SHELTER LIFE INSURANCE COMPANY

1817 West Broadway
Columbia, Missouri 65218-0001

# INDIVIDUAL LIFE INSURANCE APPLICATION

Agent Name:

Agent #:

Agent Phone #:

Family #:

## Personal Information

1. Name: Gender: SSN: Marital Status:
2. Birth Date: Age: Height: Weight: Place of Birth:
3. Physical Address: County:
3a. Mailing Address: County:
4. Home Phone: Cell Phone: Best Time to Contact:
5. Driver's License Number: State:
6. Country of Citizenship: Length of Residency in US:
   Visa Type: Category: Expiration Date:
7. Occupation: Name of Employer: Date Employed:
8. Annual Earned Income: Income All Sources:

## Coverage Information

9. Plan: Face Amount: $ Rate Class:
10. Waiver of Premium: Accidental Death: Amount: $
11. Mode Premium: $ Mode of Premium: Premium included with application: $
11a. Remarks:

## Information for Other Involved Parties

12. Primary Beneficiary:

    Contingent Beneficiary:

    Payor:

    Owner:

    Successor Owner:

## Existing Insurance Information

13. Total individual life insurance and accidental death coverage in force or pending (excluding this application):

| | (Life) | (Accidental Death) |
|---|---|---|
| With Shelter Life: | $ | $ |
| With Other Companies: | $ | $ |

13a. Amount of life insurance on: Father: Mother: Sibling #1: Sibling #2:
Sibling #3: Sibling #4: Sibling #5: Sibling #6: Sibling #7:

14. Will this insurance replace or change any existing life insurance policy or annuity contract with any company including Shelter Life?
☐ Yes ☐ No Please send replacement form(s) with this application. Policy Number:
Company being replaced: Face Amount:

Proposed Insured Name: Application Number:

## Underwriting Information

15. Have you seen a doctor within the past 5 years? Yes ☐ No ☐

Please provide the following information for your most recent doctor consultation(s):

Hospital or clinic: Date of last consultation:
Physician's name: Reason for last consultation:
Street address: Diagnosis:
City, State, Zip: Treatment:
Phone Number: Medication(s) prescribed:
Fax Number:

16. Do you have a parent or sibling who has been diagnosed with or treated for diabetes, heart or kidney disease, or hypertension? Yes ☐ No ☐
Relationship to Insured: Explanation:

17. Do you have a parent or sibling who died before age 60? Yes ☐ No ☐
Relationship to Insured: Age at death:
Explanation:

18. Have you ever engaged in or do you anticipate engaging in within the next 2 years:
a) Aviation activities, including ultralight flying, hang gliding or parachute jumping? Yes ☐ No ☐

b) Rodeo riding, underwater diving, racing of any motor powered vehicle, or rock and mountain climbing? Yes ☐ No ☐

19. In the past five years: Yes ☐ No ☐
a) Has your driver's license been suspended or revoked?
b) Have you plead guilty to a moving violation or been involved in any accident where you were found to be at fault?
c) Have you plead guilty or been convicted of driving while impaired, intoxicated, or under the influence of any drug?
Violation Date: Description:

20. Are you planning travel, residence, or employment outside the United States within the next two years? Yes ☐ No ☐
Travel Dates: Description:

21. Do you now use or have you ever used any form of tobacco or nicotine substitutes? Yes ☐ No ☐
Date last used: Details:

22. Are you in the National Guard or Reserves? Yes ☐ No ☐
Details:

23. Have you ever plead guilty to or been convicted of a felony or misdemeanor or have such a charge currently pending against you? Yes ☐ No ☐
Date of occurrence: Nature of plea, charge, or conviction:
Was prison time served? Are you currently on probation or parole?

## Medical Information

Questions in the Medical Information section (questions 24-41) may be left unanswered if a medical exam is required.

24. To the best of your knowledge and belief, have you ever been diagnosed or treated by a medical professional for hypertension, coronary artery disease, stroke, heart attack, chest pain, irregular heartbeat, or any other disease or disorder of the heart or blood vessels? Yes ☐ No ☐
Date of diagnosis:
Description of illness or injury, medical attention received, remaining effects, and any other details:

Treating hospital(s) and/or physician(s):

25. To the best of your knowledge and belief, have you ever been diagnosed or treated by a medical professional for cancer, tumor or other growth or malignancy of any kind? Yes ☐ No ☐
Date of diagnosis:
Description of illness or injury, medical attention received, remaining effects, and any other details:

Treating hospital(s) and/or physician(s):

Proposed Insured Name: Application Number:

## Medical Information Continued

26. To the best of your knowledge and belief, have you ever been diagnosed or treated by a medical professional for bronchitis, emphysema, shortness of breath or any other disease or disorder of the lungs or respiratory system? Yes ☐ No ☐
    Date of diagnosis:
    Description of illness or injury, medical attention received, remaining effects, and any other details:

    Treating hospital(s) and/or physician(s):

27. To the best of your knowledge and belief, have you ever been diagnosed or treated by a medical professional for depression, anxiety or any other behavioral, mental or nervous disorder? Yes ☐ No ☐
    Date of diagnosis:
    Description of illness or injury, medical attention received, remaining effects, and any other details:

    Treating hospital(s) and/or physician(s):

28. To the best of your knowledge and belief, have you ever been diagnosed or treated by a medical professional for epilepsy, seizures, sleep apnea or any other disease or disorder of the brain or nervous system? Yes ☐ No ☐
    Date of diagnosis:
    Description of illness or injury, medical attention received, remaining effects, and any other details:

    Treating hospital(s) and/or physician(s):

29. To the best of your knowledge and belief, have you ever been diagnosed or treated by a medical professional for diabetes, hepatitis, anemia or any other disease or disorder of the blood or glands? Yes ☐ No ☐
    Date of diagnosis:
    Description of illness or injury, medical attention received, remaining effects, and any other details:

    Treating hospital(s) and/or physician(s):

30. To the best of your knowledge and belief, have you ever been diagnosed or treated by a medical professional for arthritis, gout, or any other disease or disorder of the bones, muscles, joints, eyes or skin? Yes ☐ No ☐
    Date of diagnosis:
    Description of illness or injury, medical attention received, remaining effects, and any other details:

    Treating hospital(s) and/or physician(s):

31. To the best of your knowledge and belief, have you ever been diagnosed or treated by a medical professional for any disease or disorder of the stomach, intestines, colon, rectum, liver, pancreas or digestive system? Yes ☐ No ☐
    Date of diagnosis:
    Description of illness or injury, medical attention received, remaining effects, and any other details:

    Treating hospital(s) and/or physician(s):

32. To the best of your knowledge and belief, have you ever been diagnosed or treated by a medical professional for any disease or disorder of the kidney, bladder, prostate, urinary system or genital organs including complication of pregnancy? Yes ☐ No ☐
    Date of diagnosis:
    Description of illness or injury, medical attention received, remaining effects, and any other details:

    Treating hospital(s) and/or physician(s):

33. To the best of your knowledge and belief, have you ever been diagnosed or treated by a medical professional for Acquired Immune Deficiency Syndrome (AIDS), positive HIV test, or other immunological disorder? Yes ☐ No ☐
    Date of diagnosis:
    Description of illness or injury, medical attention received, remaining effects, and any other details:

    Treating hospital(s) and/or physician(s):

Proposed Insured Name: Application Number:

## Medical Information Continued

34. Are you now pregnant? Yes ☐ No ☐
    Approximate Delivery Date:
    Treating hospital(s) and/or physician(s):

35. Are you currently receiving treatment, taking medication, or scheduled to have surgery? Yes ☐ No ☐
    Date of diagnosis:
    Description of illness or injury, medical attention received, remaining effects, and any other details:

    Treating hospital(s) and/or physician(s):

36. Have you had weight loss of more than 10 lbs. in the past year? Yes ☐ No ☐
    Date: Number of pounds lost:
    Reason for and details of weight loss:

    Treating hospital(s) and/or physician(s):

37. Have you used or do you now use cocaine, methamphetamines, marijuana or any other drugs? Yes ☐ No ☐
    Date last used: Length of drug use:
    Amount: Frequency:
    Drug type(s):
    Details including any remaining effects:

    Treating hospital(s) and/or physician(s):

38. Have you used or do you now use alcoholic beverages? Yes ☐ No ☐
    Date of last drink: Frequency:
    Amount: Alcohol type(s):
    Details including any remaining effects:

    Treating hospital(s) and/or physician(s):

39. Have you sought or received treatment or counseling for alcohol or drug use? Yes ☐ No ☐
    Date of treatment: Duration:
    Description of illness or injury, medical attention received, remaining effects, and any other details:

    Treating hospital(s) and/or physician(s):

40. In the past five years, have you made a claim for or received benefits, compensation, or pension for any injury, sickness, disability, or impaired condition? Yes ☐ No ☐
    Dates:
    Description of illness or injury, medical attention received, remaining effects, and any other details:

    Treating hospital(s) and/or physician(s):

41. In the past 5 years, have you consulted any physician or health care facility, been hospitalized, had any abnormal diagnostic tests or been advised to have treatment for any reason not explained above? Yes ☐ No ☐
    Date of diagnosis:
    Description of illness or injury, medical attention received, remaining effects, and any other details:

    Treating hospital(s) and/or physician(s):

Proposed Insured Name: Application Number:

## Special Requests

42.

# Signatures/Declaration

The Owner and Proposed Insured, if other than the Owner, each declares that he or she has read the answers recorded in this application and that they are complete and true to the best of his or her knowledge and belief, and agrees that:

a. this application and any amendments to it and any statements made and recorded on the medical examination form shall become the basis for and be a part of any contract of insurance;

b. any policy or rider issued on the basis of this application will belong to and be solely under the control of the Owner;

c. only the Shelter Life Insurance Company, at its Home Office, may make or modify contracts or waive any of its rights or requirements, and then only in writing;

d. no Agent of Shelter Life Insurance Company and no Medical Examiner is authorized to accept or pass upon insurability; and

e. except as provided in the Conditional Coverage Receipt, if issued, insurance will not be effective unless:
(1) a policy is delivered to the Owner during the lifetime of all persons proposed for insurance; and
(2) to the best of the Owner's and Proposed Insured's knowledge there has been no material change in the answers herein since the date of this application or the completion of all medical examination requirements.

THE OWNER DECLARES THAT THE CONDITIONAL COVERAGE RECEIPT HAS BEEN DETACHED FROM THIS APPLICATION AND GIVEN TO HIM OR HER Yes ☐ No ☐

IF "YES" THE OWNER FURTHER DECLARES THAT THE TERMS AND CONDITIONS OF THE CONDITIONAL COVERAGE RECEIPT HAVE BEEN BROUGHT SPECIFICALLY TO HIS OR HER ATTENTION AND THAT HE OR SHE UNDERSTANDS AND ACCEPTS THEM.

THE PROPOSED INSURED ACKNOWLEDGES RECEIPT OF THE NOTICE OF CONSUMER REPORT AND MIB PRE-NOTICE AS REQUIRED BY THE CONSUMER PROTECTION AGENCY.

THIS APPLICATION IS A LEGAL DOCUMENT. THE POLICY MAY BE ALTERED OR RESCINDED IF THE QUESTIONS ARE NOT ANSWERED CORRECTLY AND TRUTHFULLY.

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 this _____ day of _____ _____ at _____ ☐ A.M. ☐ P.M. in the city of_____ State of _____
Month Year Time

Signature of Proposed Insured or of Parent or Legal Guardian if Under Age 18

Signature of Owner, if other than Proposed Insured, or of Parent or Grandparent Owner if Proposed Insured is Under Age 18

Owner's Social Security Number

I HEREBY CERTIFY THAT I PERSONALLY ASKED EVERY QUESTION OF THE OWNER, AND PROPOSED INSURED IF OTHER THAN OWNER, AND ACCURATELY RECORDED THE ANSWERS GIVEN AND THAT I WITNESSED THE SIGNATURE(S) ABOVE.

Print Name of Writing Agent

Signature of Writing Agent

Agent's Number

# Medical Test Authorization

I hereby authorize Shelter Life Insurance Company to obtain medical tests on blood, oral fluid, or urine samples in connection with the underwriting of my application for insurance with Shelter Life Insurance Company.

I understand that such tests will be performed by laboratories selected by Shelter Life Insurance Company and may include, but are not limited to, tests for cholesterol and related blood lipids, diabetes, hepatitis or other liver disorders, kidney disorders, infection by the Acquired Immune Deficiency Syndrome virus, immune disorders, or the presence of medications, drugs, nicotine, or their metabolites.

The results of these tests will be made known only to Shelter Insurance Companies, and/or their reinsurers, and possibly the Medical Information Bureau as described in the Pre-Notice which was given to me as part of the application process. Positive HIV and hepatitis test results will be reported to your State Department of Health if we or the testing laboratory are required to do so by law. Test results will not be released to anyone else or any institution except as required by law, by court order or by written authorization from me to release it to a physician designated by me.

| Date | Signature of Proposed Insured or Parent if Proposed Insured is a Juvenile |
|---|---|

**Authorization for Use or Disclosure**
**Of Protected Health Information**

1. I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, MIB Group, Inc. or other organization, institution, or person, that has any records or knowledge of me or my health, to give to the Shelter Life Insurance Company, its Medical Director, its reinsurers, and Shelter Mutual Insurance Company, any and all such health information. I further authorize Shelter Life Insurance Company, and its reinsurers, to disclose such protected health information to MIB Group, Inc., a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members.

2. I understand that this protected health information will be used to locate or underwrite insurance for me, or to determine whether a valid claim for benefits has been made. The information may also be disclosed by Shelter Life Insurance Company to MIB, who, upon request, may disclose such information about me in its file to another member company with whom I apply for life or health insurance or to whom a claim for benefits may be submitted.

3. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations.

4. I understand that the information in my health record may include information that may be considered a communicable or venereal disease that may include, but is not limited to diseases such as hepatitis, syphilis, gonorrhea, and acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

5. This authorization is valid for 12 months from the date of signing. I understand that I may revoke this authorization at any time by sending written notification to Shelter Life Insurance Company, 1817 West Broadway, Columbia, MO 65218-0001, except to the extent that action has been taken in reliance on this authorization. A photographic copy of this authorization will be treated in the same manner as the original.

_____
Print Name and Date of Birth of Proposed Insured

_____ _____
Signature of Proposed Insured or Parent if Proposed Insured is a Juvenile Date

_____
Print Name and Date of Birth of Spouse, If Applying

_____ _____
Signature of Spouse, If Applying Date

A copy of this signed form will be provided to the individual upon request.

THIS AUTHORIZATION MEETS THE REQUIREMENTS SET FORTH IN THE HIPAA PRIVACY RULE (45 CFR 164.508).

Detach and leave with Proposed Insured
or owner **ONLY IF** premium is collected with application.

# Conditional Coverage Receipt

CONDITIONAL COVERAGE RECEIPT - void if altered or modified or if check given in payment is not honored.

NO INSURANCE WILL BE EFFECTIVE BEFORE POLICY DELIVERY TO PROPOSED INSURED OR OTHER OWNER UNLESS ALL THE CONDITIONS ON THIS RECEIPT ARE FULFILLED EXACTLY.

Premium received from _____ Amount $_____
in connection with the application for insurance made on this date to Shelter Life Insurance Company, 1817 West Broadway, Columbia, Missouri 65218-0001.

Policy Applied For _____ Face Amount $_____

by _____ _____ _____
Signature of Writing Agent | Agent's Number | Date

ALL PREMIUM CHECKS MUST BE PAYABLE TO SHELTER LIFE INSURANCE COMPANY. DO NOT POSTDATE OR MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

If Shelter Life Insurance Company declines to issue the policy applied for, or issues it other than as applied for, which you do not accept, the payment will be returned.

PAYMENT BY CREDIT OR DEBIT CARD - Payment will be charged to your card on the date and time of the application. If Shelter Life Insurance Company declines to issue the policy applied for, or issues it other than as applied for, which you do not accept, the payment will be returned by company check.

**CONDITIONS PRECEDENT - EFFECTIVE DATE OF INSURANCE**

The insurance for which you (Proposed Insured) have applied, will be effective on the date of the application or the date a required medical examination and/or test(s) of any kind is completed, whichever is later, but only if the following conditions are met:

1. You have paid the full premium with the application;
2. You have completed all medical examination requirements;
3. We (Shelter Life Insurance Company), at our Home Office, have determined by our guidelines, that all persons for whom coverage is requested are qualified for the types and amounts of insurance requested at the premium paid.

If the above conditions are not met, no one for whom insurance is requested will be insured unless we offer and you accept the policy under modified terms. That modified policy will be effective on the date approved by us at our Home Office only if (1) we deliver your policy while all persons in the application are alive; (2) to the best of your knowledge there has been no material change in your answers on the application since the application date; and (3) you have paid any additional premium and/or signed any endorsements required.

CONDITIONAL COVERAGE AMOUNT AND LIMIT - The amount of insurance which may become effective on any person to be insured under the policy applied for prior to delivery will not exceed the lesser of: (a) $250,000, including accidental death benefits, on all pending applications or (b) the amount applied for.

NO AGENT OF SHELTER LIFE INSURANCE COMPANY IS AUTHORIZED TO CHANGE ANY PROVISION OR CONDITION OF THIS RECEIPT.

Detach and leave with Proposed Insured
when application is written.

**MIB PRE-NOTICE**

Information regarding your insurability will be treated as confidential. Shelter Life Insurance Company or its reinsurer(s) may, however, make a brief report thereon to **the 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 member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is **50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734**.

Shelter Life Insurance Company, 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 may be obtained on its website at www.mib.com.**

**NOTICE OF CONSUMER REPORT**

As a part of our normal underwriting procedure, an investigative consumer report may be made to give us applicable information concerning character, general reputation and personal characteristics except as may be related directly or indirectly to the Insured's mode of living of persons to be insured. This information will be obtained through personal interviews primarily with you or your family, friends, neighbors, business associates and financial sources. Upon written request to the Life Underwriting Department at Shelter Life Insurance Company's home office in Columbia, Missouri, additional information as to the nature and scope of the Investigative Consumer Report, if one is made, will be furnished to you.