

The Final Expense Whole Life Insurance policy delineates the procedures and requirements for agents and applicants concerning coverage, underwriting, and payment processes. It features a Jet Pre-Approval process that enables agents to assess an applicant's eligibility for coverage at the point of sale, with an average policy issuance time of 2-3 business days when utilizing Electronic Funds Transfer (EFT). The policy incorporates simplified underwriting with various coverage levels, necessitating agents to complete a checklist, gather required signatures, and conduct a telephone interview with the applicant. The effective date of coverage is dependent on the timely submission of the application and initial premium, with specific rules governing effective dates based on the application receipt. Premium payments can be made via EFT or check, adhering to strict guidelines regarding payment methods and draft dates. Applications may be rejected due to incomplete information or failure to meet residency or interview requirements. Policyholders can request changes to death benefit amounts, following specific procedures and timelines. Policies are mailed within 7 to 10 business days post-issuance, with agents responsible for their prompt delivery. The document also includes common health questions relevant to underwriting, underscoring the necessity for accurate health disclosures.

Coverage exclusions pertain to specific heart conditions, including diseases that weaken or stiffen the heart muscle or those that elevate oxygen demand beyond the heart's delivery capacity. Cardiomyopathy, characterized by inflammation of the heart muscle, is highlighted as a serious condition with various causes, including viral infections. An applicant with a pacemaker or defibrillator is not disqualified from coverage if the procedure occurred more than 24 months prior to the application date, provided they do not have a heart condition alongside diabetes. The policy includes a two-year contestable period during which claims may be scrutinized for misrepresentation of health conditions, potentially leading to policy rescission and commission chargebacks for agents.

A drug list is provided to assist agents in completing Final Expense insurance applications, identifying commonly prescribed medications that may lead to declinable status. Certain medications

can indicate ineligibility for coverage, and the list categorizes them with asterisks: those marked with one asterisk (*) are unacceptable for the Level benefit plan but may be eligible for the Modified benefit plan, while those with two asterisks (**) are unacceptable for the Level benefit plan but may qualify for either the Modified or Graded benefit plans. The document stresses that individuals taking specific medications will be declined regardless of their condition's severity and advises contacting the Underwriting Department for inquiries about questionable medications. The drug list is organized alphabetically, distinguishing between generic and brand names, and includes medications associated with conditions such as internal cancer, heart disease, Parkinson's disease, and others.

Furthermore, the document provides guidance on avoiding Not-In-Good-Order (NIGO) errors during the application process, emphasizing the importance of submitting complete and accurate forms, ensuring all health questions are answered, and that the applicant's physical address is provided. The applicant must sign a HIPAA form before the telephone interview, and the pre-approval number from the interview must be included on the application. It is crucial that all dates, including signature and policy effective dates, are accurate, and that at least one beneficiary is listed. If the policy owner is not the proposed insured, their signature is also required. Lastly, valid phone numbers and the states in which the agent is licensed must be correctly indicated.