

**EMPLOYEE LIFE APPLICATION  
SECURITY FINANCIAL LIFE INSURANCE CO.**

**A. PROPOSED INSURED**

Employer Name: \_\_\_\_\_

*(Please print in ink.)*

Name: Last: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_

Indicate all Previous Names: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Soc. Sec. No.: \_\_\_\_\_  Male  Female

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Birth Place (State): \_\_\_\_\_

Are you a U.S. Citizen?  Yes  No If NO, Country: \_\_\_\_\_ Visa Type: \_\_\_\_\_

Alien Registration Card No. (green card): \_\_\_\_\_

Married  Single  Widowed  Divorced Number of Dependents, Including Spouse: \_\_\_\_\_

**With this Employer Only:**

Date Employed: \_\_\_\_\_ Annual Compensation: \_\_\_\_\_

Are you Actively at Work Full-time?  Yes  No If NO, Explain: \_\_\_\_\_

Duties: \_\_\_\_\_

**B. OWNER**

1. **CERTIFICATE OWNER** (Complete ONLY if NOT the Proposed Insured):

Name: \_\_\_\_\_ Soc. Sec./Tax ID No.: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

2. **MASTER POLICYOWNER (Select Trust):**

SML EPIC Welfare Benefit Trust– Tax ID # 52-6867142  FBA Trust – Tax ID #42-6309001

**C. POLICY DESCRIPTION**

Face Amount: \$ \_\_\_\_\_

Tobacco  Non-Tobacco

Plan:  SML EPIC Term

FBA Term

FBA Whole Life: Include Premium Waiver

**Home Office Changes**

*(For Administrative Purposes Only.)*

Requesting Special Policy Date: \_\_\_\_\_

**D. BENEFICIARIES**

*(Unless shown differently, survivors will share equally. When unequal shares are listed and any beneficiary dies or entity ceases to exist before the Insured, each living/existing beneficiary is paid in proportion to their listed share.)*

Name (Please Print)	Relationship	P = Primary C = Contingent	Date of Birth	Soc. Sec. No.	Share %
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

**Trust:**  No  Living Trust  Testamentary Trust (Will)

If Living Trust: Name of Trust: \_\_\_\_\_

Date of Trust: \_\_\_\_\_ Trustee Name & Address: \_\_\_\_\_

**E. OTHER LIFE INSURANCE** (In force or pending on the life of the Proposed Insured.)

NONE

Company Name	Year Issued	(Check one)		Life Amount	Accidental Death Amount	(Check one)	
		Business	Personal			In force	Pending

**F. REPLACEMENT**

Is this application intended to replace or modify any life insurance or annuity now in force on the life of the Proposed Insured? (This information is required by State regulations.)

Yes  No

If YES, list each policy to be replaced and **attach any required replacement forms.**

Company Name: \_\_\_\_\_ Policy No.: \_\_\_\_\_

Coverage Type: \_\_\_\_\_ Amount: \$ \_\_\_\_\_

Company Name: \_\_\_\_\_ Policy No.: \_\_\_\_\_

Coverage Type: \_\_\_\_\_ Amount: \$ \_\_\_\_\_

**G. REINSTATEMENT, POLICY CHANGE or DUPLICATE/LOST POLICY**

Reinstatement  Policy Change  Duplicate/Lost Policy

Policy No(s): \_\_\_\_\_ Details: \_\_\_\_\_

Policy No(s): \_\_\_\_\_ Details: \_\_\_\_\_

**H. TELE-APP?** (Complete questions in Section H. if using the Tele-App program. If **NOT USING** the Tele-App program, go to Section I. and complete the entire application.)

1. Has the Proposed Insured used any form of tobacco or nicotine, including substitutes (patches, gum, etc.):

a) In the last 12 months?  Yes  No

b) In the last 24 months?  Yes  No

c) If YES, Type(s): \_\_\_\_\_ Date Last Used: \_\_\_\_\_

2. Has the Proposed Insured ever been told he/she had or been treated for diabetes, cancer, heart disease, alcohol/drug abuse or high blood pressure? If YES, circle condition.  Yes  No

3. In the last 5 years, has the Proposed Insured been convicted of a felony or served a prison sentence?  Yes  No

4. PROCEED TO PAGE 7 TO COMPLETE THE APPLICATION. (Sections I. through N. will be completed by a telephone interview.)

**I. PERSONAL FINANCIAL INFORMATION**

	Annual Earned Income	Annual Unearned Income	Total Assets	Total Liabilities	Total Net Worth
Current Year:	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
Last Year:	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____

Other Remarks:

**J. PERSONAL INFORMATION**

1. **Has the Proposed Insured used any form of tobacco or nicotine, including substitutes (patches, gum, etc.):**
- a) In the last 12 months?  Yes  No
- b) In the last 24 months?  Yes  No
- c) If YES, Type(s): \_\_\_\_\_ Date Last Used: \_\_\_\_\_
2. **Does the Proposed Insured drink alcoholic beverages?**  Yes  No
- If YES, Type(s): \_\_\_\_\_ How much per week: \_\_\_\_\_
- How much each occasion: \_\_\_\_\_ Date of last use: \_\_\_\_\_
- Did you ever drink substantially more than at the present?  Yes  No
- If YES, when? \_\_\_\_\_ Past Usage: \_\_\_\_\_
- Reason(s) for quitting: \_\_\_\_\_
3. **In the last 5 years has the Proposed Insured ever used prescription drugs without a prescription or used illegal drugs?**  Yes  No
- If YES, What Kind(s): \_\_\_\_\_
- Usual Amount: \_\_\_\_\_
- How Often Used: \_\_\_\_\_ Dates of Use: From: \_\_\_\_\_ To: \_\_\_\_\_
- Reason(s) for quitting: \_\_\_\_\_
4. **Has the Proposed Insured ever had counseling, testing, or been arrested for sale or use of drugs or alcohol?**  Yes  No
- If YES, Details: \_\_\_\_\_
- Name/Address of Treatment Facility: \_\_\_\_\_
- \_\_\_\_\_
- Dates of Treatment: From: \_\_\_\_\_ To: \_\_\_\_\_
- Member of Alcoholics Anonymous: From: \_\_\_\_\_ To: \_\_\_\_\_
5. **In the last 5 years, has the Proposed Insured been arrested for or convicted of a felony?**  Yes  No
- If YES, Date(s): \_\_\_\_\_ Reason(s): \_\_\_\_\_
- Dropped/Dismissed  Guilty  Not Guilty  Probation  Other Resolution \_\_\_\_\_
- City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_
6. **Proposed Insured's Drivers License Number: \_\_\_\_\_ State: \_\_\_\_\_**
- a) **In the last 2 years, has the Proposed Insured had 3 or more moving traffic violations?**  Yes  No
- If YES, Details and Dates: \_\_\_\_\_
- \_\_\_\_\_
- b) **In the last 5 years, has the Proposed Insured had a driver's license denied, revoked, suspended; or been convicted of driving while under the influence of alcohol or drugs; or been involved as a driver in 2 or more accidents?**  Yes  No
- If YES, Details and Dates: \_\_\_\_\_
- \_\_\_\_\_
7. **Does the Proposed Insured intend to travel or reside outside the United States or Canada in the next 24 months?**  Yes  No
- If YES, Where: \_\_\_\_\_ When: \_\_\_\_\_
- Why: \_\_\_\_\_ How long: \_\_\_\_\_
8. **Has the Proposed Insured ever had a life or health insurance application declined, modified, postponed, rated, ridered, or had renewal or reinstatement refused?**  Yes  No
- If YES, When: \_\_\_\_\_ Why: \_\_\_\_\_
- Insurance Company: \_\_\_\_\_

**K. STATEMENT OF HEALTH** *(Must complete unless the Proposed Insured will be medically examined.)*

**NOTE:** You do not have to disclose an HIV (*AIDS Virus*) test which was administered: (1) to a criminal offender or crime victim as a result of a crime that was reported to the police; (2) to a patient who received the services of emergency medical services personnel at a hospital or a medical facility; or (3) to emergency medical personnel who were tested as a result of performing emergency medical services. Refer to the Medical Authorization on page 11 for a definition of "Emergency Medical Personnel".

1. **Height and weight of the Proposed Insured:** Feet: \_\_\_\_\_ Inches: \_\_\_\_\_ Lbs.: \_\_\_\_\_
2. **Has there been any change in weight during the last 12 months?**  Yes  No  
If **YES**,  Gain  Loss Reason(s): \_\_\_\_\_
3. **Name and address of your personal physician:** *(If none, show "none")* \_\_\_\_\_
4. **AT ANY TIME has the Proposed Insured had or been treated by a physician or consulted with a health advisor for any of the following:** *(If YES to any of the following, give details below.)*

	YES	NO
a) Heart or blood vessel disorder, high blood pressure, chest pain or stroke?	<input type="checkbox"/>	<input type="checkbox"/>
b) Cancer, tumor or growth of any kind or blood disorder?	<input type="checkbox"/>	<input type="checkbox"/>
c) Seizure, emotional, mental or nervous disorders, mental retardation or attempted suicide?	<input type="checkbox"/>	<input type="checkbox"/>
d) Disorder of the brain, nervous system or paralysis?	<input type="checkbox"/>	<input type="checkbox"/>
e) Lung or breathing disorder?	<input type="checkbox"/>	<input type="checkbox"/>
f) Diabetes or thyroid disorder?	<input type="checkbox"/>	<input type="checkbox"/>
g) Muscle, bone, spine, back or joint disorder?	<input type="checkbox"/>	<input type="checkbox"/>
h) Stomach, kidney, liver, bladder, colon, intestinal or bowel disorder?	<input type="checkbox"/>	<input type="checkbox"/>
5. **Has the Proposed Insured ever been diagnosed by a medical professional for AIDS (*Acquired Immune Deficiency Syndrome*), ARC (*AIDS Related Complex*), or had a positive test for HIV (*Human Immunodeficiency Virus*) antibodies?**  Yes  No
6. **During the last 5 years, has the Proposed Insured:** *(If YES to any of the following, give details below.)*

	YES	NO
a) Been to any doctor, psychiatrist, psychologist, counselor, chiropractor, naturopath, clinic, hospital or place for medical care or counseling not listed above?	<input type="checkbox"/>	<input type="checkbox"/>
b) Had an x-ray, electrocardiogram, blood, urine or any other medical test <i>(except HIV)</i> ?	<input type="checkbox"/>	<input type="checkbox"/>
c) Been aware of any condition that might need medical care <i>(such as pain, bleeding, dizziness, infection, shortness of breath or lump)</i> ?	<input type="checkbox"/>	<input type="checkbox"/>
d) Taken any kind of medication or treatment?	<input type="checkbox"/>	<input type="checkbox"/>
7. **Is the Proposed Insured pregnant?** If **YES**, Expected Delivery Date: \_\_\_\_\_  Yes  No

Question No./Letter	Date	Reason for Visit	Treatment/Remaining Effects and/or Medications	Medical Care Provider's Name/Address

8. **Family History:** Has the Proposed Insured's father, mother, brother(s) or sister(s) had diabetes, cancer, high blood pressure, heart or kidney disease or a hereditary disorder? *(If YES, give details below.)*  Yes  No

Relationship	Disease	If Living, Age	If Deceased, Age at Death	Date of Death	Cause of Death

*(If more space is needed — use the bottom half of Page 6)*

## L. MILITARY

1. Does the Proposed Insured now belong to or intend to become a member (in the next 24 months) of the Military Service, Reserve, ROTC or National Guard?  Yes  No
2. If YES, Branch: \_\_\_\_\_ Date of Entry: \_\_\_\_\_ Rank or Rating: \_\_\_\_\_
- a) How long have you been at your present assignment? \_\_\_\_\_
- b) Have you received orders for any change in duties or assignments?  Yes  No  
If YES, Explain: \_\_\_\_\_
- c) Are you currently attending a military school?  Yes  No
- d) Do you intend to make Military or Naval Service a career?  Yes  No
- e) Expected date of separation from active service: \_\_\_\_\_

## M. AVIATION

1. Has or does the Proposed Insured ever flown or plan to fly (in the next 24 months) as a pilot, crew member or student? If YES, complete the following:  Yes  No

### 2. Schedule of Flying:

Type of Certificate & Rating	Hours as a Pilot or Co-Pilot			Hours as Other Crew Member Title: _____	
	1-2 Years Ago	Last 12 Mos.	Contemplated Next 12 Mos.	Last 12 Mos.	Contemplated Next 12 Mos.
Commercial (Flying for hire.)					
Private or Student (Not flying for hire.)					
Military, including Reserve and National Guard.					

3. Number of pilot solo hours: \_\_\_\_\_
4. Date of last flight: \_\_\_\_\_
5. Date of last medical examination: \_\_\_\_\_
6. Type of certificate and rating: \_\_\_\_\_
7. **Civil Aviation:** Indicate the nature of flying (other than as a passenger) and the types of aircraft flown during the last 3 years. (Check all that apply.)
- Scheduled Airlines  Flight Instruction  Test - Experimental
- Non-Scheduled Airline or Charter  Pleasure or Personal Business  Test - Product Line
- Dusting, Seeding, Spraying  Company Business  Other (Specify): \_\_\_\_\_
- Single Engine  Multi-Engine  Jet  Propeller  Other (Specify): \_\_\_\_\_
8. **Military Aviation:** (Including Reserve and National Guard.)
- a) Have you done any test or experimental flying?  Yes  No  
If YES, give details: \_\_\_\_\_
- b) Have you flown or do you expect to fly in any carrier-based aircraft?  Yes  No
- c) Types of aircraft flown in during the last 3 years: (Check all that apply.)
- Single Engine  Multi-Engine  Jet  Fighter or Interceptor  Bomber  Transport
- Propeller  Reconnaissance or Liaison  Other (Specify): \_\_\_\_\_
9. If an extra premium is necessary for flying activity, I:  Accept the extra premium.  
 Accept the Aviation Exclusion clause instead of the extra premium.





# AGENT'S REPORT

(Not part of the policy)

## TELEPHONE INTERVIEW INFORMATION

Proposed Insured's Telephone Numbers:

Available During Day?

Residence: ( ) \_\_\_\_\_

Yes  No

Business: ( ) \_\_\_\_\_

Yes  No

Convenient time to call: \_\_\_\_\_ A.M. \_\_\_\_\_ P.M.

## MEDICAL REQUIREMENTS

(Check all that are being arranged.)

Para-Med Examination

EKG:  Resting  Treadmill

M.D. Examination

Blood Profile

Tele-App

Urine Specimen

Other (Specify): \_\_\_\_\_

(Agent pays for unauthorized exam items. Exams from personal doctor not accepted.)

## PREMIUM CALCULATION

Basic Plan: \_\_\_\_\_ \$ \_\_\_\_\_

Riders: \_\_\_\_\_ \$ \_\_\_\_\_

\_\_\_\_\_ \$ \_\_\_\_\_

\_\_\_\_\_ \$ \_\_\_\_\_

\_\_\_\_\_ \$ \_\_\_\_\_

\_\_\_\_\_ \$ \_\_\_\_\_

Total Annual Premium: \$ \_\_\_\_\_

x Mode Factor: \$ \_\_\_\_\_

Total Mode Premium: \$ \_\_\_\_\_

List numbers of other SFL policies on Proposed Insured: \_\_\_\_\_

## AGENT INFORMATION

Writing Agent

Agent Number

% Commission Split

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## COMMENTS:

All parts of this application have been double-checked by: \_\_\_\_\_

(Signature)