

**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.

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) 284-1050 or Toll Free: 1 (800) 574-7117

**SIMPLE SECURITY 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 (if other than the Proposed Insured):  
Address City State Zip  
Telephone Number Relationship

Payor's Name (if other than the Proposed Insured):  
Address City State Zip  
Telephone Number Relationship

Primary Beneficiary: Address City State Zip Telephone Relationship  
Contingent Beneficiary: Address City State Zip Telephone Relationship

Plan:  Simple Security Plan - Preferred  Simple Security Plan - Standard  Simple Security Plan - Modified 2 year ROP + 10%  
Premium Payable:  EFT  Direct Monthly Bill  Debit/Credit Card  Monthly  Quarterly  Semi-Annual  Annual  
Face Amount: \$ \_\_\_\_\_  
Rider Face Amount:  AD \$ \_\_\_\_\_  Child \$ \_\_\_\_\_

Amount of premium paid with the application: \$ \_\_\_\_\_  
(Check must be made payable to Security National Life Insurance Company)

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: 1st - 21st OR Select Billing Week:  2nd Wednesday  3rd Wednesday  4th Wednesday

Replacement: Do you have an existing life insurance policy or annuity contract?  Yes  No  
If "Yes", please fill out and submit the notice regarding the replacement of life insurance or annuities.

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 1-19 are answered "No", the Proposed Insured is eligible for the Simple Security Preferred Plan.  
**MEDICAL QUESTIONS (Section One) – Answer all medical questions.**  
If any medical question in Section One is answered "Yes", the Proposed Insured is not eligible for the Simple Security Plan.  
If all medical questions are answered "No", complete Sections Two and Three on page 2 of the application.  
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:

Medical Condition	Yes	No
1. Are you now, or within the past 30 days been treated or admitted in a hospital, nursing home, health care facility, long-term care facility, hospice care, or been advised by a licensed member of the medical profession to be confined to a bed? Have you been medically diagnosed, tested or treated by a licensed member of the medical profession with having a terminal illness resulting in death within the next 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
2. Within the past 30 days, have you been medically diagnosed, tested or treated in a hospital by a licensed member of the medical profession for a seizure?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you need assistance or supervision with dressing, eating, personal hygiene (bathing or toilet), or transferring to or from a bed or chair?	<input type="checkbox"/>	<input type="checkbox"/>
4. Are you now, or within the past 90 days been diagnosed, tested or treated by a licensed member of the medical profession for any type of tumors or cancers, except basal cell skin cancer?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever been diagnosed by a licensed member of the medical profession as having Alzheimer's, dementia, ALS (Lou Gehrig's disease), sickle cell anemia, hepatitis C, chronic of the liver, cyclic thrombocytopenia, or organ transplant?	<input type="checkbox"/>	<input type="checkbox"/>
6. Are you currently receiving dialysis treatment?	<input type="checkbox"/>	<input type="checkbox"/>
7. 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)?	<input type="checkbox"/>	<input type="checkbox"/>

HOME OFFICE ADDITIONS OR CORRECTIONS

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**(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.

Applicant's Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

**MEDICAL QUESTIONS (Section Two) – Answer all medical questions.**  
If all medical questions in Sections One and Three are answered "Yes", the Proposed Insured is only eligible for the Simple Security Standard Plan.  
If all medical questions in Sections One and Three are answered "No", but question 8 in Section Two is answered "Yes", the Proposed Insured is eligible for the 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, 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:

Medical Condition	Yes	No
9. Angioplasty, stent implant, bypass surgery, heart valve surgery or pacemaker?	<input type="checkbox"/>	<input type="checkbox"/>
10. Any type of tumors or cancers, except basal cell skin cancer?	<input type="checkbox"/>	<input type="checkbox"/>
11. If now cancer-free, indicate month and year you were diagnosed by a licensed member of the medical profession that you were cancer-free.	<input type="checkbox"/>	<input type="checkbox"/>
12. Brain tumor, brain disorders, TIA (mini stroke) or strokes of any kind?	<input type="checkbox"/>	<input type="checkbox"/>
13. Heart disease of any type, angina, heart attack, enlarged heart, congestive heart failure (CHF), arrhythmic disorder, or other heart disorders or conditions?	<input type="checkbox"/>	<input type="checkbox"/>
14. Lung disease, emphysema, or chronic obstructive pulmonary disease (COPD) or any other type of pulmonary or lung disease or condition?	<input type="checkbox"/>	<input type="checkbox"/>
15. Kidney disease or failure, renal failure or insufficiency, liver disease, hepatitis B, disease of the pancreas or other organ failure or disease?	<input type="checkbox"/>	<input type="checkbox"/>
16. Diabetes with complications that could include: diabetic coma, insulin shock, eye disease or disorder, neuropathy, amputation, hospitalized for diabetes, take 100 units or more of insulin in a 24-hour period, or insulin use prior to age 60?	<input type="checkbox"/>	<input type="checkbox"/>
17. Parkinson's disease, paralysis, multiple sclerosis, lupus, muscular dystrophy, down syndrome, cerebral palsy, epilepsy, seizures or any other neurological disorders?	<input type="checkbox"/>	<input type="checkbox"/>
18. Have you 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)?	<input type="checkbox"/>	<input type="checkbox"/>
19. Have you received medical treatment, counseling or advised by a licensed member of the medical profession regarding abuse or excessive use of alcohol, non-prescribed drugs, prescribed drugs, narcotics or any other habit forming substances?	<input type="checkbox"/>	<input type="checkbox"/>
20. Do you use a medical appliance such as a wheelchair, walker, hospital bed or oxygen?	<input type="checkbox"/>	<input type="checkbox"/>

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 conditions. 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	Medical Condition Yes/No	Birthdate	Age	Gender (M or F)	Relationship to Applicant

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Application form with fields for Applicant Name, Social Security Number, Prescription Authorization, and Agent's Statement.

(RED) Applicant Name and Social Security Number

(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 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.

Form with sections for Payor Information and Electronic Funds Transfer (EFT) Authorization Agreement, Terms and Conditions, and Conditional Receipt.