Standard Life
And Casualty Insurance Company

Secure Advantage
Preferred Whole Life

Application

Ages 0 – 49

March, 2013

www.slacins.com
www.sl-agentlink.com

SI2006A

THIS SECTION IS FOR AGENT USE ONLY – NOT FOR PUBLIC DISTRIBUTION

Secure Advantage Preferred Whole Life

The Secure Advantage program provides you with the tools to fulfill a vital niche in the smaller face amount life insurance market.

Secure Advantage is a whole life insurance program for your healthiest clients

By balancing tighter underwriting with extremely competitive rates, we're able to provide your healthiest clients with a product that will save them money, get them more coverage for their premium dollar, maximize your renewals through the higher persistency expected from lower premium rates, and minimize the possibility of someone replacing the policy later.

For Ages 0—49, Secure Advantage uses a simplified-issue application along with a telephone verification interview, prescription history and MIB records to provide quick processing of your business.

Agent Instructions:

Issue Ages: 0—49 **Issue Amounts: $3,000 to $50,000**
(Applicants ages 50—85 require a different application and telephone interview process.
See AgentLink, the agent portal at https://sl-agentlink.com for further details).

A Point-of-Sale Telephone Interview is required for each application. It should be done from the Proposed Insured's home phone, or on a 3-way call.

Call 1-800-737-6972, refer to "Standard Life Secure Advantage."

Telephone Interview Normal business hours (Eastern Time):
Monday-Friday 8:30 am - Midnight
Saturday-Sunday 10:00 am - 4:00 pm

If the application is written after business hours, leave a message with the Proposed Insured's name and telephone number(s), along with the best time to call the applicant. An interviewer will contact the applicant and complete the interview.

Most complete applications for amounts **of $25,000 and under** are **issued within 24 hours of receipt**. By "complete", we mean: (1) the application must be correctly and completely filled out, (2) the phone interview must be completed, and (3) there is no MIB record or prescription history record which contradicts the applicant's answers to the application questions.

The proposed insured must review the entire application, including the marked answers to each health question, before signing.

Sometimes medical impairments listed in the application are known to the applicant by another name. If either you or the applicant are not sure of something or have **any questions about medical treatments, medications or conditions, get as much information as you can and include it in the Comments section of the application. With more information, we are much more likely to be able to issue the policy.**

Medication is a form of treatment. Medications used as a treatment for any impairment listed in the health questions in the application would require a "yes" answer to the appropriate question. We do *not* consider medications for hypertension (high blood pressure) or cholesterol to be a treatment for a heart/circulatory disorder; we consider these maintenance drugs.

Ineligible Persons include anyone who:

* Is incarcerated in a penal institution
* Is on parole or released from prison within the last 2 years
* Is in a psychiatric facility
* Is terminally ill
* Is mentally incompetent and/or lacks the legal capacity or mental facility to conduct their own affairs
* Has not been a permanent US resident for at least 12 months

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******* If any questions 1-6 are answered "YES", the applicant is NOT eligible for this coverage. *******

Rate Quoting: Ages 0—49

For applicants under the age of 50, we will add a rating for certain conditions such as controlled high blood pressure, that would not be rated-up on applicants ages 50 and over. Applicants in this age range who exceed the weight table limitations may still apply but they will generally be rated up. The table below shows the likely rating for certain conditions in applicants under age 50. Using this, you will usually be able to quote the proper premium at the point of sale:

- Outside Height/Weight Table ····· Add 7 years to age
- Type 1 (insulin) Diabetes ····· Decline
- Type II (non-Insulin) Diabetes, NOT combined with High Blood Pressure ····· Add 6 years to age
- Type II (non-insulin) Diabetes, COMBINED with High Blood Pressure ····· Decline
- High Blood Pressure, NOT combined with any kind of diabetes ····· Add 6 years to age
- Any prior heart or circulatory surgery, disease or disorder···· We will order records and rate for cause

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- We must have a physical address. If the applicant wants to be billed at a PO Box, indicate that in the comments section of the application.
- Age: Use the Proposed Insured's age at last birthday.
- Use black ink; no felt tipped pens.
- Any corrections must be initialed and dated by the Proposed Insured/Owner. Do not use white-out.
- Include all Social Security numbers of beneficiaries, if available. Also list each beneficiary's share.
- The Owner's Tax ID / Social Security Number is required.
- For children under the age of 18, a parent's signature is required, even if the parent is not the owner.
- Premium Receipt — leave with owner only if collecting the initial premium payment.
- We do not accept cash, money orders, counter checks, or agent/agency checks.

Build Tables for Ages 0 - 49:

Height	Rate 7 Years if Over:	Decline if Over:	Height	Rate 7 Years if Over:	Decline if Over:
4' 9"	166	176	5' 10"	240	284
4' 10"	171	181	5' 11"	247	291
4' 11"	176	203	6' 0"	254	301
5' 0"	181	212	6' 1"	260	310
5' 1"	187	219	6' 2"	268	318
5' 2"	192	227	6' 3"	275	327
5' 3"	198	236	6' 4"	283	335
5' 4"	204	243	6' 5"	289	342
5' 5"	210	250	6' 6"	297	352
5' 6"	216	258	6' 7"	305	360
5' 7	221	260	6' 8"	312	366
5' 8"	228	269	6' 9"	319	372
5' 9"	234	277	6' 10"	325	382

Standard Life And Casualty Insurance Company

Home Office
PO Box 510690
Salt Lake City, UT 84151-0690
Phone: (800) 327-0695 www.slacins.com

FAX COVER PAGE

Final Expense Life

Fax To: (866) 754-9350 or (801) 538-0392

You may use one cover page to fax multiple applications. If you are faxing more than one application using this cover page, enter the names of each applicant below.

NUMBER OF APPLICANTS IN THIS FAX TRANSMISSION: _____

Total Pages (Including Cover Page): _____

Name(s) of Applicant(s)

Fax the following:

- ☐ Properly signed and completed application.
- ☐ Properly signed and completed *Authorization to Obtain and Disclose Records*.

If applicant has provided a check for first premium (Quarterly, Semi-Annual, or Annual):

- ☐ Follow instructions above for faxing in application. Then, either:
  - ◊ Mail the check along with a copy of the first page of each application to; or
  - ◊ Fax a copy of the filled out check, the *Authorization to Fax Check* form, and all completed application materials to:

Regular USPS Mail:	**Overnight Courier Delivery:**
Standard Life And Casualty Insurance Company PO Box 510690 Salt Lake City, UT 84151-0690	Standard Life And Casualty Insurance Company 420 East South Temple Street Suite 555 Salt Lake City, UT 84111

Agent Information:

Name		**Agent ID**	
E-mail Address		**Phone Number**	

Standard Life And Casualty Insurance Company • PO Box 510690 • Salt Lake City, UT • 84151

LIFE INSURANCE APPLICATION

Proposed Insured's Full Name (First Middle Last)	Phone ( )
Street Address	SS #
City State Zip	State of Birth / Height / Weight

Sex	Date of Birth Mo/Day/Year	Age	Premium Payor:	
❑ Male ❑ Female			❑ Insured ❑ Owner	Plan _____ Amt. of Insurance $_____ ❑ Accidental Death Benefit $_____ ❑ Check here if insured does NOT want Automatic Premium Loan

Mode Premium $ _____

❑ Annual ❑ Semi-Annual

❑ Quarterly ❑ Monthly PAC

Draft Date (circle one):

5th 10th 15th 25th

Owner (if other than Proposed Insured)

Name: _____ SSN: _____

Address: _____ Phone: _____

City, ST Zip: _____ Relationship: _____

Will this insurance replace any existing insurance or annuity? ❑ Yes ❑ No

If "yes": Company:

_____

Policy Number

_____

Beneficiary: _____ Relationship: _____

Contingent Beneficiary:_____ Relationship: _____

	YES	NO
Has the proposed insured used tobacco during the past two years?.....	❑	❑
1. **In the past 12 months**, has the Proposed been: bedridden; hospitalized two or more times; confined to a nursing facility; received hospice or home health care; required use of a wheelchair; waiting for an organ transplant; required personal assistance with any normal activities of daily living such as bathing, dressing, eating, toileting or moving about; advised by a medical professional to have surgery, testing or further evaluation, or recommended for hospital confinement or nursing facility confinement and have not done so?.....	❑	❑
2. **In the past two years**, has the Proposed Insured been diagnosed with or treated (including medication) for: Alzheimer's disease or memory loss, liver disease, cirrhosis, ALS (Lou Gehrig's Disease, brain, mental or nervous system disorders, alcoholism or drug abuse, heart attack, pacemaker, any procedure to improve circulation to the heart or brain, stroke, TIA/ministroke, aneurysm, angina (chest pain), renal insufficiency, kidney failure, emphysema, chronic obstructive lung disease (COPD), or used oxygen for a chronic condition, or had an organ or tissue transplant?.....	❑	❑

Proposed Insured's Full Name (First Middle Last)	

	YES	NO
3. In **the past four years**, has the Proposed Insured been diagnosed with, received treatment for, or had: internal cancer, malignant melanoma, leukemia, lymphoma, Hodgkins disease, myeloma, sarcoma; or any type of cancers or malignancy or remission? ·····	❑	❑
4. Ha**s the Proposed Insured ever:** been diagnosed with or received treatment (including medication) for: Congestive Heart Failure, Sickle Cell Anemia, Acquired Immune Deficiency Syndrome (AIDS) or tested positive for Human Immunodeficiency Virus (HIV)? ·····	❑	❑
5. Does the Proposed Insured have Insulin-dependent diabetes? ·····	❑	❑
6. During the past 24 months, has the Proposed Insured been diagnosed with or treated (including medication) for coronary artery disease, seizures, Parkinson's disease; complications from diabetes including diabetic neuropathy, retinopathy, nephropathy, diabetic coma, insulin shock, experienced periods of blood sugar levels over 175; or was the Proposed Insured originally diagnosed with any form of diabetes before his/her 40th birthday?·····	❑	❑
7. If under age 50, has the Proposed Insured been diagnosed with:		
a. Insulin-dependent diabetes, Down's syndrome, cerebral palsy, muscular dystrophy, spina bifida, cystic fibrosis, sickle cell anemia, or un-operated heart defects? *(If "Yes", do not submit the application)* ·····	❑	❑
b. Any kind of diabetes *(see agent guide for rating instructions)* ·····	❑	❑
c. High Blood Pressure *(see agent guide for rating instructions)* ·····	❑	❑

Comments, medications (if on no medications, state "No Medications") and explanations to "Yes" **answers *here (attach separate sheet if necessary):***

Home Office Endorsements (Home Office Use Only):

EXECUTION: I have read or have had read to me all of the statements and answers indicated above. They are true and complete to the best of my knowledge and belief. I understand that the coverage of the policy will become effective on the Issue Date specified by Standard Life And Casualty Insurance Company in the policy, if the policy is issued. I understand that if the policy is not issued, no coverage will be in effect and any premium paid will be refunded. **I understand that no agent may waive, change or alter any of the terms or conditions of the policy.**

MIB Authorization: I hereby authorize the Medical Information Bureau or any licensed physician, medical practitioner, hospital, clinic or other medically related facility, institution or person that has any record or knowledge of me or my dependents to give Standard Life And Casualty Insurance Company ("STANDARD") or its representatives any such information. A photographic copy of this authorization shall be as valid as the original. The authorization is valid for two and one-half years (two years if I reside in Kentucky) from the date this form is signed. I understand that I or my authorized representative may receive a copy of this authorization. I have received the Notice of Disclosure Information regarding the investigative consumer report and the Medial Information Bureau, and authorize the company to obtain a consumer investigative report if deemed necessary.

NOTICE: Any person who knowingly and with intent to defraud any insurance company submits an application for insurance or statement of claim containing any materially false information or conceals information concerning any fact material thereto for the purpose of misleading is committing a crime which is subject to criminal and civil penalties.

Signatures:_____ _____

PROPOSED INSURED *Date* *OWNER (if other than proposed insured)* *Date*

_____ _____

Witness – Licensed Agent *Date* *Dated at (City, State)*

AGENT'S STATEMENT: ***I certify, as recording agent, that:***

1) I personally asked the Proposed Insured all questions on this application, and accurately recorded the answers supplied by the Proposed Insured.
2) I saw the Proposed Insured at the time of application and witnessed the signatures.
3) The answers recorded did not conflict with my observations and knowledge of the Proposed Insured.
4) **Replacement:** Do you have reason to believe that this insurance is or may be intended to replace any life insurance or annuity?

Yes ❑ No ❑ (If Yes, submit any special forms required by the state in which the application is signed).

Agent's Signature: _____ Date: _____ Agent # _____

Deliver to: ❑ OWNER ❑ AGENT

Standard Life And Casualty Insurance Company

Home Office
PO Box 510690
Salt Lake City, UT 84151-0690
Phone: (800) 327-0695
www.slacins.com

BANK DRAFT AUTHORIZATION

Mail in Form or Fax to: (866) 754-9350 or (801) 538-0392

Insured: _____ Policy #: _____

Please draft my account on the following date (check one):

☐	1st	☐	15th	☐	2nd Wednesday
☐	3rd	☐	20th	☐	3rd Wednesday
☐	5th	☐	25th	☐	4th Wednesday
☐	10th				

Deduction Amount ($): _____

Sign the authorization below and provide a voided check or provide the info from the account you would like to use for bank draft. Your premium will be paid by your bank and will be reflected in your bank statement.

As a convenience to me, I hereby request and authorize Standard Life And Casualty Insurance Company (Standard) to pay and charge to my account checks or credits on my account by and payable to Standard Life And Casualty Insurance Company, Salt Lake City, UT provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that Standard's rights in respect to each such check or credit shall be the same as if it were a check drawn on me and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until Standard actually receives such notice I agree that Standard shall be fully protected in honoring any such check or credit. I further agree that if any such check or credit be dishonored, whether with or without cause and whether intentionally or inadvertently, Standard shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

_____ ___|___|___|___|___|___|___|___|___ ___|___|___|___|___|___|___|___|___|___|___|___
Bank Name *Bank Routing/ABA #* *Bank Account #* ☐ Checking ☐ Savings

_____ _____
Signature EXACTLY as it appears on bank records *Date*

_____
Printed name of authorized signatory on account

_____ _____
Signature of Insured/Policy Owner if other than Insured *Date*

AUTHORIZATION TO OBTAIN AND DISCLOSE RECORDS:

Life Insurance Application

This Authorization Complies with the HIPAA Privacy Rule.

Print Name of Proposed Insured/Patient: _____ **Date of Birth:** ____ / ____ / _____

I understand Standard Life and Casualty Insurance Company (SLACIC), its reinsurers, insurance support organizations, and their authorized representative, may obtain medical and other information in order to evaluate my application for insurance. I authorize any Medical Providers, as described below, to disclose or release Protected Health Information, as described below, to Standard Life and Casualty Insurance Company at 420 East South Temple St.; Suite 555; Salt Lake City, UT 84111 or its authorized representative.

- Medical Providers: All physicians, medical or dental practitioners, hospitals, clinics, pharmacies, pharmacy benefit managers, other medical care facilities and all other providers of medical or dental services who have provided treatment or other health care services to me or on my behalf.

- Protected Health Information: Any and all records and health information within such Medical Person's possession such as medical history, entire medical records, mental, psychiatric (excluding psychotherapy notes) and physical condition, prescription drug records, tobacco, drug and alcohol use and any other protected health information concerning me. This includes information which may be considered to be a communicable or a sexually transmitted disease, which may include, but are not limited to diseases such as Hepatitis, Syphilis, Gonorrhea, the Human Immunodeficiency Virus (HIV) and the Acquired Immune Deficiency Syndrome (AIDS).

- In addition, I authorize the Veterans Administration, the MIB, Inc., my employer, consumer reporting agency, insurance company or other organization who possesses information, records or knowledge of me including information about drugs, alcoholism or mental illness, to furnish such information to SLACIC, its reinsurers and their authorized representative upon presenting this authorization.

By my signature below, I acknowledge that any agreements I have made to restrict my Protected Health Information do not apply to this authorization and I instruct any Medical Provider to release and disclose my entire medical record without restriction.

The purpose of the release of the above information is for SLACIC to evaluate and underwrite an application for insurance coverage, to determine the rates and terms that apply to such insurance coverage, and/or to resolve any issues of incomplete, incorrect or misrepresented information on the application which may arise during the processing of the application.

I authorize Standard Life and Casualty Insurance Company or its reinsurers to make a brief report of my Protected Health Information to MIB, Inc. SLACIC or its reinsurers may make a brief report regarding me or my children to other insurance companies to whom I have applied or may apply.

I also understand that information disclosed may be subject to re-disclosure by the recipient in which case it may no longer be protected under the HIPAA Privacy Rule.

This authorization will remain in effect from the date signed below for a period of 24 months, and a copy of this authorization is as valid as the original. I understand that this authorization may be revoked at any time by sending written notice of such to SLACIC at the address above. The right to revoke this authorization is limited to the extent that SLACIC has taken action in reliance on the authorization or the law provides the Company with the right to contest a claim under the policy for which I have applied or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may no longer be covered by federal rules governing privacy and confidentiality of health information, but it will not be re-disclosed by the recipient except as authorized by me or as allowed by law.

I understand that my Medical Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization, SLACIC may not issue the insurance coverage for which I am applying or if coverage has been issued may not be able to make any benefit payments. I understand that any Personal Representative or I will receive a copy of this authorization upon request.

I authorize Standard Life and Casualty Insurance Company to obtain an investigative consumer report on me, if required.

❑ I elect to be interviewed if any investigative consumer report is prepared in connection with this application.

APPLICANT:

_____ _____

Signature of Proposed Insured or Personal Representative **Date**

_____

Description of Personal Representative's Authority and Relationship to Patient

LEAVE THIS PAGE WITH APPLICANT

MIB Pre-Notice

Information regarding your insurability will be treated as confidential. Standard Life And Caualty Insurance Company, or its reinsurers, may, however, make a brief report thereon to MIB, Inc., a not-for-profit membership organization of insurance companies that operates an information exchange on behalf of its members. If you apply to another MIB, Inc. member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the MIB, Inc., upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the MIB, Inc. will arrange disclosure of any information it may have in your file. Please contact MIB, Inc. at 866-692-6901 (TTY: 866-346-3642). If you question the accuracy of information in the MIB, Inc.'s file, you may contact MIB, Inc. and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB, Inc. is: 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Standard Life and casualty Insurance Company, or its reinsurers, may also release information in its file to MIB, Inc. and 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.

FAIR CREDIT REPORTING ACT NOTICE

In Compliance with 15 USC 1681 et. seq., this notice is to inform you that:
In making this application for insurance it is understood that an investigative consumer report may be made whereby information is obtained through personal interviews with third parties, such as family members, business associates, financial sources, friends, neighbors or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics and mode of living, whichever may be applicable. You have the right to make a written request to Standard Life And Casualty Insurance Company at PO Box 510690, Salt Lake City, UT 84151 within a reasonable period of time for a complete and accurate disclosure of additional information concerning the nature and scope of the investigation.

RECEIPT FOR ADVANCED PREMIUM

Valid only if signed by an agent of the Company

Standard Life And Casualty Insurance Company ● PO Box 510690 ● Salt Lake City, UT 84151-0690 ● (800) 327-0695

MAKE YOUR PREMIUM CHECK PAYABLE TO
"Standard Life" OR **"Standard Life And Casualty"**
DO **NOT** MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

Received from _____ on _____ the sum of $_____ , being payment on of an advanced premium on an application for life insurance to Standard Life And Casualty Insurance Company, which application bears the same date as this receipt.

Proposed Insured: _____

The insurance applied for will not take effect until a policy issued on the basis of this application has been delivered to the proposed insured, and the full first premium paid. This must be all during the lifetime and before any change in the insurability of the proposed insured as stated in the application. Otherwise, there shall be no liability on the part of the Company except to refund this payment upon surrender of this receipt.

The Company shall have 60 days within which to consider and act upon the said application. If within such period a policy has not been issued to the applicant as applied for or if notice of approval or rejection has not been given, then the application shall be deemed to have been declined by the Company. If you do not receive a policy or refund of the amount paid within 60 days from this date, please notify the Company, in writing, at the address above. Please provide your name, date and the amount of payment, and the name of the agent.

AGENT NAME (PRINTED): _____

AGENT SIGNATURE: _____ DATE: _____

LEAVE THIS PAGE WITH APPLICANT

PRIVACY NOTICE

Confidentiality and Security of Your Information

We maintain appropriate physical, electronic and procedural safeguards to protect the security and confidentiality of your nonpublic personal information. We educate our employees about the terms of this Notice and the importance of customer privacy. We restrict access to nonpublic personal information about you to those employees and others who need to know that information to provide products or services to you, to maintain your accounts or conduct our business.

Personal Information We Collect About You

Collecting personal information from you is essential to our ability to offer quality insurance products and financial services. As part of that process, we may collect nonpublic personal information about you from the following sources:

- Information we receive from you on applications and other forms;
- Information about your transactions with us, our affiliates or others;
- Based upon the products purchased or services provided, information we receive from consumer reporting agencies; and
- Information that is used to facilitate visits to our web sites or e-mails from you.

Categories of Information We Disclose and to Whom

We do not disclose any personal information about our customers or former customers to anyone, except as permitted or required by law. We may disclose the types of information listed below to companies that help us conduct our business, that perform administrative or other services on our behalf, or other financial institutions with which we have joint marketing agreements:

- Information we receive from you on applications and other forms, such as your name, address, Social Security number, assets, income and beneficiaries;
- Information about your transactions with us, our affiliates or others, such as policy coverage, premiums and payment history; and
- Information we receive from a consumer reporting agency and other sources, such as your credit worthiness and history, medical information and employment information.

When information is disclosed to third parties as described above, we require recipients to adhere to appropriate confidentiality procedures and practices to protect your privacy.

Your Medical Information

We do not share your nonpublic personal health information except as necessary to underwrite a product, administer your policy, as authorized by you or as permitted or required by law.

Fair Credit Reporting Act

We do not share information subject to the Fair Credit Reporting Act with our affiliates except as permitted or required by law.

Your Records

We strive to maintain the accuracy of your personal information. In order to help us maintain that accuracy, you may have the right to reasonably access your information. If you believe any of the information in our possession is inaccurate, you may request that we amend or delete the information you believe to be erroneous. If we concur with your conclusion, we will amend or delete the information in question. To avail yourself of this process, you must write our Privacy Officer at the address below in order to obtain our complete policy on accessing and amending your nonpublic personal information.

This Policy Applies to You

This Privacy Notice applies to our relationships with individual consumers who inquire about and/or obtain products or services from Standard Life And Casualty Insurance Company and its affiliates listed below, for personal, family or household purposes.

Questions?

Because Standard Life And Casualty Insurance Company does not share information outside permitted exceptions, there is no need to take any action under this Notice. In the event you have questions about this Notice of Privacy and Insurance Information Practices, please write the Privacy Officer at the address provided below.

Standard Life And Casualty
PO Box 510690
Salt Lake City, UT 84151-0690