Security National Life Insurance Company

SECURITY NATIONAL LIFE APPLICATION BROCHURE

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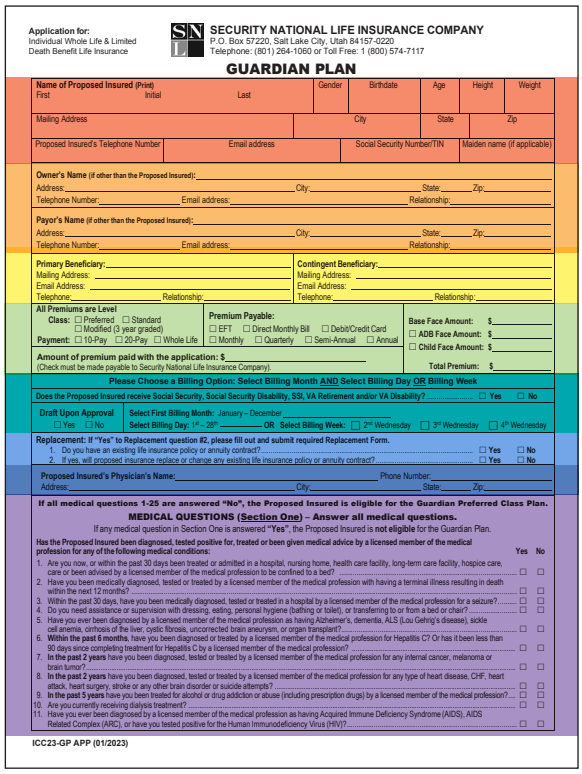

Application for:
Individual Whole Life & Limited Death Benefit Life Insurance

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

GUARDIAN 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:

All Premiums are Level
Class: ☐ Preferred ☐ Standard ☐ Modified (3 year graded)
Payment: ☐ 10-Pay ☐ 20-Pay ☐ Whole Life

Premium Payable:
☐ EFT ☐ Direct Monthly Bill ☐ Debit/Credit Card
☐ Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annual

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

Base Face Amount: $
☐ ADB Face Amount: $
☐ Child Face Amount: $
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 ☐ Yes ☐ No

Select First Billing Month: January – December
Select Billing Day: 1st – 28th OR Select Billing Week: ☐ 2nd Wednesday ☐ 3rd Wednesday ☐ 4th Wednesday

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:

If all medical questions 1-25 are answered "No", the Proposed Insured is eligible for the Guardian Preferred Class 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 Guardian Plan.

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, care or been advised by a licensed member of the medical profession to be confined to a bed?	☐	☐
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?	☐	☐
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?	☐	☐
4. Do you need assistance or supervision with dressing, eating, personal hygiene (bathing or toilet), or transferring to or from a bed or chair?	☐	☐
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, cirrhosis of the liver, cystic fibrosis, uncorrected brain aneurysm, or organ transplant?	☐	☐
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?	☐	☐
7. **In the past 2 years** have you been diagnosed, tested or treated by a licensed member of the medical profession for any internal cancer, melanoma or brain tumor?	☐	☐
8. **In the past 2 years** have you been diagnosed, tested or treated by a licensed member of the medical profession for any type of heart disease, CHF, heart attack, heart surgery, stroke or any other brain disorder or suicide attempts?	☐	☐
9. **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?	☐	☐
10. Are you currently receiving dialysis treatment?	☐	☐
11. 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)?	☐	☐

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(RED) Should include name, gender, date of birth, age, height, weight, mailing address, phone number, email address, social security number, & maiden name (if applicable).

(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.

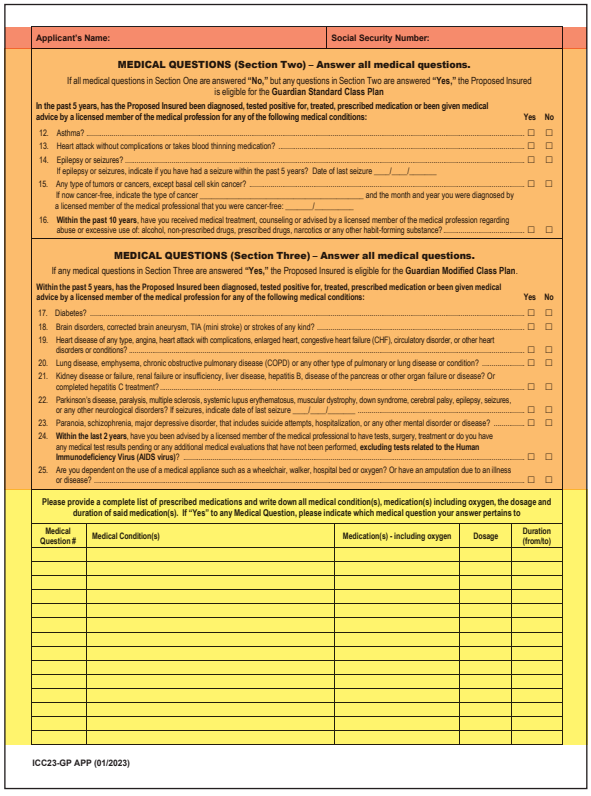
(GREEN) Plan Selection. Enter Plan, Premium Payable, Amount of Premium, Face Amount, and Rider info.

(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 1 – Answer all health questions.



Applicant's Name: | Social Security Number:

MEDICAL QUESTIONS (Section Two) – Answer all medical questions.
If all medical questions in Section One are answered **"No,"** but any questions in Section Two are answered **"Yes,"** the Proposed Insured is eligible for the **Guardian Standard Class Plan**

In the past 5 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:	Yes	No
12. Asthma?	☐	☐
13. Heart attack without complications or takes blood thinning medication?	☐	☐
14. Epilepsy or seizures? If epilepsy or seizures, indicate if you have had a seizure within the past 5 years? Date of last seizure ___/___/_____	☐	☐
15. Any type of tumors or cancers, except basal cell skin cancer? If now cancer-free, indicate the type of cancer _____ and the month and year you were diagnosed by a licensed member of the medical professional that you were cancer-free: _____/_____	☐	☐
16. **Within the past 10 years**, 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 substance?	☐	☐

MEDICAL QUESTIONS (Section Three) – Answer all medical questions.
If any medical questions in Section Three are answered **"Yes,"** the Proposed Insured is eligible for the **Guardian Modified Class Plan**.

Within the past 5 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:	Yes	No
17. Diabetes?	☐	☐
18. Brain disorders, corrected brain aneurysm, TIA (mini stroke) or strokes of any kind?	☐	☐
19. Heart disease of any type, angina, heart attack with complications, enlarged heart, congestive heart failure (CHF), circulatory disorder, or other heart disorders or conditions?	☐	☐
20. Lung disease, emphysema, chronic obstructive pulmonary disease (COPD) or any other type of pulmonary or lung disease or condition?	☐	☐
21. Kidney disease or failure, renal failure or insufficiency, liver disease, hepatitis B, disease of the pancreas or other organ failure or disease? Or completed hepatitis C treatment?	☐	☐
22. Parkinson's disease, paralysis, multiple sclerosis, systemic lupus erythematosus, muscular dystrophy, down syndrome, cerebral palsy, epilepsy, seizures, or any other neurological disorders? If seizures, indicate date of last seizure ___/___/___	☐	☐
23. Paranoia, schizophrenia, major depressive disorder, that includes suicide attempts, hospitalization, or any other mental disorder or disease?	☐	☐
24. **Within the last 2 years**, have you been advised by a licensed member of the medical professional 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)**?	☐	☐
25. Are you dependent on the use of a medical appliance such as a wheelchair, walker, hospital bed or oxygen? Or have an amputation due to an illness or disease?	☐	☐

Please provide a complete list of prescribed medications and write down all medical condition(s), medication(s) including oxygen, the dosage and duration of said medication(s). If "Yes" to any Medical Question, please indicate which medical question your answer pertains to

Medical Question #	Medical Condition(s)	Medication(s) - including oxygen	Dosage	Duration (from/to)

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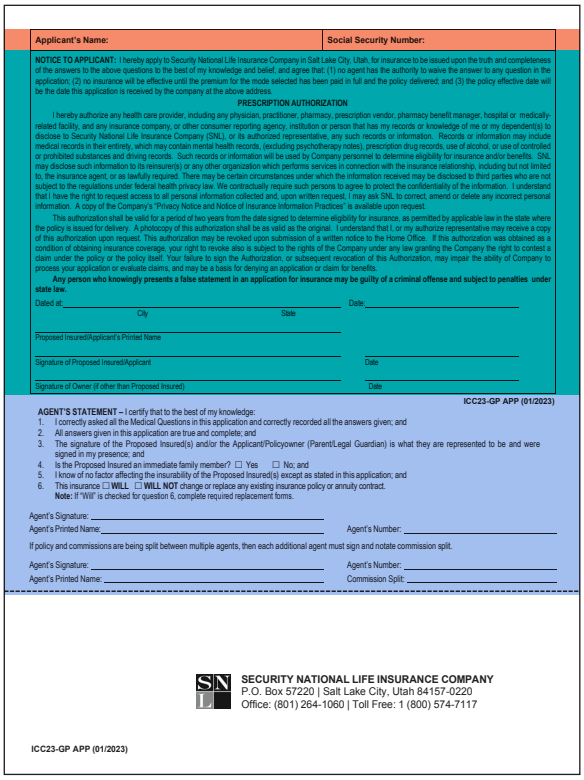
(RED) Applicant Name and Social Security Number

(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).



Applicant's Name: | Social Security Number:

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 belief, 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.

PRESCRIPTION AUTHORIZATION

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 reinsurer(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.

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 authorize 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. Your failure to sign the Authorization, or subsequent revocation of this Authorization, may impair the ability of Company to process your application or evaluate claims, and may be a basis for denying an application or claim for benefits.

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.

Dated at: _____ (City) _____ (State) Date: _____

_____
Proposed Insured/Applicant's Printed Name

_____ _____
Signature of Proposed Insured/Applicant Date

_____ _____
Signature of Owner (if other than Proposed Insured) Date

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AGENT'S STATEMENT – I certify that to the best of my knowledge:

1. I correctly asked all the Medical Questions in this application and correctly recorded all the answers given; and
2. All answers given in this application are true and complete; and
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
4. Is the Proposed Insured an immediate family member? ☐ Yes ☐ No; and
5. I know of no factor affecting the insurability of the Proposed Insured(s) except as stated in this application; and
6. This insurance ☐ **WILL** ☐ **WILL NOT** change or replace any existing insurance policy or annuity contract.
   Note: If "Will" is checked for question 6, complete required replacement forms.

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

If policy and commissions are being split between multiple agents, then each additional agent must sign and notate commission split.

Agent's Signature: _____ Agent's Number: _____
Agent's Printed Name: _____ Commission Split: _____

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Office: (801) 264-1060 | Toll Free: 1 (800) 574-7117

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(RED) Applicant Name and Social Security Number

(TEAL) Disclosures & Signatures – City & state where the application was signed. Date of signature of insured. Signature and signature date 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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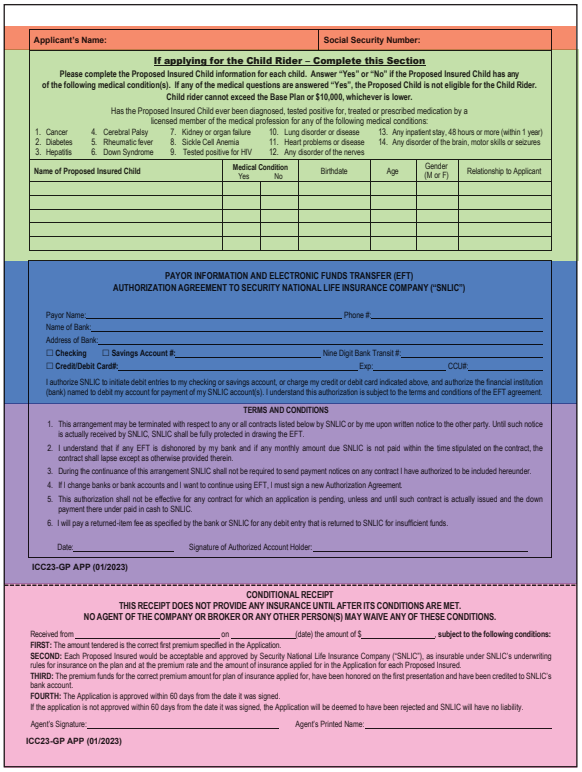
(RED) Applicant Name and Social Security Number

(GREEN) Child Rider – If applying for a Child Rider, provide all information.

(DARK BLUE) Payor Name, Phone, and Address. Enter banking information.

(PURPLE) EFT disclosures. Date and signature of authorized account holder.

(PINK) Conditional Receipt: Payor Name, Date, Cash With App, Agent Signature and Agent Name.



Applicant's Name: | Social Security Number:

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	Medical Condition No	Birthdate	Age	Gender (M or F)	Relationship to Applicant

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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