address _____</p> <p>Customer Name _____</p> <p>Name of Bank _____</p> <p>Address of Bank _____</p> <p>Checking Account # _____ or Savings Account # _____</p> <p>Nine Digit Bank Transit # _____</p> <p>Credit/Debit Card # _____ Exp: _____ CVV# _____</p> <p>I authorize SNL 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 SNL account(s). I understand this authorization is subject to the terms and conditions of the EFT agreement.</p> <p>TERMS AND CONDITIONS</p> <ol style="list-style-type: none"> 1. This arrangement may be terminated with respect to any or all contracts listed below by SNL or by me upon written notice to the other party. Until such notice is actually received by SNL, SNL 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 SNL 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 SNL 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 SNL. 6. I will pay a returned-item fee as specified by the bank or SNL for any debit entry that is returned to SNL for insufficient funds. 7. The EFT will apply to the following contract(s): <p>Name _____ Contract # _____</p> <p>Name _____ Contract # _____</p> <p>Date _____ Signature _____</p> <p style="text-align: right;">Authorized Account Holder</p> <p>IC17-GAP1 APP (06/2016)</p> <p>CONDITIONAL RECEIPT</p> <p>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.</p> <p>Received from _____ on _____ (date) the sum of \$ _____ the correct first premium specified in the application, subject to the following conditions:</p> <p>FIRST: If each Proposed Insured would be acceptable and approved by Security National Life Insurance Company in Salt Lake City, Utah, as insurable under the company's underwriting rules for insurance on the plan and at the premium rate and the amount of insurance applied for on the application for all Proposed Insured(s).</p> <p>SECOND: The premium funds for the correct premium amount for plan of insurance applied for, have been honored on the first presentation and result in the funds being credited to Security National Life Insurance Company's bank account.</p> <p>THIRD: 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 Security National Life Insurance Company will have no liability.</p> <p>Agent's Signature _____ Agent's Name (Please Print) _____</p>			