COVID-19 QUESTIONNAIRE

COVID-19 Questionnaire Rules:

1. Questionnaire is only required on full benefit or first day coverage applications.
2. No questionnaire is required on full benefit applications under the age of 65.
3. If either question on the questionnaire is answered "yes" then we postpone the application for 25 days.

Name of Proposed Insured (please print): _____

Name of Owner (please print): _____

Application Date: _____

If the answer to any of these questions is "Yes", submission of the insurance application will be postponed for 25 days and subjected to further review.

	Yes	No
1. Within the past 30 days has the proposed insured been examined, diagnosed, treated, been given medical advice, tested positive, or tested without results regarding COVID-19 by a member of the medical profession?	☐	☐
2. Within the past 30 days has the proposed insured been quarantined or self-isolated based upon the advice of a member of the medical profession regarding Covid-19?	☐	☐

To the best of my knowledge, the answers to the above questions are true and complete. Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

_____ _____

Proposed Insured's Signature Date

Application for:
Whole Life & Limited Death
Benefit Life Insurance

1. Name of Proposed Insured (Print) Last First Initial		Sex	Birthdate MM/DD/YYYY	Age	Height	Weight
Street Address	City	State	Zip	Birth State	Social Security No.	
Proposed Insured's Email			Telephone Number			

2. ☐ Simple Security Plan - Preferred ☐ Simple Security Plan - Standard ☐ Simple Security Plan - Graded 2 year ROP + 10%	3. Face Amount $_____ Premium $_____	3a. Premium Payable: ☐ EFT ☐ Debit/Credit Card ☐ Direct Monthly Bill ☐ Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annual
	3b. Amount of Premium Submitted with the Application: $_____ (Check must be made payable to Security National Life Insurance Company).	

3c. Please choose a billing option:

Select a bill date and beginning month **OR** **Select a billing week and day of week**

Requested Bill Date: 1st – 28th ☐	Draft Immediately ☐ Yes ☐ No	Week of Month 1 2 3 4 Day of Week M T W Th F	Draft Immediately ☐ Yes ☐ No
First Bill Month: Jan – Dec ☐			

4. Primary Beneficiary	Relationship	Contingent Beneficiary	Relationship
Primary Beneficiary's Email		Contingent Beneficiary's Email	

5. Owner, if other than the Proposed Insured — **Social Security No.**

Name: **Relationship:**
Address: **Email Address:**
City, State, Zip:

6. Replacement
Do you have an existing life insurance policy or annuity policy? ☐ **Yes** ☐ **No**
Will proposed insurance replace any existing policy? ☐ **Yes** ☐ **No**
If yes, submit required replacement form.

7. Primary Physician: _____
Address: _____
Phone: _____

8. Tobacco Question. Have you used tobacco in any form within the past 12 months? ☐ Yes ☐ No

Medical Questions (Section One) – Answer all medical questions.

☐ If any questions 9-11 are answered "Yes", the applicant will not be eligible for any coverage.
☐ If all questions 9-11 are answered "No", applicant is eligible to proceed to the next section for Simple Security Plans.

	Yes	No
9. Are you now, or within the past 30 days been confined or treated in a hospital, nursing home, health care facility or in hospice care?	☐	☐
10. a) Do you currently have, been diagnosed with, or are you currently being treated for any tumors or cancers?	☐	☐
b) Have you received medical advice, treatment, been advised to have treatment or surgery, or taken medication for Alzheimer's or organ transplant?	☐	☐
11. Have you ever tested positive for HIV in a test taken for the purpose of obtaining insurance? Have you ever been diagnosed as having AIDS or ARC caused by the HIV infection or other sickness or condition derived from such infection?	☐	☐

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Medical Questions (Section Two) – Answer all medical questions.

- ☐ If all questions 12-16 are answered "No", applicant is eligible for Preferred Rate.
- ☐ If any question 12-15 is answered "Yes", applicant is only eligible for Graded Rate.
- ☐ If three or more are answered "Yes" to questions 12-15, applicant is not eligible for Simple Security Plan.

*** With all "Yes" answers, please include full description below.**

	Yes	No
12. Within the past two years, have you received medical advice, treatment, been advised to have treatment or surgery, or taken medication for:		
a) Angioplasty, stent implant, bypass surgery, heart valve surgery or pacemaker?	☐	☐
b) Any type of tumors or cancers?	☐	☐
c) ALS (Lou Gehrig's disease), dementia, brain tumor, brain disorders or strokes of any kind?	☐	☐
d) Heart disease of any type, angina, heart attack, enlarged heart, congestive heart failure (CHF) or other heart disorders or conditions?	☐	☐
e) Lung disease, emphysema, or chronic obstructive pulmonary disease (COPD)? Or any type of other pulmonary disease or condition?	☐	☐
f) Kidney disease or failure, renal failure or insufficiency, liver disease, hepatitis, cirrhosis, disease of the pancreas or other organ failure or disease?	☐	☐
g) Parkinson's disease, paralysis, multiple sclerosis, lupus, muscular dystrophy, epilepsy, seizures or any other neurological disorders?	☐	☐
h) Diabetes with complications that could include eye disease or disorder, circulatory disorder, neuropathy, amputation, or take 100 units or more of insulin in a 24- hour period?	☐	☐
i) Paranoia, schizophrenia, bi-polar disorder, major depressive disorder, or any other mental disorder or disease?	☐	☐
j) Diagnosed, tested, treated for, or told that you abuse or use in excess: alcohol, drugs (including prescription drugs), narcotics or any other substance?	☐	☐
13. Within the last two years, have you ever been advised by a medical professional to have tests, surgery, treatment, or additional medical evaluations that have not been performed, or do you have any medical test results pending?	☐	☐
14. Do you use a medical appliance such as a wheelchair, walker or hospital bed, oxygen or do you need assistance or supervision by another individual with dressing, eating, personal hygiene (bathing or toilet), walking, or transferring to or from bed or chair?	☐	☐
15. Within the past year have you had any application for life insurance declined or postponed for any reason?	☐	☐

Medical Questions (Section Three) – Answer all medical questions.

- ☐ If all questions are answered "No" except question number 16, applicant is eligible for Standard Rate.

16. Do you use any type of insulin medication for any type of diabetes?	☐	☐

Remarks: Please list all medications or oxygen: including dosages, duration and reason for taking.

Question #	Medication	Duration	Reason	Dosage	# of times daily

I hereby apply to Security National Life Insurance Company, Salt Lake City, Utah, for insurance to be issued upon the truth and completeness of the answers to the above questions to the best of my knowledge, and agree that: (1) No agent has the authority to waive the answer to any question in the application; (2) no insurance will be effective until the Premium for the Mode selected has been paid in full and the policy delivered; and (3) the policy effective date will be the date this application is received by the company at the above address.

PRESCRIPTION AUTHORIZATION

I hereby authorize any health care provider, including any physician, practitioner, pharmacy, prescription vendor, pharmacy benefit manager, hospital or medically-related facility, and any insurance company, or other consumer reporting agency, institution or person that has my records or knowledge of me or my dependent(s) to disclose to Security National Life Insurance Company (SNL), or its authorized representative, any such records or information. Records or information may include medical records in their entirety, which may contain mental health records, (excluding psychotherapy notes), prescription drug records, use of alcohol, or use of controlled or prohibited substances and driving records. Such records or information will be used by Company personnel to determine eligibility for insurance and/or benefits. SNL may disclose such information to its reinsurer(s) or any other organization which performs services in connection with the insurance relationship, including but not limited to, the insurance agent, or as lawfully required. There may be certain circumstances under which the information received may be disclosed to third parties who are not subject to the regulations under federal health privacy law. We contractually require such persons to agree to protect the confidentiality of the information. I understand that I have the right to request access to all personal information collected and, upon written request, I may ask SNL to correct, amend or delete any incorrect personal information. A copy of the Company's "Privacy Notice and Notice of Insurance Information Practices" is available upon request.

This authorization shall be valid for a period of (2) years from the date signed to determine eligibility for insurance. A photocopy of this authorization shall be as valid as the original. I understand that I, or my authorize representative may receive a copy of this authorization upon request. This authorization may be revoked upon submission of a written notice to the Home Office. If this authorization was obtained as a condition of obtaining insurance coverage, your right to revoke also is subject to the rights of the Company under any law granting the Company the right to contest a claim under the policy or the policy itself.

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 may be guilty of a felony of the third degree.

Dated at _____ Date: _____
City State (MMDDYY)

Signature of Applicant: _____ Date: _____

Signature of Owner (if other than proposed insured): _____ Date: _____

AGENT'S STATEMENT- I certify that to the best of my knowledge:

1. I correctly asked all the Medical Questions in this application and correctly recorded all the answers given; and
2. All answers given in this application are true and complete; and
3. **This insurance ☐ WILL ☐ WILL NOT change or replace any existing insurance or annuity; and**
4. The signature of the proposed insured(s) and/or the applicant/policyowner (parent/legal guardian) is what they are represented to be and were signed in my presence; and
5. I know of no factor affecting the insurability of the proposed insured (s) except as stated in this application.

Agent's Signature: _____

Agent's Printed Name: _____ Agent's Number: _____

Note: If "Will" is checked in number 3 above, complete required replacement forms.
If policy and commissions are being split between multiple agents, then each additional agent must sign and notate commission split.

Agent's Signature: _____ Agent's Number: _____

Agent's Printed Name: _____ Commission Split: _____

ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION AGREEMENT TO SECURITY NATIONAL LIFE INSURANCE COMPANY (SNL)

Customer Name:_____

Name of Bank: _____

Address of Bank:_____

Checking Account #: _____ or Savings Account #: _____

Nine Digit Bank Transit #: _____

Credit Card #: _____ Exp. _____ CCU# _____

I authorize SNL to initiate debit entries to my checking or savings account, indicated above, and authorize the financial institution (bank) named to debit my account for payment of my SNL account(s). I understand this authorization is subject to the terms and conditions of the EFT agreement.

TERMS AND CONDITIONS

1. This arrangement may be terminated with respect to any or all contracts listed below by SNL or by me upon written notice to the other party. Until such notice is actually received by SNL, SNL shall be fully protected in drawing the EFT.
2. I understand that if any EFT is dishonored by my bank and if any monthly amount due SNL is not paid within the time stipulated on the contract, the contract shall lapse except as otherwise provided therein.
3. During the continuance of this arrangement SNL shall not be required to send payment notices on any contract I have authorized to be included hereunder.
4. If I change banks or bank accounts and I want to continue using EFT, I must sign a new Authorization Agreement.
5. This authorization shall not be effective for any contract for which an application is pending, unless and until such contract is actually issued and the down payment there under paid in cash to SNL.
6. I will pay a returned-item fee as specified by the bank or SNL for any debit entry that is returned to SNL for insufficient funds.
7. The EFT will apply to the following contract(s):

Name:_____ Contract # _____

Name:_____ Contract #_____

Date:_____ Signature: _____

Authorized Account Holder

This authorization must be accompanied by a voided check or deposit slip.

CONDITIONAL RECEIPT

THIS RECEIPT DOES NOT PROVIDE ANY INSURANCE UNTIL AFTER ITS CONDITIONS ARE MET. NO AGENT OF THE COMPANY OR BROKER OR ANY OTHER PERSON(S) MAY WAIVE ANY OF THESE CONDITIONS.

Received from _____ on _____
date

the sum of $_____, the correct first premium specified in the application, subject to the following conditions:

FIRST: If each proposed insured would be acceptable and approved by Security National Life Insurance Company in Salt Lake City, Utah, as insurable under the company's underwriting rules for insurance on the plan and at the premium rate and the amount of insurance applied for on the application for all proposed insured(s).

SECOND: The premium funds for the correct premium amount for plan of insurance applied for, have been honored on the first presentation and result in the funds being credited to Security National Life Insurance Company's bank account.

THIRD: We will, within 60 days of the date of this Application, provide you with your policy, or notify you as to whether or not your Application was accepted, and will give you reason for any further delay.

_____ Agent's Signature

_____ Agent's Name (Please Print)