LOYALTY SALES DIVISION

Pending Policy Correction Form

PLEASE NOTE: All corrections are subject to home office review.

Insured Name ______________________________ **Policy # or SSN** ______________ **Date** __________

BANKING INFORMATION – Select the Correction and Provide Detailed Description:

❑ Bank Correction ❑ Redraft Initial Premium

Please complete the following and return your check with your payment. This check will be used to set up automatic payment.

I authorize Security National Life Insurance Company to debit my bank account or debit/credit card for my premium payment on my insurance policy.

Signature ______________________________ Date __________

Bank Name ______________ ❑ Checking ❑ Savings ABA # ______________ Account # ______________

CC # ______________________________ Exp __________ CVV __________

DRAFT DATE CHANGE

Draft Date Stated on Application __________ New Draft Date __________ Payor Signature ______________

PREMIUM CORRECTION – for amounts less than $10

Premium Stated on Application ______________ New Premium ______________

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.

LOYALTY FAMILY SUPPORT PLAN – Add/change co-members
Required information for members: Name, Address, City, State, Zip, Phone #, Email

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REPLACEMENT / EXISTING COVERAGE

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
If replacing, please complete replacement form.

PROPOSED INSURED CORRECTION

First Name ______________________ Initial _____ Last Name ______________________

Gender ______________ Birth date ______________ Age ________ Height ________ Weight ________

Mailing Address ______________________ City ______________ State _____ Zip ________

(Continued on next page)

PROPOSED INSURED CORRECTION (Continued)

Proposed Insured Telephone Number ____________________ Email Address ______________________________________

Social Security Number __________________________ Maiden Name ______________________________________

OWNER CORRECTION

Owner's Name (if other than the Proposed Insured) ____

Mailing Address____ City ____________________ State _____ Zip ________

Telephone Number _______________ Email Address ____________________________________ Relationship ______________

PAYOR CORRECTION

Payor Name (if other than the Proposed Insured) ____

Mailing Address____ City ____________________ State _____ Zip ________

Telephone Number _______________ Email Address ____________________________________ Relationship ______________

BENEFICIARY CORRECTION

Primary Beneficiary _________________________ ____

Mailing Address____ City ____________________ State _____ Zip ________

Telephone Number _______________ Email Address ____________________________________ Relationship ______________

Contingent Beneficiary _________________________ ____

Mailing Address____ City ____________________ State _____ Zip ________

Telephone Number _______________ Email Address ____________________________________ Relationship ______________

TOBACCO / NICOTINE

Tobacco/Nicotine Question: Have you used tobacco and/or nicotine in any form within the past 12 months? ❑ Yes ❑ No

MEDICAL INFORMATION – If additional room is needed, please attached a separate page

Medical Question #	Medical Condition(s)	Medications(s) - Including Oxygen	Dosage	Time Period (from/to)

OTHER ____

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Agent Name ____ **Agent #** ______________

Agent Signature ____ **Date** ______________

Signature of Approving Underwriter______________________________________ **Date** ______________