

**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. **Has the Proposed Insured ever used marijuana or drugs without a prescription?** 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.)*

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), or ARC (AIDS Related Complex).** 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 (except HIV)?	<input type="checkbox"/>	<input type="checkbox"/>
c) Been aware of any condition that might need medical care (such as pain, bleeding, dizziness, infection, shortness of breath or lump)?	<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.

N. HAZARDOUS SPORTS/ACTIVITIES

1. **Does the Proposed Insured participate or intend to participate in (in the next 24 months):** Yes No
(Check all that apply.)

- Ballooning
- Parakiting/Parasailing/Parascuba/Paraskiing
- Motor-powered racing/speed trials
- Big-game hunting
- Hang gliding
- Ultra light
- Horse racing
- Boxing/Wrestling
- Skydiving/Parachuting
- Skin or scuba diving
- Rodeo
- Mountaineering

2. If YES, complete the following:

- a) **Skin or scuba diving:** Certification: _____ Maximum Depth: _____
 How long have you been diving: _____
 How often: _____ Date of last dive: _____
 Usual maximum time under water: _____
 Do you dive as an occupation? Yes No
 If YES, explain: _____
- b) **Motor-powered racing:** Type: _____ Make/Model: _____
 Horsepower: _____ Speeds attained: _____
 Modifications: _____
- c) **Other sports or activities as checked above:** *(Describe)* _____

3. If professional in any sport and/or activity, which one(s): _____

4. Association or club affiliation(s): _____

The following information is in addition to the information in this application:

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

Additional Information:

(If more space is needed — use SUPPLEMENT TO APPLICATION)

AUTHORIZATION AND ACKNOWLEDGMENT

I agree and acknowledge:

- This application will become a part of any policy issued by SFL.
- Any policy issued on this application shall not take effect unless SFL approves this application and the first full premium is paid during the lifetime of the Proposed Insured.
- If no advance premium payment is made with this application, any change in health status before the issue date of the policy may affect the application process.
- All answers and statements made on this application or medical examination are in writing, complete and true to the best of my knowledge and belief.
- The incontestability and suicide clauses, as applicable, are renewed for any new coverage.
- No premium notices will be sent while premiums are paid through a payroll deduction or automatic banking arrangement.
- My employer may make deductions from my earnings for my share of the premiums.
- No agent or medical examiner has the authority to accept any risk, determine insurability, alter any receipt provisions or waive or change any questions on this application.
- SFL may indicate changes for administrative purposes only in the Home Office Changes space in Section C. of this application. In those states where it is required, changes in plan of insurance, amount, benefits, classification or age at issue will be made only with the Certificate Owner's written consent.
- SFL will appoint the directors of the Company and their successors to act as proxy as long as they remain directors, and authorize them to vote on all matters coming before any meeting of the Policyholders unless the Certificate Owner is present in person or represented by special proxy.

I certify under penalties of perjury the number shown in Sections A. and/or B. in this application is my correct taxpayer identification number and I am not subject to backup withholding.

I received the notification about the Federal Fair Credit Reporting Act and the Medical Information Bureau.

I understand that the Certificate Owner or the Certificate Owner's authorized representative is entitled to receive a copy of this authorization.

I authorize any medical practitioner, medical facility, insurance company and the Medical Information Bureau to provide SFL or its reinsurers with information regarding the Proposed Insured(s). The information may be about my health, use of drugs or alcohol, habits, general reputation, characteristics and mode of living (*except as related directly or indirectly to sexual orientation*). **I agree** this information may be used to accept or reject this application for insurance, a copy of this authorization shall be as valid as the original, and this authorization shall be valid for 30 months from the date indicated below.

Dated at: _____
 City State

On: _____
 Month Day Year

Signature of Proposed Insured

Signature of Certificate Owner
(If other than Proposed Insured)

Witness (If other than Agent)

Print Witness Name

AGENT'S STATEMENT

Do you have knowledge that this application will replace existing insurance?

Yes No

I certify:

- Each question on this application was asked and answered.
- All answers on this application were recorded completely and accurately.
- All signatures on this application were made by the person(s) indicated and completed in my presence if I signed as witness.

Agent's Signature: _____

State License Number (Where state required): _____

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)