

**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):**

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

C. POLICY DESCRIPTION

Face Amount: \$ _____

Tobacco Non-Tobacco

Plan: SFL EPIC Term

FBA Term

FBA Whole Life: Include Premium Waiver

Requesting Special Policy Date: _____

Home Office Changes

(For Administrative Purposes Only.)

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	<i>(Check one)</i>		Life Amount	Accidental Death Amount	<i>(Check one)</i>	
		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
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

- a) Heart or blood vessel disorder, high blood pressure, chest pain or stroke?
- b) Cancer, tumor or growth of any kind or blood disorder?
- c) Seizure, emotional, mental or nervous disorders, mental retardation or attempted suicide?
- d) Disorder of the brain, nervous system or paralysis?
- e) Lung or breathing disorder?
- f) Diabetes or thyroid disorder?
- g) Muscle, bone, spine, back or joint disorder?
- h) Stomach, kidney, liver, bladder, colon, intestinal or bowel disorder?

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.)

<input type="checkbox"/> Scheduled Airlines	<input type="checkbox"/> Flight Instruction	<input type="checkbox"/> Test - Experimental
<input type="checkbox"/> Non-Scheduled Airline or Charter	<input type="checkbox"/> Pleasure or Personal Business	<input type="checkbox"/> Test - Product Line
<input type="checkbox"/> Dusting, Seeding, Spraying	<input type="checkbox"/> Company Business	<input type="checkbox"/> Other (Specify): _____
<input type="checkbox"/> Single Engine	<input type="checkbox"/> Multi-Engine	<input type="checkbox"/> Jet
<input type="checkbox"/> Propeller	<input type="checkbox"/> Jet	<input type="checkbox"/> Propeller
<input type="checkbox"/> Other (Specify): _____	<input type="checkbox"/> Other (Specify): _____	<input type="checkbox"/> 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.)

<input type="checkbox"/> Single Engine	<input type="checkbox"/> Multi-Engine	<input type="checkbox"/> Jet	<input type="checkbox"/> Fighter or Interceptor	<input type="checkbox"/> Bomber	<input type="checkbox"/> Transport
<input type="checkbox"/> Propeller	<input type="checkbox"/> Reconnaissance or Liaison	<input type="checkbox"/> Other (Specify): _____	<input type="checkbox"/> Other (Specify): _____	<input type="checkbox"/> Other (Specify): _____	<input type="checkbox"/> 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:

Residence: () _____

Business: () _____

Convenient time to call: _____ A.M. _____ P.M.

Available During Day?

Yes No

Yes No

MEDICAL REQUIREMENTS

(Check all that are being arranged.)

Para-Med Examination

M.D. Examination

Tele-App

Other (Specify): _____

EKG: Resting Treadmill

Blood Profile

Urine Specimen

(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)