CONTRACT

Agent Name_____

Agent # _____

Agent Telephone #_____

Applicant's Family #_____

SHELTER LIFE INSURANCE COMPANY

1817 WEST BROADWAY, COLUMBIA, MISSOURI 65218-0001

LIFE INSURANCE APPLICATION

PROPOSED INSURED

1. Name (Last) (First) (MI) (Suffix) | Soc. Sec. No. | ☐ Male ☐ Female
2. Marital Status | Hgt. ' " | Wgt. lbs. | Birth Date | Age | State of Birth
3. Physical Address (Street) (City) (County) (State) (Zip)
3a. Mailing Address If Different
4. Home Phone | Cell Phone | Best Time to Contact
5. Driver's License No. | State
6. Country of Citizenship: ☐ US ☐ Other
   If Other, provide the following: Country of Citizenship _____ Length of Residency in US _____
   Visa Type: ☐ Permanent ☐ Temporary If Temporary, Category | Expiration Date
7. Occupation | Name of Employer | Date Employed
   Annual Earned Income $ | Income All Sources $

BENEFICIARY

8. Primary (List name, address, age, relationship, payment option) (If a trust, list name of trustee, name & date of trust)

   Contingent

TERM / TRADITIONAL

9. ☐ 10 Yr. Level Term to 100 ☐ Whole Life ☐ YRT to 85 | Face Amount $
   ☐ 20 Yr. Level Term to 100 ☐ 20 Pay Whole Life ☐ | Mode Premium $
   ☐ 30 Yr. Level Term to 100 ☐ Secure Whole Life ☐
10. Rate Class: **(LT)** ☐ T ☐ PRF/T ☐ NT ☐ PRF/NT ☐ ULT PRF/NT **(YRT)** ☐ STD ☐ STD/NT ☐ PRF/NT **(All other)** ☐ STD ☐ NT
11. WP ☐ Yes ☐ No | AD ☐ Yes Amount $_____ ☐ No | Auto Prem Loan ☐ Yes ☐ No (Not available on term insurance)
12. Dividend Options: (WL & WL 20 Pay Only) ☐ Pd. Up. Adds ☐ Accum. at Interest ☐ Cash ☐ Reduce Premium (N/A on Special Monthly)

UNIVERSAL

13. ☐ Specified Amount - New Policy $ | Target Prem $ | Planned Prem (If more than Target) $
14. ☐ Specified Amount - Increase $ | to UL Policy # | Planned Prem after Increase $
15. Rate Class: ☐ STD ☐ NT | ☐ Option A (Level) ☐ Option B (Increasing) | WMD ☐ Yes ☐ No | AD ☐ Yes ☐ No

RIDERS

16. ☐ Paid Up Additional Insurance Rider Premium Amount (WL and 20 Pay WL) $_____ 1035 Exchange ☐ Yes ☐ No
17. ☐ Guaranteed Insurability Rider - Amount $ | 18. ☐ Payor Death or Disability Benefit (WL, 20 Pay WL, Secure WL)
19. Payor To Be Insured | Relationship | Sex | Hgt | Wgt | Birth Date | Age | US Cit? | Birth St. | SS No.

Payor's Occupation	Payor's Address

PREMIUM

20. ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Payroll Deduction
    ☐ PAC - Withdrawal Day of Month _____ Send Form & Void Check ☐ Government Allotment (Except YRT)
    ☐ Special Billing - Name & Address of Company _____
    Remarks _____
    ☐ Prem included with application $ ☐ COD | ☐ Paid Up Additional Insurance Rider Prem Collected $
21. Name and address of person paying premium **only if** other than proposed insured or owner

IN FORCE

22. a. Total individual life insurance and accidental death coverage in force or pending (excluding this application) in all companies including Shelter Life:	(Life) $	(Accidental Death) $	
b. If Proposed Insured is under 16, show amount of life insurance on:	(Father) $	(Mother) $	(Sibling[s]) $

REPLACEMENT

23. Will this insurance replace or change any existing life insurance policy or annuity contract with any company including Shelter Life?
☐ Yes ☐ No If Yes, list name of company, policy number, face amount and send replacement form(s) with application.

QUESTIONS 24 THROUGH 40 MUST BE ANSWERED FOR EACH PERSON TO BE INSURED

UNDERWRITING INFORMATION

24. List attending physician(s) for proposed insured(s) and provide name, address, phone number, date and reason for most recent consultation(s), treatment received and medications prescribed:

Physicians name, address and telephone number	Date/Reason/Diagnosis/Treatment/Medications Prescribed

	Yes	No
25. Do you have a parent, brother or sister who:		
a. has been diagnosed or treated for diabetes, heart disease, kidney disease or hypertension?	☐	☐
b. died before age 60? If yes, list relationship, age & cause of death in question 32	☐	☐
26. Have you engaged in or do you anticipate in the next two years engaging in:		
a. Aviation activities, including ultralight flying, hang gliding or parachute jumping?	☐	☐
b. Rodeo riding, underwater diving, racing of any motor powered vehicle or rock and mountain climbing?	☐	☐
27. In the past five years:		
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?	☐	☐
28. Are you planning travel, residence or employment outside the United States in the next two years?	☐	☐
29. Do you now use or have you ever used any form of tobacco or nicotine substitutes?	☐	☐
If yes, give date last used in question 32.		
30. Are you in the National Guard or Reserves?	☐	☐
31. Have you ever plead guilty to or been convicted of a felony or misdemeanor or have such a charge currently pending against you?	☐	☐
If yes, please list the nature of the plea, conviction or charge; the date of occurrence; whether prison time was served; and if you are currently on probation or parole.		

32. FOR ALL YES ANSWERS TO QUESTIONS 25 THRU 31. GIVE FULL DETAILS BELOW.

Question No.	Name of Person	Date	Details

QUESTIONS 33 THROUGH 40 MAY BE OMITTED IF A MEDICAL EXAM IS REQUIRED.

	Yes	No
33. To the best of your knowledge and belief, in the last 10 years have you been diagnosed or treated by a medical professional for:		
a. hypertension, coronary artery disease, stroke, heart attack, chest pain, irregular heartbeat, or any other disease of the heart or blood vessels?	☐	☐
b. cancer, tumor or other growth or malignancy of any kind?	☐	☐
c. bronchitis, emphysema, shortness of breath or any other disease or disorder of the lungs or respiratory system?	☐	☐
d. depression, anxiety or any other behavioral, mental or nervous disorder?	☐	☐
e. epilepsy, seizures, sleep apnea or any other disease or disorder of the brain or nervous system?	☐	☐
f. diabetes, hepatitis, anemia or any other disease or disorder of the blood or glands?	☐	☐
g. arthritis, gout, or any other disease or disorder of the bones, muscles, joints, eyes or skin?	☐	☐
h. any disease or disorder of the stomach, intestines, colon, rectum, liver, pancreas or digestive system?	☐	☐
i. any disease or disorder of the kidney, bladder, prostate, urinary system or genital organs including complication of pregnancy?	☐	☐
j. Acquired Immune Deficiency Syndrome (AIDS), positive HIV test, or other immunological disorder?	☐	☐
34. If female, are you now pregnant? If yes, give approximate delivery date in question 40.	☐	☐
35. Are you currently receiving treatment, taking medication, or scheduled to have surgery?	☐	☐
36. Weight loss of more than 10 lbs. in past year? If yes, list # of lbs. and reason in question 40.	☐	☐
37. Have you:		
a. used or do you now use cocaine, methamphetamines, marijuana or any other drugs? If Yes, list type, amount, frequency and date last used in question 40	☐	☐
b. used or do you now use alcoholic beverages? If Yes, provide type, frequency and amount in question 40	☐	☐
c. sought or received treatment or counseling for alcohol or drug use?	☐	☐
38. 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?	☐	☐
39. In the past five 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?	☐	☐

40. FOR ALL YES ANSWERS IN QUESTIONS 33 THRU 39 GIVE FULL DETAILS BELOW.

Question No.	Name of Person	Describe Illness or Injury and Medical Attention	Date Mo Day Yr	Duration	Details Including Any Remaining Effects	Names, Addresses, and Phone Numbers of Physicians & Hospitals

UNDERWRITING INFORMATION

41. List name, address, date of birth and relationship of OWNER if other than Proposed Insured.

42. List name, address and relationship of SUCCESSOR OWNER. (A successor owner is not required.)

43. Special Requests.

44. 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.

SIGNATURES/DECLARATION

45. 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.

_____ (Signature of Writing Agent)

_____ (Print Name of Writing Agent)

_____ (Agent's Number)

AGENT'S STATEMENT

1. Does proposed insured have other life insurance in force with Shelter Life?
   ☐ Yes ☐ No If yes, give policy numbers

2. Has a Medical Examination and/or other testing been arranged? ☐ Yes ☐ No. SEE MANUAL FOR REQUIREMENTS.

3. If blood profile is required, have you attached the special blood test authorization form if one is required in your state? ☐ Yes ☐ No

4. Do you know or have any reason to believe that replacement of existing Life insurance is involved? ☐ Yes ☐ No
   If yes, give policy numbers, names and addresses of companies that issued such policies and expected date of lapse.

5. Does this application involve a 1035 exchange? ☐ Yes ☐ No (UL, PUA Only) If Yes, send appropriate form. ☐ External ☐ Internal

6. AS REQUIRED BY FEDERAL LAW, did you detach and give the NOTICE OF CONSUMER REPORT to the Proposed Insured (or Owner if the Proposed Insured is a juvenile)? ☐ YES.

7. Did you solicit this business? ☐ Yes ☐ No. If No, explain

8. Is any person applying for coverage related to you? ☐ Yes ☐ No. If Yes, give relationship

_____ _____
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, test 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

_____ _____
Date Signature of Spouse, if applying

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 MADE 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.

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 your best 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.