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

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

GUARDIAN PLAN

Proposed Insured

First Name	M.I.	Last Name	Gender	Birthdate	Age	Height	Weight
			☐ Female ☐ Male	____ / ____ / _____		___ ft ___ in	

Mailing Address	City	State	Zip

Phone #	Email	SSN / TIN
( ) –		___ ___ ___ – ___ ___ – ___ ___ ___ ___

Owner (if other than the Proposed Insured)

First Name	M.I.	Last Name	Phone #	Email	Relationship
			( ) –		

Mailing Address	City	State	Zip	SSN / TIN
				___ ___ ___ – ___ ___ – ___ ___ ___ ___

Primary Beneficiary

First Name	M.I.	Last Name

Mailing Address

City	State	Zip

Phone #	Email	Relationship
( ) –		

Contingent Beneficiary

First Name	M.I.	Last Name

Mailing Address

City	State	Zip

Phone #	Email	Relationship
( ) –		

Medical Questions – Section One

If any question in Section One is answered **"Yes"**, the Proposed Insured is **not eligible** for any Guardian Plan.

1. **Within the past 30 days have you been bedridden, required assistance with activities of daily living, admitted to a hospital, nursing home, long term care facility, hospice care, had a seizure or received dialysis treatment?** ..... ☐ Yes ☐ No
2. **In the past 2 years have you been diagnosed, tested, treated, or advised by a licensed medical professional for any of the following conditions:**
   A. Any type of tumor or cancer (except basal cell skin cancer), brain disease, disorders, stroke, or suicide attempts? ..... ☐ Yes ☐ No
   B. Any heart or circulatory diseases including congestive heart failure (CHF), heart attack, or heart surgery? ..... ☐ Yes ☐ No
3. **In the past 5 years, have you been diagnosed, treated, prescribed medication, or been given advice by a licensed medical professional for alcohol or drug abuse, including prescription drugs?** ..... ☐ Yes ☐ No
4. **Have you ever tested positive for HIV in a test taken for the purpose of obtaining insurance or been diagnosed as having AIDS or ARC caused by the HIV infection?**
5. **Have you ever been diagnosed, tested positive for, or treated by a licensed medical professional for any of the following conditions:**
   A. Alzheimer's, dementia, ALS (Lou Gehrig's Disease), sickle cell anemia, cirrhosis of the liver, cystic fibrosis, uncorrected brain aneurysm, organ transplant, or untreated hepatitis C? ..... ☐ Yes ☐ No
   B. As having a life expectancy of twelve (12) months or less? ..... ☐ Yes ☐ No

Medical Questions – Section Two

If any questions in Section Two are answered **"Yes"** the Proposed Insured is eligible for the Standard Plan.

6. **In the past 5 years, have you been diagnosed, treated, prescribed medication, or been given advice by a licensed medical professional for asthma, epilepsy, seizures, any tumors or cancers (except basal cell skin cancer), or taken blood thinning medication?** ..... ☐ Yes ☐ No
7. **In the past 10 years, have you been diagnosed, treated, prescribed medication, or been given advice by a licensed medical professional for alcohol or drug abuse, including prescription drugs?** ..... ☐ Yes ☐ No

Medical Questions – Section Three

If any questions in Section Three are answered **"Yes"** the Proposed Insured is eligible for the Modified Plan.

8. **Have you had an amputation due to an illness or depend on medical appliances such as wheelchair, walker, or oxygen?** ☐ Yes ☐ No
9. **In the past 5 years, have you been diagnosed, treated, prescribed medication, or been given advice by a licensed medical professional for any of the following conditions:**
   A. Any heart or circulatory diseases, or disorders including congestive heart failure (CHF), heart attack, or heart surgery?.. ☐ Yes ☐ No

Applicant Name:	*SSN / TIN:* ___ ___ ___ – ___ ___ – ___ ___ ___ ___

Medical Questions – Section Three (continued)

B. Diabetes? ☐ Yes ☐ No

C. Any brain diseases, disorders, corrected brain aneurysm, or stroke? ☐ Yes ☐ No

D. Any lung or pulmonary diseases, including chronic obstructive pulmonary disease (COPD)? ☐ Yes ☐ No

E. Diseases, disorders, or failures of kidney, liver, pancreas, renal or other organs, including hepatitis B or C? ☐ Yes ☐ No

F. Any neurological or mental diseases or disorders? ☐ Yes ☐ No

10. **Within the past 2 years have you been advised by a licensed medical professional to have diagnostic tests, surgery, or treatments relating to any of the questions listed above which have not been completed or results have not been received, excluding those related to the Human Immunodeficiency Virus (AIDS virus)?** ☐ Yes ☐ No

If all medical questions are answered "No", the proposed insured is eligible for Preferred Plan.

Medication List

Provide a complete list of medications (including oxygen), and the dosages and time periods for all medications.

Medical Condition(s)	Medication(s) – including oxygen	Dosage	Dates Taken (From/To)

Proposed Insured's Physician's Name: _____

Phone Number: (_____) _____ City: _____ State: _____ Zip: _____

Child Rider

If applying for the Child Rider, complete this section.

Answer "Yes" or "No" if the Proposed 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 Child ever been diagnosed, tested positive for, treated or prescribed medication by a licensed medical professional for any of the following 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 Each Proposed Child	Medical Condition Yes	Medical Condition No	Birthdate	Age	Gender	Relationship to Applicant
			___ / ___ / _____		☐ Female ☐ Male	
			___ / ___ / _____		☐ Female ☐ Male	
			___ / ___ / _____		☐ Female ☐ Male	
			___ / ___ / _____		☐ Female ☐ Male	
			___ / ___ / _____		☐ Female ☐ Male	
			___ / ___ / _____		☐ Female ☐ Male	

Plan and Premium

Class: ☐ Preferred ☐ Standard ☐ Modified *(3 year graded)*

Payment: ☐ 10-Pay ☐ 20-Pay ☐ Whole Life

Premium Method: ☐ EFT ☐ Direct Monthly Bill ☐ Debit/Credit Card

Frequency: ☐ Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annual

Policy Face Amount: $_____

☐ ADB Rider Face Amount: $_____

☐ Child Rider Face Amount: $_____

Total Premium: $_____

Automatic Premium Loan Provision? ☐ Yes

Initial Withdrawal Date:

_____ _____

Month (January-December) *Date (1st-28th)*

AND Recurring Billing Day or Week:

☐ **Billing Day:** _____ *Date (1st-28th)*

Or **Billing Week:** ☐ 2nd Wednesday ☐ 3rd Wednesday ☐ 4th Wednesday

If the policy cannot be issued by the initial withdrawal date, the withdrawal will be processed on the next available date following approval.

Applicant Name:	*SSN / TIN:* ____ ____ ____ – ____ ____ – ____ ____ ____ ____

Payor ☐ Same as Insured ☐ Same as Owner

First Name	M.I.	Last Name	Phone # ( ) –	
Mailing Address		City	State	Zip
Email		Relationship		

Payment

Name of Bank		
☐ Checking ☐ Savings	Account #	Routing #
☐ Credit/Debit	Card #	Exp / CVV

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 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: _____

Other Coverage

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

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.

GP APP (10/2025)-CA

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GP APP (10/2025)-CA

3

Applicant Name:	*SSN / TIN:* ____ ____ ____ – ____ ____ – ____ ____ ____ ____

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

For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Dated at: _____ Date: _____ / _____ / _____
City State

_____
Proposed Insured/Applicant's Printed Name

_____ Date: _____ / _____ / _____
Signature of Proposed Insured/Applicant

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

Agent 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/Policy Owner (Parent/Legal Guardian) is what they are represented to be and were signed in my presence; and
4. Is the Proposed Insured a 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 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: _____

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: _____