Application for [Marketing Name] Individual Term Life [Insurance]

[PARACHUTE]

Issuing company:
Securian Life Insurance Company
[400 Robert Street North
St. Paul, Minnesota 55101-2098]

FIRST NAME	[MIDDLE NAME]	LAST NAME	[SUFFIX]

HOME ADDRESS

CITY	STATE	ZIP

DATE OF BIRTH	GENDER

PHONE NUMBER	EMAIL ADDRESS

[PLACE OF BIRTH]	[SOCIAL SECURITY NUMBER]

[DRIVER'S LICENSE / STATE ID NUMBER]	[HEIGHT FT. IN.]	[WEIGHT LBS]

Select the term for your non-renewable term life insurance:

☐ [X Years]

Select the coverage amount:

☐ [$X,XXX]

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[Please add [XYZ optional benefit] ☐ Yes

[Children to be insured:]

[Child Name _____
Gender _____
Date of Birth _____]]

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[Do you have any existing life insurance or any annuity contracts in force with any insurer?
☐ Yes ☐ No

Do you intend for this policy to replace or change any annuity or life insurance policy (excluding AD&D coverage) you have with any company? ☐ Yes ☐ No

[What is your annual household income? _____]

[Are you a United States citizen or a permanent resident of the United States in possession of a valid, unexpired green card? ☐ Yes ☐ No]

[Are you actively performing all the duties of your regular occupation for a [full work week] of [30 hours] or more? ☐ Yes ☐ No]

[In the past [12 months], have you used tobacco or nicotine products in any form including cigarettes, chewing tobacco, cigars, e-cigarettes or vaping products? ☐ Yes ☐ No]

[Have you been:
[a) Hospitalized for heart disease or stroke within the past [12 months]; ☐ Yes ☐ No]
[b) Diagnosed by a medical professional or tested positive for a condition, disorder, or disease that could limit your life expectancy to [two years] or less within the past [two years]; ☐ Yes ☐ No]
[c) Diagnosed or treated by a member of the medical profession for cancer within the past [12 months]? ☐ Yes ☐ No]]

[Within the past [two years] have you been advised by a medical professional to have any surgery, hospitalization, or test (except for tests related to HIV or AIDS) which was not completed?
☐ Yes ☐ No]

[Have you missed [five] or more consecutive work days [or have you been unable to dress yourself, feed yourself, bathe yourself, or walk] due to disability, injury, or sickness within the past [two years]? ☐ Yes ☐ No]

[Have you had life, disability, or health insurance declined, postponed, changed, rated-up, canceled or withdrawn within the past [five years]? ☐ Yes ☐ No]

[During the past [five years], have you been convicted of driving while intoxicated, had your driver's license suspended or revoked, or been convicted of more than [three] moving violations?
☐ Yes ☐ No]

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[Have you declared bankruptcy in the last [five years] (personal or business)? ☐ Yes ☐ No]

[Have you ever been convicted of a felony or are felony charges currently pending? ☐ Yes ☐ No]

[Have you [within the past [five years]] [ever] been treated or diagnosed by a medical professional for any of the following?

Check all that apply.

[☐ High blood pressure]
[☐ High cholesterol]
[☐ Heart disease or disorder]
[☐ Stroke or mini-stroke, heart attack, heart disease, heart blockage, stents, or bypass surgery for artery and/or vein cancers or tumors]
[☐ Diabetes]
[☐ Cancer]
[☐ Neurological disorders]
[☐ Autoimmune or other immune system disorders]
[☐ Respiratory or lung disorder [, except for mild asthma]]
[☐ Kidney [failure or kidney condition requiring dialysis] [disease]
[☐ Mental or nervous disorder]
[☐ None of these]]

[Have you ever been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)? ☐ Yes ☐ No]

[In the last [ten years], have you] [Have you ever] been diagnosed with or treated for cancer or a cyst, polyp, lesion or tumor by a medical professional? ☐ Yes ☐ No]

[Have you ever been treated or diagnosed for drug or alcohol abuse or addiction or been advised by a medical professional to discontinue the use of drugs or alcohol? ☐ Yes ☐ No]

[Other than alcohol and cannabis/marijuana, [in the last [ten years], have you] [have you ever] used any drugs other than as directed or prescribed by your physician or been advised by a medical professional to reduce your use of drugs? ☐ Yes ☐ No]

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[[In the last [ten years], have you] [Have you ever] used cannabis/marijuana in any form?
☐ Yes ☐ No]

[How many alcoholic beverages do you consume per day on average? _____]

[Have you had any unexplained weight loss or gain of more than [10] pounds in the last [90 days]?
☐ Yes ☐ No]

[What is the name and address of your primary care physician or treatment facility? If none, state so:

Name: _____

Address: _____

State: _____ Zip Code: _____

☐ I do not have a primary care physician]

[Have you had a biological parent or sibling die from heart disease, cancer, stroke, or diabetes before the age of [70]? ☐ Yes ☐ No]

[Have you, your biological parents or siblings ever been diagnosed with or treated by a medical professional for [Polycystic Kidney Disease, Huntington's Chorea, or Sickle Cell Anemia (not Sickle Cell Trait)]? ☐ Yes ☐ No]

[[In the last [ten years], have you] [Have you ever] been treated or diagnosed by a medical professional for mental or nervous disorders? ☐ Yes ☐ No]

[Except for reasons previously disclosed or routine physicals with normal results, have you been treated, examined or advised by a medical professional [within the past year]? ☐ Yes ☐ No]

[Except for reasons previously disclosed, have you been hospitalized [and/or treated] by a medical professional for any other condition [within the past year]? ☐ Yes ☐ No]

[Are you taking any other medication (prescription or over the counter) for a condition not previously disclosed? ☐ Yes ☐ No]]

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[In the past [five years] were you hospitalized for Coronavirus, also known as COVID-19? ☐ Yes ☐ No]

[ADDITIONAL UNDERWRITING INFORMATION]

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Beneficiary

Who do you want to leave the insurance proceeds to?

BENEFICIARY #1		
NAME	SOCIAL SECURITY NUMBER	
RELATIONSHIP TO YOU	PHONE NUMBER	
ADDRESS		PERCENTAGE OF PROCEEDS

BENEFICIARY #2		
NAME	SOCIAL SECURITY NUMBER	
RELATIONSHIP TO YOU	PHONE NUMBER	
ADDRESS		PERCENTAGE OF PROCEEDS

BENEFICIARY #3		
NAME	SOCIAL SECURITY NUMBER	
RELATIONSHIP TO YOU	PHONE NUMBER	
ADDRESS		PERCENTAGE OF PROCEEDS

TOTAL = 100%

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I agree that:

- I have read the application and to the best of my knowledge and belief, all statements in this application for life insurance are true and complete.
- I understand that if the initial premium payment is not received within 7 days of the application, my coverage will be voided.
- If any of the statements or information provided in this application are false or incomplete, the policy may be rescinded. Any amounts paid will be returned without interest, and no benefits will be paid to any beneficiary.
- 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.
- The statements and answers in the application are the basis for any policy issued by the company. No information about you will be considered to have been given to the company unless it is stated in the application. You will notify the company of any changes in the statements or answers given in the application between the time of application and delivery of policy.

Note:

- Agent does not have the company's authorization to accept risk, pass on insurability, or make void, waive or change any conditions or provisions of the application, policy, or receipt, as applicable.
- Securian Life Insurance Company will have no liability until policy is issued on this application and delivered to and accepted by the owner; and the initial premium due is paid in full while each proposed insured is alive.

[[Authorization]

I authorize Securian Life Insurance Company ("the Company") to share any information provided in this application with any physician, medical practitioner, hospital, clinic or other health care provider, pharmacy, pharmacy benefits manager, insurance or reinsuring company, consumer reporting agency, the MIB, Inc., or any other data aggregator (collectively the "Sources") which has any records or knowledge of my credit worthiness, credit standing, credit capacity, character, general reputation, personal characteristics, mode of living, purchase history, drug prescriptions, driving records, hazardous avocations, court records, foreign travel records, or physical or mental health (collectively, "Personal Information"), and/or the Personal Information of each minor child listed as the proposed insured for the purpose of performing actuarial or internal business studies, research, analytics, or other analysis. This shall include ALL INFORMATION as to any medical history, consultations, diagnoses, prognoses, prescriptions or treatments and tests, including information regarding alcohol or drug abuse, genetic testing results and findings and AIDS or AIDS-related conditions. To facilitate rapid submission of such information, I authorize all the Sources

to give such records or knowledge to Securian Life Insurance Company or with the exception of MIB, Inc., to any agency employed by Securian Life Insurance Company to collect and transmit such information.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this Authorization and I instruct any physician care professional, hospital, clinic, medical facility, or other health provider to release and disclosure my entire medical history without restriction.

I understand the Personal Information is to be used to: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; 5) perform actuarial or internal business studies, research, analytics, and other analysis; or 6) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Company. I understand the Personal Information may be made available to Underwriting, Claims, and support staff, licensed representatives, and firms of Securian Life Insurance Company. I authorize Securian Life Insurance Company or its reinsurers to release any such Personal Information to reinsuring companies, the MIB, Inc., or other persons or organizations performing business or legal services in connection with my application, claim or as may be otherwise lawfully required or as I may further authorize. I authorize Securian Life Insurance Company, or its reinsurers, to make a brief report of my personal, or if applicable, my protected health information to MIB, Inc. I understand that information used or disclosed under this authorization may be redisclosed by the recipient and may no longer be protected by federal or state law.

I agree this authorization shall be valid for 24 months from the date it is signed. The 24-month time limit complies with the time limit, if any, permitted by applicable law in the state where the policy is delivered or issued for delivery. I may revoke this authorization at any time by sending a written request addressed to Individual Underwriting department, Securian Life Insurance Company, [400 Robert Street North, St. Paul, MN 55101-2098]. I understand that a revocation is not effective to the extent that any action has been taken in reliance on this authorization.

I understand that the Sources may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization. I understand that if I refuse to sign this Authorization to release my complete medical record, Securian Life Insurance Company may not be able to process my application, or if coverage has been issued may not be able make any benefit payments.

I understand that I, or my legal representative, have the right to request and receive a copy of this Authorization and that a photocopy shall be as valid as the original.]

[[Consumer Privacy Notice

To underwrite your insurance request, the Company may ask for additional personal information, such as an insurance medical exam; lab tests; medical records from your insurance company,

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physician or hospital; a report from the MIB, Inc., a non-profit organization of life insurance companies that exchanges information among its members. Information about your insurability is confidential. Without your express authorization, the Company or its reinsurers may send your information to government agencies that regulate insurance; or, without identifying you, to insurance organizations for statistical studies. If you apply to a MIB, Inc. member company for life or health insurance, or submit a benefits claim for benefits to a member company, the MIB, Inc., upon request, will supply the member company with the information in its file. You or your authorized representative have the right to: receive by mail or to copy your personal information in the Company or MIB, Inc. files, including the source and who received copies within the past two years; to correct or amend personal information in these files; to know specific reasons why coverage was not issued as applied for; and to revoke your authorization at any time. At your written request, within 30 days the Company will explain in writing how to learn what is in your file, its source, how to correct or amend it or how to learn why coverage was not issued as applied for. You can send the Company a written statement as to why you disagree. If we correct or amend the information, we will notify you and anyone who may have received the information. If we do not agree with your statement, we will notify you and keep your statement in your file:

For further information about your application or your rights, contact:

Customer Service

[Securian Life Insurance Company

400 Robert Street North

St. Paul, Minnesota 55101-2098]

Telephone: [1-XXX-XXX-XXXX]

For information about the MIB, Inc., you may contact:

MIB, Inc

[50 Braintree Hill, Suite 400

Braintree, MA 02184-8734]

[MIB, Inc. Telephone: (866) 692-6901

MIB, Inc. TTY: (866) 346-3642]

[Website: www.mib.com]]

YOUR SIGNATURE		DATE: (MM/DD/YYYY)
[LICENSED AGENT SIGNATURE		DATE: (MM/DD/YYYY)
AGENT NAME	AGENT NUMBER	CONTACT INFORMATION]