

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) 264-1060 or Toll Free: 1 (800) 574-7117

LOYALTY PLAN

Name of Proposed Insured (Print) First Initial Last			Gender	Birthdate	Age	Height	Weight
Mailing Address				City		State	Zip
Proposed Insured's Telephone Number		Email address		Social Security Number/TIN		Maiden name (if applicable)	

Owner's Name (if other than the Proposed Insured): _____
 Address: _____ City: _____ State: _____ Zip: _____
 Telephone Number: _____ Email address: _____ Relationship: _____

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

Primary Beneficiary: Mailing Address: _____ Email Address: _____ Telephone: _____ Relationship: _____	Contingent Beneficiary: Mailing Address: _____ Email Address: _____ Telephone: _____ Relationship: _____
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Plan: <input type="checkbox"/> Loyalty Plan – Preferred <input type="checkbox"/> Loyalty Plan – Standard <input type="checkbox"/> Loyalty Plan – Modified 2 year ROP + 10%	Premium Payable: <input type="checkbox"/> EFT <input type="checkbox"/> Direct Monthly Bill <input type="checkbox"/> Debit/Credit Card <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Annual	Policy Face Amount: \$ _____ <input type="checkbox"/> ADB Rider Face Amount: \$ _____ <input type="checkbox"/> Child Rider Face Amount: \$ _____
Amount of premium paid with the application: \$ _____ (Check must be made payable to Security National Life Insurance Company).		Total Premium: \$ _____

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 <input type="checkbox"/> Yes <input type="checkbox"/> No	Select First Billing Month: January – December _____ Select Billing Day: 1 st – 28 th _____ OR Select Billing Week: <input type="checkbox"/> 2 nd Wednesday <input type="checkbox"/> 3 rd Wednesday <input type="checkbox"/> 4 th Wednesday
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Replacement: If "Yes" to Replacement question #2, please fill out and submit required Replacement Form.

1. Do you have an existing life insurance policy or annuity contract? Yes No
 2. If yes, will proposed insurance replace or change any existing life insurance policy or annuity contract? Yes No

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 1-25 are answered "No", the Proposed Insured is eligible for the Loyalty Preferred Plan.

MEDICAL QUESTIONS (Section One)

If any medical question in Section One is answered "Yes", the Proposed Insured is **not eligible** for any Loyalty Plan.
 If all medical questions in Section One are answered "No", complete Sections Two and Three.

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:

	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?	<input type="checkbox"/>	<input type="checkbox"/>
2. 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"/>
3. 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"/>
4. 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"/>
5. 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"/>
6. Within the past 6 months, have you been diagnosed or treated by a licensed member of the medical profession for Hepatitis C? Or has it been less than 90 days since completing treatment for Hepatitis C by a licensed member of the medical profession?	<input type="checkbox"/>	<input type="checkbox"/>
7. 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, cirrhosis of the liver, cystic fibrosis, uncorrected brain aneurysm, or organ transplant?	<input type="checkbox"/>	<input type="checkbox"/>
8. Are you currently receiving dialysis treatment?	<input type="checkbox"/>	<input type="checkbox"/>
9. 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"/>

Applicant's Name: _____	Social Security Number: _____
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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 | 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		Birthdate	Age	Gender (M or F)	Relationship to Applicant
	Yes	No				

**PAYOR INFORMATION AND ELECTRONIC FUNDS TRANSFER (EFT)
AUTHORIZATION AGREEMENT TO SECURITY NATIONAL LIFE INSURANCE COMPANY ("SNLIC")**

Payor Name: _____ Phone #: _____

Name of Bank: _____

Address of Bank: _____

Checking **Savings Account #:** _____ **Nine Digit Bank Transit #:** _____

Credit/Debit Card#: _____ **Exp:** _____ **CCU#:** _____

I authorize SNLIC 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 SNLIC account(s). I understand this authorization is subject to the terms and conditions of the EFT agreement.

TERMS AND CONDITIONS

1. This arrangement may be terminated with respect to any or all contracts listed below by SNLIC or by me upon written notice to the other party. Until such notice is actually received by SNLIC, SNLIC 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 SNLIC 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 SNLIC 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 SNLIC.
6. I will pay a returned-item fee as specified by the bank or SNLIC for any debit entry that is returned to SNLIC for insufficient funds.

Date: _____ Signature of Authorized Account Holder: _____

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CONDITIONAL RECEIPT

**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.**

Received from _____ on _____ (date) the amount of \$ _____, **subject to the following conditions:**

FIRST: The amount tendered is the correct first premium specified in the Application.

SECOND: Each Proposed Insured would be acceptable and approved by Security National Life Insurance Company ("SNLIC"), as insurable under SNLIC's underwriting rules for insurance on the plan and at the premium rate and the amount of insurance applied for in the Application for each Proposed Insured.

THIRD: The premium funds for the correct premium amount for plan of insurance applied for, have been honored on the first presentation and have been credited to SNLIC's bank account.

FOURTH: The Application is approved within 60 days from the date it was signed.

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 SNLIC will have no liability.

Agent's Signature: _____ Agent's Printed Name: _____

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