Standard Life and Accident Insurance Company

Application to Standard Life and Accident Insurance Company
Mailing Address: [P.O. Box 3297, Springfield, MO 65804-9998]
[888.519.5819]

[* A P P *]

APPLICATION FOR INDIVIDUAL LIFE INSURANCE

Please Print — Use Black Ink

1. PRIMARY PROPOSED INSURED

Name _____ (First) (Middle Initial) (Last)

Date of Birth (MM/DD/YYYY) _____ Age _____ Sex _____ Social Security Number _____

Height _____ Weight _____ Birthstate/Birthplace _____

Marital Status: ❑ Married ❑ Single ❑ Separated ❑ Widowed ❑ Divorced

Have you ever used tobacco or nicotine in any form? ..... ❑ Yes ❑ No

(Tobacco or nicotine includes cigarettes, cigars, pipes, chewing tobacco, nicotine patches or other products containing nicotine. If "Yes," when was tobacco or nicotine last used? MONTH/YEAR _____)

Residence Address _____ City _____ State _____ Zip _____

Years at Residence _____ Annual Income $ _____ Net Worth $ _____

Phone _____ Email _____

Type of Business _____ Employer Name _____

Occupation/Job Title _____ Business Phone _____

Job Duties (Be Specific) _____ Date of Employment _____

Business Address _____ City _____ State _____ Zip _____

U.S. Citizen: ❑ Yes ❑ No If No, type of Visa _____ Expiration Date _____

2. OWNER (If other than Primary Proposed Insured)

Name _____ (First Name) (Middle Initial) (Last Name)

Relationship to Primary Proposed Insured _____ If Trust, date created _____

Date of Birth (MM/DD/YYYY) _____ Age _____ Sex _____ Social Security Number _____

Mailing Address _____ City _____ State _____ Zip _____

Contingent Owner (if any) _____ (First Name) (Middle Initial) (Last Name)

Relationship to Primary Proposed Insured _____

3. SECONDARY OR ALTERNATE ADDRESSEE (Optional Secondary Addressee for notification of past due premiums)

Name _____ (First Name) (Middle Initial) (Last Name)

Mailing Address _____ City _____ State _____ Zip _____

4. CHILDREN PROPOSED FOR INSURANCE (Complete for children term rider)

Last Name	First Name	MI	Relationship to Primary Proposed Insured	Date of Birth (MM/DD/YYYY)	Age	Ht.	Wt.	Sex (M/F)	Social Security Number

a. Has the name of any child age 18 or younger been omitted? ❑ Yes (Explain) _____ ❑ No

b. Is any child NOT living at the same address as the Primary Proposed Insured? ❑ Yes (Explain) _____ ❑ No

5. BENEFICIARY FOR PRIMARY PROPOSED INSURED (Unless specified, all beneficiaries in the same class share equally)

Primary: Last Name	First Name	MI	Relationship to Primary Proposed Insured	Date of Birth (MM/DD/YYYY)	Sex (M/F)	Social Security Number	Date of Trust (MM/DD/YYYY)	% Payable

Special beneficiary settlement options: ❑ Yes ❑ No (If Yes, complete and submit the state appropriate form for Additional Beneficiary Page)

5. BENEFICIARY FOR PRIMARY PROPOSED INSURED *(Continued)*

Contingent: Last Name	First Name	MI	Relationship to Primary Proposed Insured	Date of Birth (MM/DD/YYYY)	Sex (M/F)	Social Security Number	Date of Trust (MM/DD/YYYY)	% Payable

6. PRODUCT INFORMATION

Plan of insurance: ❑ ART ❑ 10-year ❑ 15-year ❑ 20-year ❑ 30-year

Face Amount $ _____ Premium amount $ _____

7. OPTIONAL RIDER

❑ Children Term Rider Face Amount $ _____ Premium Amount $ _____

8. INSURANCE AND REPLACEMENTS

a. Do you have existing life insurance or annuity coverage? ..... ❑ Yes ❑ No
If Yes, provide details. _____

b. Will the insurance applied for replace or use cash values of any existing life insurance or annuity issued by any company?.... ❑ Yes ❑ No
If Yes, indicate which one below. **Agent must provide and complete the appropriate replacement form.**

c. Total Insurance/Annuities in force on Proposed Insured(s): If none in force indicate "NONE".

Full Name of Company	Policy Number	Issue Date	Insured's Name	Plan	Amount	See "8b"

9. PRIMARY PROPOSED INSURED FAMILY HISTORY - COMPLETE IF FACE AMOUNT IS $100,000 OR GREATER

Parents:

	Is parent living (Yes/No)	Age if living	Age at death	Cause of death
Father				
Mother				

Siblings:

Number of living	Number Deceased	Age at death	Cause of death

a. Has anyone in the immediate family received treatment or a diagnosis of heart disease or stroke/cerebral vascular accident?... ❑ Yes ❑ No
Age at diagnosis _____

b. Has anyone in the immediate family received treatment or a diagnosis of internal cancer or melanoma? ..... ❑ Yes ❑ No
Type _____ Age at diagnosis _____

10. FAMILY PHYSICIAN, SPECIALIST OR CLINIC

Family physician, specialist or clinic of **Primary Proposed Insured:**

Provider Name _____ Date last visited _____

Reason for visit _____ Phone _____

Address _____ City _____ State _____ Zip _____

11. MEDICAL HISTORY QUESTIONS - LIFETIME

(For questions 11a through 13c, underline the reason for any Yes answer(s) and give complete details as requested in Section 14.)

a. Is any Proposed Insured taking any medication(s)?..... ❑ Yes ❑ No
If Yes, list medications and prescribed dosages _____

_____

HAS ANY PROPOSED INSURED EVER BEEN DIAGNOSED, TREATED, TESTED POSITIVE FOR, OR BEEN GIVEN MEDICAL ADVICE BY A MEMBER OF THE MEDICAL PROFESSION FOR A DISEASE OR DISORDER FOR:

b. a heart attack, heart murmur, chest pains, irregular heartbeat, stroke, high blood pressure, anemia or any disease or abnormality of the heart, blood or blood vessels? ..... ❑ Yes ❑ No

c. cancer, a tumor or abnormal growth of any kind? ..... ❑ Yes ❑ No

d. human immunodeficiency virus (AIDS virus), Acquired Immune Deficiency Syndrome (AIDS), or AIDS Related Complex (ARC)? .... ❑ Yes ❑ No

12. MEDICAL HISTORY QUESTIONS - LAST TEN YEARS

HAS ANY PROPOSED INSURED, WITHIN THE LAST TEN YEARS EVER BEEN DIAGNOSED, TREATED, TESTED POSITIVE FOR, OR BEEN GIVEN MEDICAL ADVICE BY A MEMBER OF THE MEDICAL PROFESSION FOR A DISEASE OR DISORDER FOR:

a. seizure, depression, anxiety, psychiatric treatment or counseling, paralysis, dizziness or any disease or abnormality of the brain or nervous system? ❑ Yes ❑ No

b. asthma, emphysema, chronic bronchitis, sleep apnea, tuberculosis, Chronic Obstructive Pulmonary Disease (COPD) or any disease or abnormality of the respiratory system? ❑ Yes ❑ No

c. any disease or abnormality of the stomach, intestines, rectum, pancreas, or liver, including cirrhosis, hepatitis and colitis? ❑ Yes ❑ No

d. any disease or abnormality of the kidneys, urinary bladder, prostate or genital system, including sugar or blood in the urine? ❑ Yes ❑ No

e. diabetes or any disease of the thyroid or other gland? ❑ Yes ❑ No

f. arthritis, lupus, physical deformity, any disease of the bones, muscles or joints, or any disease or abnormality of the eyes, ears or skin? ❑ Yes ❑ No

g. treatment or counseling for use of alcohol or alcoholism? ❑ Yes ❑ No

h. treatment or counseling for drug use or used marijuana, cocaine, heroin, barbiturates, amphetamines, hallucinogenics, narcotics or other habit-forming drugs, other than those prescribed by a physician? ❑ Yes ❑ No

i. if any Proposed Insured(s) is less than one year old, give birth weight: _____lb. _____oz. Was birth premature? ❑ Yes ❑ No

13. MEDICAL HISTORY QUESTIONS - LAST FIVE YEARS

HAS ANY PROPOSED INSURED, WITHIN THE LAST FIVE YEARS:

a. had any consultation, testing (except tests related to HIV), treatment, been examined by any physician or practitioner for any cause not previously mentioned in the application or had investigation recommended by a physician which has not been completed ❑ Yes ❑ No

b. had treadmill EKG or other cardiovascular test, chest X-ray, blood or other laboratory test (excluding HIV related testing)? ❑ Yes ❑ No

c. had a surgical operation or been under observation or treatment in any hospital or clinic or been advised to have an operation which was not performed? ❑ Yes ❑ No

14. MEDICAL HISTORY EXPLANATIONS

(Give full details below of all Yes answers to questions 11a through 13c)

Question	Person	Reason, condition, disease, injury, etc.	Date
% of Recovery	Name of attending physician	Attending physician address: Number/Street City State	
Question	Person	Reason, condition, disease, injury, etc.	Date
% of Recovery	Name of attending physician	Attending physician address: Number/Street City State	
Question	Person	Reason, condition, disease, injury, etc.	Date
% of Recovery	Name of attending physician	Attending physician address: Number/Street City State	
Question	Person	Reason, condition, disease, injury, etc.	Date
% of Recovery	Name of attending physician	Attending physician address: Number/Street City State	

15. INSURANCE HISTORY AND NON-MEDICAL HAZARDS

a. Has any Proposed Insured, in the past five (5) years, applied for life, accident or health insurance or for reinstatement of any such insurance that was declined, postponed, cancelled or withdrawn or modified as to plan, amount or rate? ..... ❑ Yes ❑ No
If Yes, give details._____

b. Has any Proposed Insured in the last six (6) months, applied for — or in the next six (6) months, is any Proposed Insured contemplating applying for — other insurance with this, or any other, company? ..... ❑ Yes ❑ No
If Yes, state how much and to whom._____

c. Has any Proposed Insured, in the past five (5) years, made — or is any Proposed Insured contemplating within the next twelve (12) months, making — flights as a pilot, student pilot, crew member, or observer? ..... ❑ Yes ❑ No
If Yes, complete and submit the appropriate questionnaire.

d. Has any Proposed Insured, in the past five (5) years, engaged in or in the next twelve (12) months, does any Proposed Insured intend to engage in mountain climbing, rock climbing, racing, SCUBA diving, hang-gliding, ballooning or skydiving? ..... ❑ Yes ❑ No
If Yes, complete and submit the appropriate questionnaire.

e. Has any Proposed Insured, in the past five (5) years, been convicted of a felony? ..... ❑ Yes ❑ No
If Yes, give details including county and state of conviction._____

f. Is any Proposed Insured currently on parole or probation? ..... ❑ Yes ❑ No
If Yes, give details._____

g. Has any Proposed Insured in the last two (2) years resided outside of the United States for more than four (4) weeks? ..... ❑ Yes ❑ No

h. Does any Proposed Insured plan to travel outside of the United States for more than four (4) weeks within the next twelve (12) months? ..... ❑ Yes ❑ No
If Yes, complete and submit the appropriate Questionnaire.

Primary Proposed Insured

i. Driver's license number _____ State _____

j. Have you plead guilty or been convicted of DWI/DUI or reckless driving in the last five (5) years? ..... ❑ Yes ❑ No
If Yes, give details._____

k. Have you plead guilty or been convicted of any other moving violations in the last five (5) years? ..... ❑ Yes ❑ No
If Yes, give details._____

AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE MEDICAL INFORMATION

I hereby authorize any physician, medical practitioner, hospital, clinic or other medical related facility, insurance company, insurance support organization, business partner, pharmacy, pharmacy benefit manager, government agency, group policy holder, employer, benefit plan administrator, the [MIB, Inc.,] the Department of Motor Vehicle Registration, and paramedical facility to provide to Standard Life and Accident Insurance Company, or to any agent, attorney, consumer reporting agency or independent administrator, including medical record retrieval services or pharmaceutical services, acting on Standard Life and Accident Insurance Company's or its reinsurers' behalf, information concerning advice, care or treatment sought by or provided to me and/or any other applicant for coverage, including information relating to medical history, medical conditions, treatment, hospitalizations or confinements, ailments, and/or drug, alcohol or tobacco usage of the Applicant(s). It is understood that Standard Life and Accident Insurance Company underwriters, claim examiners, reinsurers, attorneys, or the medical director may disclose such health information to the aforementioned parties for purposes of underwriting, compliance, record clarification or explanation, or in response to litigation, summons, or subpoenas. I understand that after this information is disclosed, the recipient may redisclose it resulting in loss of protection by federal regulations.

I understand that:

1. such information will be used by Standard Life and Accident Insurance Company for underwriting and insurability determinations;
2. I may refuse to sign this authorization and that my refusal to sign will affect my ability to obtain life insurance coverage;
3. a picture copy or photocopy of this authorization shall be as valid as the original; and
4. any authorized representative of the Proposed Insured is entitled to receive a copy of this authorization upon request. This authorization is valid from the date signed for a duration of 24 months. I understand I may revoke the authorization at any time, except to the extent that action has been taken in reliance on this authorization, by sending written notice to the Life Underwriting Department of STANDARD LIFE AND ACCIDENT INSURANCE COMPANY[P.O. Box 1720, Galveston, Texas 77553.]I may inspect or copy any information used or disclosed under this authorization, if signed.

APPLICATION DECLARATIONS AND AGREEMENTS

Each of the undersigned declare for themselves, and all other interested parties, that all of the answers in all pages of this application and any supplements to it are full, complete and true to the best of their knowledge and belief.

They also agree that:

1. these answers as written:
   i. were given to induce the Company to issue a Policy; and
   ii. shall form the basis for and become a part of any Policy issued on this application;
2. except as otherwise provided in the conditional receipt, no Policy will be effective until it is:
   i. issued;
   ii. delivered to the Applicant; and
   iii. the full first premium paid, all during the lifetime and good health of the insured(s);
3. the Company may issue a policy different from that specified in this application by listing the difference(s) on the Policy Data Page, and acceptance of such different Policy will be a ratification of the changes except that no change in:
   i. amount of insurance;
   ii. classification;
   iii. plan of insurance; or
   iv. benefits, will be effective unless agreed to by the Applicant in writing;
4. the Company is not bound by any statements made by anyone or any other facts known to anyone concerning any Proposed Insured(s) if not in writing in this application or any supplement, amendment, or modification to it which has been approved by the Company; and
5. only the President or a Vice President or Secretary of the Company has the authority to waive any of the Company rights or requirements or to waive or alter any of the provisions of:
   i. this application and any supplement, amendment or modification to this application which has been approved by the Company; or
   ii. any Policy issued on this application including any supplement, amendment or modification to this application which has been approved by the Company.

FRAUD WARNING

Any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and may subject such person to criminal and civil penalties.

FCRA / MIB ACKNOWLEDGEMENT

I have received the notification about the Federal Fair Credit Reporting Act and the [MIB, Inc.]

APPLICATION SIGNATURES

If Conditional Receipt to be attached, I hereby certify that I have read and received the conditional receipt, and agree to its terms. I understand that the company will not permit acceptance of my deposit or detachment of the conditional receipt unless this statement is true (if one given).

Date	Dated at: City, State, Country
Signature of Primary Proposed Insured	Signature of owner if other than Proposed Insured
Print agent's name	Witnessed by: Signature of licensed agent

CONDITIONAL RECEIPT

THIS RECEIPT SHALL BE VOID IF ALTERED OR MODIFIED

Standard Life and Accident Insurance Company
Mailing Address: [P.O. Box 3297, Springfield, MO 65804-9998]

PREMIUM CHECK(S) MUST BE MADE PAYABLE TO STANDARD LIFE AND ACCIDENT INSURANCE COMPANY. DO NOT MAKE CHECK(S) PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

I have received $_____ in connection with an application for life insurance. If each of the following four conditions is satisfied fully, then, subject to the maximum amount limitation described below, insurance as provided by the terms and conditions of the Policy applied for will become effective on the effective date, as defined below.

1. The payment received with the application must equal the minimum initial premium required for the plan(s) and amount(s) of insurance applied for and the mode of premium payment selected;
2. All medical examinations and tests required under the Company's initial application requirements must be completed and the reports of those medical examinations and tests must be received at the company's Home Office within 45 days after the date of this receipt;
3. On the effective date, as defined below, all persons proposed for insurance must be in good health and insurable at standard premium rates for the plan(s) and amount(s) of insurance requested in the application.
4. There is no material misrepresentation in the application.

MAXIMUM AMOUNT LIMITATION: At no time and in no event shall the total liability of the Company under this receipt and all other receipts providing conditional insurance coverage with the Company on the lives of all the persons proposed for insurance exceed $500,000.

EFFECTIVE DATE MEANS THE LATEST OF: (a) the date of completion of the application; (b) the date of completion of all medical exams and tests required by the Company; and (c) if the Applicant requests a Policy date which is later than the date of this receipt, the Policy date requested by the Applicant.

REFUND OF PAYMENT: If one or more of the above conditions 1, 2, 3 or 4 have not been satisfied fully within 45 days after the date of this receipt, the Company's liability is limited to a refund of the amount paid. Only the President, a Vice President or Secretary of the Company has the authority to waive any of the Company rights or requirements, or to waive or alter any of the provisions of this receipt or amend it in any way.

_____ _____

Date Dated at: City State

_____

Signature of Licensed Agent

I have read this Conditional Receipt. It has been explained to me by the agent.

_____

Signature of Primary Proposed Insured

_____

Signature of Owner (if other than Primary Proposed Insured)

AGENT: THIS NOTICE MUST BE LEFT WITH THE PROPOSED INSURED.

Standard Life and Accident Insurance Company
Mailing Address: [P.O. Box 3297, Springfield, MO 65804-9998]

In connection with your application, Standard Life and Accident Insurance Company (Standard Life), or its reinsurers, may obtain medical and other information for evaluation purposes. Standard Life may obtain that information from MIB, Inc. or any medical professional, medically related facility, insurance support organization or insurance company who possesses information about the care, treatment or advice given you or your family. That information could concern drugs, alcoholism or mental illness. Standard Life may also obtain an investigative consumer report on you.

[MIB, Inc. Pre-notification – Information regarding your insurability will be treated as confidential. Standard Life or its reinsurers may, however, make a brief report thereon to MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB, Inc. member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, Inc. upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information in your file. Please contact MIB, Inc. at 866.692.6901. If you question the accuracy of the information in MIB, Inc.'s file, you may contact MIB, Inc. and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB, Inc.s information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Standard Life, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB, Inc. may be obtained on its website at www.mib.com.]

Fair Credit Reporting Act Pre-notification – Federal and state laws require notification that, with your application, we may request an investigative consumer report. In addition, such a report may be requested subsequently to update our records or if you apply for additional coverage. Upon written request, we will inform you whether or not an investigative consumer report was requested and, if such report was requested, the address and telephone number of the investigative agency to which the request was made. By contacting the local office and providing the proper identification, you may inspect, or for the appropriate fee, receive a copy of such report. Typically, the report will contain information as to character, general reputation, personal characteristics, and mode of living, which information is obtained through an interview with you or an adult member of your family, employers or business associates, financial sources, friends, neighbors, or others with whom you are acquainted. The information will consist, when applicable, of a confirmation of your identity, age, residence, marital status, and past and present employment including occupational duties, financial information, driving record, sports and recreational activities, health history, use of alcohol or drugs if any, living conditions and type of community.