

PLEASE TYPE OR PRINT

Application for E-Z Life Insurance

REQUESTED EFFECTIVE DATE

____/____/____
MONTH DAY YEAR

*APL Yes No
*Automatic Premium Loan Option

*ADB Yes No
*Accelerated Death Benefit

If YES, sign Disclosure on reverse side

1. Name of Proposed Insured (First, Middle Initial, Last Name) _____ Sex _____ Age _____ Birth Date _____ State of Birth _____ Height _____ Weight _____

2. Residence of Proposed Insured
Home Phone Number (____) _____
Street Number _____ City _____ State _____ Zip Code _____

3. Occupation _____ **4. Proposed Insured's Social Security Number** _____ - _____ - _____

5. Face Amount (Choose from \$2,500 to \$25,000) \$ _____

6. Premium Payment Mode Annually Semi-Annually Quarterly PAC Monthly Direct Monthly Credit Card Monthly
Visa/MasterCard/Discover # _____ Expiration Date _____

7. Primary Beneficiary _____ Relationship _____
Contingent Beneficiary _____ Relationship _____

8. Applicant (Owner), if other than the Proposed Insured: (Complete below and sign Signature Block at bottom of Application)
Name _____ Relationship _____
Address _____ City _____ State _____ Zip _____
Social Security or Tax ID number of Applicant _____ - _____ - _____

9. Will the proposed insurance replace any existing Life Insurance policy or annuity? _____ Yes No
If yes, list company name, address and policy number: _____

- 10. Health questions (if the answer is "YES" to any question A- G, the Proposed Insured is not eligible for coverage).**
- A)** Is the Proposed Insured currently bedridden, confined to a nursing facility or hospital, receiving Hospice or Home Health Care, requiring assistance with activities of daily living such as walking, eating, bathing, toileting or dressing, waiting for or had an organ transplant, been advised to use or using oxygen to assist in breathing, or paralyzed? _____ Yes No
 - B)** Has the Proposed Insured ever:
 - i) Had, been told they have, been treated for, or been prescribed medication for Alzheimer's disease, dementia, memory loss, sickle cell anemia, liver disease or cirrhosis, muscular dystrophy, Huntington's disease, ALS (Lou Gehrig's disease), congestive heart failure, or had a Pacemaker installed? _____ Yes No
 - ii) Had, been told they have, been treated for, or been prescribed medication for Chronic Obstructive Pulmonary Disease (COPD), Emphysema, chronic kidney disease, kidney failure (renal insufficiency including dialysis), Parkinson's Disease, Multiple Sclerosis, Cystic Fibrosis, Cerebral Palsey, or Down's Syndrome? _____ Yes No
 - iii) Been diagnosed as having, or been treated for, or tested positive by a physician or someone in the medical field for, Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive for antibodies to Human T-Cell Lymphotropic Virus, Type III (HTLV-III) or HIV? _____ Yes No
 - C)** In the past 10 years, has the Proposed Insured used illegal drugs of any kind or been convicted of a felony? _____ Yes No
 - D)** In the past 5 years, has the Proposed Insured been told they have or been treated by surgery, chemotherapy, radiation, or prescribed medication for internal cancer, leukemia, Hodgkin's disease, or malignant melanoma or had more than one occurrence in their lifetime, other than Basal Cell Skin Cancer? _____ Yes No
 - E)** In the past two 2 years, has the Proposed Insured been hospitalized as an inpatient for Diabetes or complications of Diabetes, or was diagnosed with Diabetes before the age of 40, or had any amputation caused by disease? _____ Yes No
 - F)** In the past 2 years, has the Proposed Insured been told they have, been treated for, or taken medication or had surgery for:
 - i) Heart bypass, angioplasty (balloon procedure), stent placement, heart valve disorder, heart attack, angina (chest pain), stroke, circulation or blood clot problems in the legs or to the heart or brain, or systemic lupus? _____ Yes No
 - ii) Drug or alcohol abuse/dependency or addiction? _____ Yes No
 - G)** In the past 6 months, has the Proposed Insured been advised to have testing, hospitalization, surgery, or treatment by a medical professional and not done so? _____ Yes No

If all the above questions A-G are answered "NO" you may be eligible for a full face amount policy. You must meet the Height and Weight Requirements for the Plan. Your acceptance of a Life Insurance Policy is subject to approval by the Home Office of United Security Life and Health Insurance Company.

INSURED'S STATEMENT AND HIPAA COMPLIANT AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby apply to United Security Life and Health Insurance Company ("USL&H") for insurance. I represent the statements I have made herein are complete and true. I understand the following: (a) if any material information on this application is incorrect, this coverage may be voided; and, (b) if this application is declined and a Policy is not issued, USL&H's only obligation will be to return any premium paid; and, (c) there is no insurance in force until a Policy indicating the effective date is received from USL&H and the initial premium, including the applicable fee, is paid in full. By this form (or copy), I authorize any medical practitioner, physician, pharmacist, pharmacy-related facility, hospital, clinic, healthcare professional, medical or medically-related facility, records custodian, insurance company, or the Medical Information Bureau, that has any records of my health, to give USL&H, its reinsurers, affiliates, or business associates, any such information which shall include, but not be limited to, Alcohol or Drug abuse treatment, Mental Health diagnosis and treatment, Pharmacy prescriptions, HIV testing and treatment, Sexually Transmitted Disease (STD) testing and treatment, Genetic testing, Sickle Cell testing and treatment, lab data, and diagnostic testing. I understand the information obtained by use of this authorization will be used by USL&H to determine eligibility for insurance. Any information obtained will not be released by USL&H to any person or organization except to reinsurance companies, the Medical Information Bureau, or other persons or organizations performing business or legal service in connection with my application, claim, or as may be otherwise lawfully required or as I may further authorize. I understand that any information that is disclosed pursuant to this authorization may be rediscovered and no longer covered by federal rules governing privacy and confidentiality of health information. This authorization shall be valid for two and one half years from the date shown below. (For residents of Arizona, this authorization is valid for 180 days for any HIV-related information.) I acknowledge receipt of the important notice regarding a consumer report and disclosure of information to the Medical Information Bureau. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to USL&H, P.O. Box 388342, Chicago, Illinois 60638. Attention: Privacy Officer. I understand that a revocation is not effective to the extent that any of my providers has relied on this authorization or the extent that USL&H has a legal right to contest a claim under an insurance policy or to contest the policy itself within the two year Contestable Period. A photographic copy of this authorization and acknowledgement shall be as valid as the original. Upon request I, or my authorized representative, is entitled to receive a copy of this authorization form. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an Application for Insurance may be guilty of a crime and may be subject to fines and confinement in prison.

I have paid the sum of \$ _____ with this Application, dated at _____ City _____ State _____ this _____ day of _____ 20 _____

X _____ Signature of Proposed Insured X _____ Signature of Applicant /Owner (if other than Proposed Insured)

AGENT'S STATEMENT: Is insurance being applied for intended to replace any insurance now in force?

If "YES", submit required Replacement Form. Yes No

I have truly and accurately recorded in this Application, the information supplied by applicant.

Print Agent Name _____ X _____ **Licensed Agent Signature** _____ **Agent No.** _____

**AUTHORIZATION TO HONOR CHECKS DRAWN BY
UNITED SECURITY LIFE & HEALTH INSURANCE COMPANY**

Name of Bank: _____
Address of Bank: _____

As a convenience to me, I hereby request and authorize you to pay and charge my account (checks or electronic debits) drawn on my account by and payable to United Security Life & Health, provided there are sufficient funds in said account to pay the same on presentation. I agree that your rights with respect to each such debit shall be the same as if it were a check drawn on you and signed personally by me. I further agree that if any such check or electronic debit be dishonored, whether with or without cause, and whether intentionally or inadvertently, you shall be under no liability whatsoever, even though such dishonor results in the forfeiture of insurance. This authorization is to remain in effect until revoked by me in writing, and until you actually receive such notice.

Printed Name of Depositor

Signature of Depositor

Date
If Bank Check Plan or Electronic Transfer **ATTACH
VOIDED CHECK HERE** and Sign Authorization Above

Sample Premium Calculation: (age at last birthday)
Example: Male age 24 Your sex and age _____/_____

Face Amount	\$10,000	Face Amount	\$ _____
Annual Premium (See Premium Chart)	\$18.40	Annual Premium per \$1,000	\$ _____
x 10		No. of face amount units (1 unit = \$1,000)	X _____
Total Annual Premium	\$184.00	Total Annual Premium	\$ _____
x .084 (Bank Draft)		Modal Factor	X _____
		Modal Premium	\$ _____
		Optional Accelerated Death Benefit (ADB)	+ _____
		Modal Premium with (ADB)	\$ _____
		Policy Fee	+ _____
		Total Premium	\$ _____

For payment modes other than annual, multiply annual premium by: .52 for Semi-Annual, .265 for Quarterly, .084 for Bank Draft or Credit Card, and .095 for Monthly Direct.

Proposed Insured's Telephone Number:
Home (_____) _____
Available during day Yes No
Business: (_____) _____
Available during day Yes No
Best time to contact: _____

ACCELERATED DEATH BENEFIT PAYMENT RIDER SUMMARY AND DISCLOSURE STATEMENT

THE EFFECT OF ACCELERATION OF A BENEFIT:

Any benefits paid under the Rider will reduce the Cash Value, Death Benefit, any Outstanding Policy Loan and Premiums of the Policy. The Death Benefit will be reduced by the amount of eligible proceeds You select when You exercise Your rights under the Rider. Any eligible proceeds requested under the Rider will be reduced by the amount required to repay a pro-rata portion of any outstanding loan, including any related accrued interest, and by the deduction of the processing charge. A Benefit Payment notice will be sent to You, the Owner, upon receipt by Us, United Security Life and Health Insurance Company of a request for Acceleration of Benefits. This notice will show the effect the Advance Payment will have on Policy benefits, and other Policy Values. When an Advance Payment is made under the Rider, a revised Schedule Page for the Policy will be furnished to You to show the revised Policy Values then in force..

TAX CONSEQUENCES:

The receipt of an Advance Payment may be considered a taxable event. The receipt of an Advance Payment may also affect the Insured's eligibility to receive, or continue to receive, Medicaid benefits or other government benefits and entitlements. As with all legal matters, a personal tax and/or other legal advisor should be consulted to assess the impact of the receipt of an Advance Payment under the Rider.

THE BENEFIT:

Upon written request by You, We will make an Advance Payment, subject to the limitations and requirements outlined in the Rider. An Advance Payment will only be paid one time. This benefit can not be exercised if the Policy to which the Rider is attached has been assigned as collateral for a loan. If this Policy is in the Grace Period when an Advanced Payment is elected, the premium and fee due to pay this Policy current will be deducted from the Advanced Payment.

THE AMOUNT:

The amount of Eligible Proceeds is selected by You, subject to certain limitations. The minimum amount available for acceleration is \$1,250 of Eligible Proceeds. The maximum amount available for acceleration is 50% of the Eligible Proceeds, as defined in the Rider. After the Advance Payment is made to You, the amount of Eligible Proceeds remaining in force must be at least \$1,250.

SAMPLE ILLUSTRATION OF ACCELERATED BENEFIT PAYMENT

ASSUMPTIONS:

1. Eligible Proceeds	\$ 10,000.00
2. Premium	\$ 19.96 per month
3. Cash Value	\$ 1,725.00
4. Outstanding Policy Loan	\$ 600.00
5. Eligible Proceeds Selected	\$ 5,000.00
6. Processing Charge	\$ 100.00

THE COST:

There is a \$1.00 per month charged for the Accelerated Death Benefit Payment Rider. A processing charge, not to exceed \$100, may be deducted from the Eligible Proceeds. The processing charge is directly associated with Our administrative costs related to the Advance Payment.

DIAGNOSIS:

A Terminal Illness or Injury must be diagnosis by a licensed practitioner, practicing within the scope of his or her license. Upon diagnosis of a life expectancy of 180 days or less, satisfactory evidence of such diagnosis may be required. Satisfactory evidence includes certification by a doctor of the Insured's expected death within 180 days. We may require a second examination, at Our expense, by a doctor of Our choice, or any other evidence We deem necessary.

TERMINATION:

The Accelerated Death Benefit Payment Rider will terminate when:
1. An Advance Payment is made in accordance with the provisions of the Rider; 2. You make a written request to terminate the Rider and You return the Policy and Rider to Us; or 3. The Policy terminates.

DEFINITIONS:

Eligible Proceeds means the amount You requested in accordance with the limitations of the Rider. Prior to payment to You, this amount will be used to repay a pro-rata portion of any outstanding Policy Loan and will be further reduced by the deduction of the processing charge. Terminal Illness or Injury is defined as a condition with a life expectancy of 180 days or less, as diagnosed by a licensed practitioner. Practitioner or Doctor means a person who is duly qualified, legally licensed and practicing within the scope of the license who is: 1. a physician or surgeon practicing medicine and surgery; and authorized to and uses the designation M.D.; or 2. a physician of osteopathy who uses the designation D.O.. However, "Practitioner" or "Doctor" does not include the Owner, Insured, spouse, son or daughter, brother or sister, parent, grandchild, or grandparent of the Owner or the Insured.

POLICY STATUS BEFORE AND AFTER ELECTION:

<u>Before</u>	<u>After</u>
\$ 10,000.00	\$ 5,000.00
\$ 19.96 per month	\$ 11.23 per month
\$ 1,725.00	\$ 862.50
\$ 600.00	\$ 300.00
Advance Payment = Eligible Proceeds Selected less Loan Reduction Amount less	
<i>Processing Charge</i>	
Advance Payment = \$5,000.00 --- \$300.00 --- \$100.00	
Advance Payment = \$4,600.0	

ACKNOWLEDGEMENT

I (We), the undersigned, hereby acknowledge that I (we) have received the above Accelerated Death Benefit Payment Rider Summary and Disclosure Statement which was furnished to me (us) prior to the signing of the application for insurance.

Proposed Insured's Signature

Date

Owner's Signature

Date

Agent's Signature

Date