Standard Life
And Casualty Insurance Company

Secure Advantage
Final Expense Life

with Point-Of-Sale Application Processing

Application

Ages 50 – 85

March, 2013

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

SIWL-APP2

Secure Advantage Final Expense Life

Our Secure Advantage program provides you with the tools to fulfill a vital niche in the final expense / senior life market.

Secure Advantage is a final expense 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.

The Point-Of-Sale Application Processing feature of the Secure Advantage program relies completely on Yes and No answers to the health questions on the application. There is no judgment-based underwriting involved in the approval process of the application. This program uses the application form, MIB report, prescription history, and a telephone verification call with the applicant. The answers to the questions determine if the application is approved or declined. We call this approach "Rules-Based Processing".

What is Rules-Based Processing?

About the Underwriting Process

At the time of sale, a telephone interview is conducted with the applicant to review and confirm the applicant's answers to the application questions. The telephone interview is required with every application. The benefit of the point-of-sale interview is that you and the applicant will know if they are approved or denied during the presentation, before they have to pay for their coverage.

To aid the underwriting process, the interviewer will access the Medical Information Bureau and the applicant's prescription medication history at the time of the interview. These underwriting tools are used to help ensure a prompt and accurate underwriting decision.

Correct answers are critical. If there is a Yes answer, or the available underwriting information indicates misrepresentation, the application is declined. If all questions are answered No, the policy is approved for issue. With rules-based processing, no further judgment, analysis or evaluation occurs if an immediate decision cannot be made at the time of sale. If the producer or applicant wants to demonstrate the lack of severity of a particular medical condition and its effect on mortality, the purpose and efficiency of rules-based processing is defeated. It is the spirit of the program that no underwriter's judgment is interjected into the process and the simple Yes or No answer be accepted regardless of the severity or perceived consequence on mortality.

About the Telephone Inspection Service

Standard Life has contracted with Elite Sales Processing, Inc. (ESP), a consumer reporting agency with extensive life insurance underwriting experience, to provide point-of-sale inspections for English speaking applicants. Interviewers are focused on providing excellent customer service. They are trained to ask follow-up questions in a non-threatening manner and have enough medical knowledge to clearly interpret answers to medical questions.

Simple Telephone Interview Process:

Secure Advantage's highly competitive rates will allow you to look to Standard Life as your first choice. Keep in mind that we understand that if the applicant does not qualify based on our rules-based application process, the agent is at liberty to place them with another company.

1. Complete the application, including the HIPAA and MIB Authorizations, and ask all the health questions before initiating the phone interview.
2. Call **1-888-908-7812** from the applicant's home, or from a 3-way call if not in the home. Provide **Standard Life And Casualty**'s name and your name.
   Be sure to advise the operator if the applicant does not speak English.
3. The interviewer will complete the Agent Checklist with you, including your Standard Life agent number.
   Be sure to answer the questions accurately.
4. Have the applicant speak with the interviewer in order to confirm the answers to the application questions. When completed, the interviewer will speak with you again.
5. The interviewer will advise you whether or not the application fits within our approval guidelines.
6. The interviewer will give you a Telephone Interview Code that you will record in the Agent's Statement section of the application.
7. *If approved, submit the application, making sure that all questions on the application are answered completely. If declined, send us the application form, indicating that it was declined.*
8. Standard Life receives the Interview data by the next morning. You will see your production on our agent website by 10:00 am the day after the interview. Issued policies will be printed and mailed the business day after you submit the application.

If the application is written after normal business hours, you will simply need to leave a voice message in the 24-hour mailbox for an interviewer to call the client back. Since the client will be completing the interview on the next business day, it will be indicated on the Agent Checklist as "Agent Not Present." After the Point-of-Sale Interview has been completed, ESP will call you with the results

(888) 908-7812

INTERVIEWERS AVAILABLE:

Monday-Thursday
8:00am - 9:30pm, CST

Friday
8:00am - 5:00pm, CST

Weekends
24-Hour Voicemail
(Call for the interview before leaving your client's home)

For Non-English Speaking Applicants: Follow the same procedures and ESP will connect your applicant to the appropriate interpreter.

Underwriting

About the Underwriting Process

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 that are treatment for any impairment listed in the health history questions would require a "yes" answer to the appropriate question.

Ages 50 - 85

First, complete the application with the proposed insured, then follow the instructions for the telephone interview process shown above. Submit the application to us after the telephone interview is complete.

Ineligible Persons

- 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, who lacks the legal capacity or mental facility to conduct their own affairs
- Has not been a permanent U.S. resident for at least 12 months

Ages and Amounts

Minimum Face Amount: **$5,000**
Maximum Face Amount:
Ages 50 – 80: **$25,000**
Ages 81 – 85: **$15,000**

Additional Considerations:

- We must have a physical address; if the applicant wants to be billed at a P.O. 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.
- 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.

Submitting Applications

You may submit completed applications to us via any of the methods listed below:

Toll-Free Fax

FAX ALL PARTS OF THE COMPLETED APPLICATION TO: **1-866-754-9350**
We will draft the initial premium for faxed applications.

File Upload of Scanned Applications

If you have scanned the application to a PDF format, you may upload it to us using our HIPAA-Secure communications server. Directions are available at **https://sl-agentlink.com**.
We will draft the initial premium for uploaded applications.

By Mail

Standard Life
New Business
PO Box 510690
Salt Lake City, UT 84151-0690

By Overnight Delivery

Standard Life
New Business
420 East South Temple St.
Suite 555
Salt Lake City, UT 84111

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

FRAUD NOTICE

READ FOR YOUR PROTECTION
THE LAW REQUIRES THE FOLLOWING WARNINGS:

COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or Producer of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony in the third degree.

GEORGIA: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, may be guilty of insurance fraud.

KENTUCKY: Any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime.

LOUISIANA and TEXAS: Any person who knowingly presents a false or fraudulent claim for payment of loss or benefit or knowingly presents false information in an Application for insurance, is guilty of a crime and may be subject to fines and confinement in prison.

TENNESSEE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines and denial of insurance benefits.

ALL OTHER STATES:
Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits and application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Proposed Insured's Initials:

_____

_____

PROPOSED INSURED "A"

Name (First, MI, Last)		**Address (City, State, Zip Code)**		
SSN	Gender	Date of Birth	Birth State	Phone Number ( )

OWNER "A" (If other than Proposed Insured "A")

Owner "A" Name (First, MI, Last)		**Owner's Address (City, State, Zip Code)**	
Owner's SSN	Owner's Date of Birth	Relationship to Proposed Insured "A"	Phone Number ( )

BENEFICIARY

Primary	Address	Relationship to "A"	%
Primary	Address	Relationship to "A"	%
Contingent	Address	Relationship to "A"	%
Contingent	Contingent	Relationship to "A"	%

PROPOSED INSURED "B"

Name (First, MI, Last)		**Address (City, State, Zip Code)**		
SSN	Gender	Date of Birth	Birth State	Phone Number ( )

OWNER "B" (If other than Proposed Insured "B")

Owner "B" Name (First, MI, Last)		**Owner's Address (City, State, Zip Code)**	
Owner's SSN	Owner's Date of Birth	Relationship to Proposed Insured "B"	Phone Number ( )

BENEFICIARY

Primary	Address	Relationship to "B"	%
Primary	Address	Relationship to "B"	%
Contingent	Address	Relationship to "B"	%
Contingent	Contingent	Relationship to "B"	%

Section C: Height and Weight must be within the maximum range for this product. [Non-Tobacco and Within Build Table 1: Quote Preferred Rate] [Non-Tobacco and Within Build Table 2, OR Tobacco User: Quote Standard Rate]	ANSWERS FOR PROPOSED INSURED: "A"	"B"
1. What is your height?		
2. What is your weight?		
3. Has the Proposed Insured used nicotine based products in the last 12 months?	❑Yes ❑No	❑Yes ❑No
Section D: **If any question in Section D is answered "Yes", NO COVERAGE CAN BE ISSUED.**		
4. Have you had, or been medically advised to have, an organ transplant, or have you been medically diagnosed as having a life expectancy of 12 months or less?	❑Yes ❑No	❑Yes ❑No
5. Have you been medically treated or diagnosed as having Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC), or any immune deficiency related disorder or tested positive for the Human Immunodeficiency Virus (HIV)?	❑Yes ❑No	❑Yes ❑No
6. Are you currently: hospitalized, confined to a bed or nursing facility, or using oxygen equipment to assist in breathing, or receiving Hospice Care?	❑Yes ❑No	❑Yes ❑No
7. Do you have any impairment, whether physical or mental, for which you need or receive assistance or supervision in performing normal activities of daily living such as dressing, eating, bathing, incontinence, toileting, taking medications, or moving without any type of physical assistance?	❑Yes ❑No	❑Yes ❑No
8. In the last 6 months, have you been disabled or received disability compensation?	❑Yes ❑No	❑Yes ❑No
9. Have you ever been medically diagnosed, treated or taken medication for: a) Alzheimer's, dementia, mental incapacity, or Organic Brain Syndrome; b) Schizophrenia, bipolar disorder, or psychosis; c) Lou Gehrig's disease (ALS), Huntington's disease; d) Congestive heart failure or cardiomyopathy; e) chronic kidney (renal) failure, insufficiency or disease; or ever had kidney dialysis; f) Paralysis of two or more extremities; or g) liver failure or insufficiency?	❑Yes ❑No	❑Yes ❑No
10. Within the past 60 months have you been treated by a member of the medical profession for: Insulin shock, diabetic coma, diabetic retinopathy, or hospitalized two or more times for any diabetic complications?	❑Yes ❑No	❑Yes ❑No
11. Within the past 24 months, have you been confined more than twice to a hospital, nursing facility, convalescent care facility, assisted living facility, mental facility or Hospice Care?	❑Yes ❑No	❑Yes ❑No
12. Within the past 24 months, have you been diagnosed with internal cancer or melanoma; or have you been diagnosed by a member of the medical profession as having more than one occurrence or any metastasis of any cancer in your life time (excluding basal cell or squamous cell skin cancer), or are you currently being treated for cancer or recurrence of cancer?	❑Yes ❑No	❑Yes ❑No
13. Within the past 24 months, have you: a) been medically diagnosed, treated or taken medication for: angina, chronic hepatitis or hepatitis C, respiratory failure, cystic fibrosis, chronic obstructive pulmonary disease (COPD), pulmonary fibrosis, emphysema or used oxygen to assist breathing? b) been diagnosed as having, been treated for or hospitalized for: heart attack, heart disease, heart or circulatory surgery (including pacemaker, by-pass, heart valve replacement, angioplasty, stent implant), any procedure to improve circulation to the heart or brain, or uncontrolled high blood pressure? c) had a stroke, mini-stroke or transient ischemic attack (TIA)? d) had Hodgkin's Disease, lymphoma, leukemia, cirrhosis, liver disease or systemic lupus (SLE)? e) had any neuromuscular disease (including, but not limited to, cerebral palsy, multiple sclerosis, grand mal seizures) or Parkinson's disease? f) had an amputation caused by disease?	❑Yes ❑No	❑Yes ❑No

14. In the past 10 years, have you been convicted of a felony or are you now on parole or probation?	❑Yes ❑No	❑Yes ❑No
15. In the last 5 years have you been treated for, or been advised to have treatment for, or used alcohol in excess or any drugs of abuse; or have you been convicted of operating a vehicle while intoxicated or impaired, or had your driver's license suspended or revoked; or attempted suicide?	❑Yes ❑No	❑Yes ❑No
16. Have you been declined or postponed for Life or Health insurance in the past 12 months?	❑Yes ❑No	❑Yes ❑No
Section E:		
17. Have you applied for Life Insurance with any other Insurance companies in the last 2 years?	❑Yes ❑No	❑Yes ❑No
18. Driver's License Number:_____, and State _____		
Section F:		
19. Are you taking medication for any impairment in section D?	❑Yes ❑No	❑Yes ❑No

If Q# 19 is answered "Yes", please list the drug and the condition: *(attach a separate sheet if necessary):*

[NOTE: Listing of medications below is waived for point-of-sale tele-underwritten applications.]

Applicant "A"		**Applicant "B"**
	Medication Name (copy off pharmacy label)	
	Date originally prescribed	
	Frequency and Dosage	
	Diagnosis / Condition	
	Medication Name (copy off pharmacy label)	
	Date originally prescribed	
	Frequency and Dosage	
	Diagnosis / Condition	
	Medication Name (copy off pharmacy label)	
	Date originally prescribed	
	Frequency and Dosage	
	Diagnosis / Condition	

	Medication Name (copy off pharmacy label)	
	Date originally prescribed	
	Frequency and Dosage	
	Diagnosis / Condition	
	Medication Name (copy off pharmacy label)	
	Date originally prescribed	
	Frequency and Dosage	
	Diagnosis / Condition	
	Medication Name (copy off pharmacy label)	
	Date originally prescribed	
	Frequency and Dosage	
	Diagnosis / Condition	

Use this section to give us any details or additional information (attach a separate sheet if necessary):

FULL NAME OF PRIMARY CARE PHYSICIAN: _____

_____

COMPLETE ADDRESS AND PHONE NUMBER: _____

_____

Section G:

	PROPOSED INSURED **"A"**	PROPOSED INSURED **"B"**
FACE AMOUNT:	$_____	$_____
ACCIDENTAL DEATH RIDER AMT:	$_____	$_____
Check here only if owner does ***not*** want the Automatic Premium Loan provision:	❑	❑
Quoted Mode Premium:	$_____	$_____

Premium Mode: ❑ Monthly PAC ❑ Quarterly ❑ Semi-Annual ❑ Annual

HOME OFFICE ENDORSEMENT: (HOME OFFICE USE ONLY):

Section H:

PROPOSED INSURED'S STATEMENT

I understand all of the questions that I have read or that have been read to me on this application. I am not currently taking and I am not under the influence of any medications or drugs that would affect my ability to fully understand and to fully and accurately complete this application. All of the statements and answers in this application for life insurance are true and complete to the best of my knowledge and belief. I agree that this application will be the basis for, and will become part of, any policy that is issued by Standard Life and Casualty Insurance Company (the Company) and that no information about me will be considered to have been given to the Company unless it is stated in the application. I agree that any policy shall not be in effect until it has been issued by the Company and all premiums have been paid. I understand that the agent has no authority to approve the application, change the policy or waive any policy provisions. I understand no insurance will be effective until the date stated in the policy and all eligibility requirements are met. I am not being paid cash and have not been promised services as an inducement to enter into this application. The purpose of this application is not to sell or assign it to any type of viatical settlement, senior settlement or life settlement company. I acknowledge receipt of a copy of the Fair Credit Reporting Act and MIB, Inc. notices.

Replacement: Does any applicant have existing life insurance policies or annuity contracts: ❑Yes ❑No

Replacement: Will the proposed insurance replace, discontinue, or change an existing policy or contract? ❑Yes ❑No

Signatures:

_____ _____

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

(Parent or Guardian if under age 18)

_____ _____

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

(Parent or Guardian if under age 18)

Section H:

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

1. I certify that I personally asked the Proposed Insured(s) all questions on this application, and accurately recorded the answers supplied by the Proposed Insured; and that the answers recorded did not conflict with my observations and knowledge of the Proposed Insured. I further certify that I have verified the personal information of the Insured(s) by viewing a state driver's license, state issued I.D. card, military I.D. card, Permanent U.S. Resident (Green Card), passport or other government-issued I.D. Card.
2. 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

TELEPHONE INTERVIEW CODE: _____

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 "A":

_____ _____

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

_____

Description of Personal Representative's Authority and Relationship to Patient

APPLICANT "B":

_____ _____

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

_____

Description of Personal Representative's Authority and Relationship to Patient

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.

_____ ___|___|___|___|___|___|___|___|___ ___|___|___|___|___|___|___|___|___|___|___|___ ☐ Checking ☐ Savings

Bank Name *Bank Routing/ABA #* *Bank Account #*

_____ _____

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*

LEAVE THIS PAGE WITH APPLICANT

MIB Pre-Notice

Information regarding your insurability will be treated as confidential. Standard Life and Casualty 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 P.O. 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
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