Providing Innovative Health Care Solutions for today’s medical uncertainties:

Offering:

**AFFORDABILITY – ACCESSIBILITY-FLEXIBILITY-VERSATILITY**

- Out Patient Benefits ........... *No Deductible or CoPay*
- Inpatient Benefits .................. *No Deductible or CoPay*
- Well Care benefits ................. *No Deductible or CoPay*
- Surgical Benefits .................. *No Deductible or CoPay*
  
  Both Inpatient and Outpatient
- Immunizations ........................ *No Deductible or CoPay*
- Pap Smears Screening ..... *No Deductible or CoPay*
- And the Freedom to Choose your own Doctors and Hospitals

Unlike conventional health insurance plans, our plan pays a specified cash amount on a per day or per period basis, regardless of what your provider charges you. Cash is paid to you or your provider, if you assign the benefits.

*Our Policy Pays Regardless of any Other Policy you May Have.*

PROUDLY UNDERWRITTEN BY:

Southwest Service Life Insurance Company, Fort Worth, Texas

*All benefits are subject to the policy provisions; including Limitations, Exclusions and any Waiting Periods for Effectiveness of Coverage.*

*This is not your policy. This is a summary of the policy benefits.*
## BENEFITS

<table>
<thead>
<tr>
<th>Plan A</th>
<th>Plan B</th>
<th>Plan C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aggregate for Policy Year</td>
<td>$50,000</td>
<td>$75,000</td>
</tr>
<tr>
<td>Aggregate for Lifetime</td>
<td>$200,000</td>
<td>$200,000</td>
</tr>
<tr>
<td>Daily Hospital Confinement Benefit</td>
<td>$1,000 / per Day</td>
<td>$1,500 / per Day</td>
</tr>
<tr>
<td>Outpatient Events Policy-Year Aggregate</td>
<td>$2,000 / per Insured</td>
<td>$2,000 / per Insured</td>
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</tbody>
</table>

**ALL BENEFITS ARE ON A PER DAY OR PER PERIOD BASIS RATHER THAN ON ACTUAL CHARGES:**

### MEDICAL AND SURGICAL EVENTS BENEFITS FOR ALL PLANS

- **Hospital ICU Confinement Benefit**
  - Additional $500 per Day of Hospital ICU Confinement.

- **Anesthesia Benefit**
  - $200 per Day covered surgical procedure is performed.

- **Attending Physician Benefit**
  - $50 per Day per Period of Hospital Confinement.

- **Private-duty Nursing Benefit**
  - $50 per Day per Period of Hospital Confinement.

### TREATMENTS FOR CANCER ONLY

- **Radiation or Chemotherapy Delivery Benefit**
  - $1,000 per Day of delivery. Limit $25,000 lifetime maximum.

- **Hospice within 14 days of Hospitalization**
  - $50 per Day of hospice confinement.

### OUTPATIENT BENEFITS FOR ALL PLANS

- **Emergency Care or Urgent Care Facility visit**
  - $125 per Day of visit. Limit 1 visit per Policy Year.

- **Physician’s Office visit**
  - $75 per Day of visit.

- **Well-care visit**
  - $35 per Day of visit. Limit 3 visits per Policy Year.

- **Immunizations**
  - $50 per Day per immunization. Limit 3 immunizations per Policy Year.

- **MRI Scan**
  - $750 per Day of MRI scan.

- **PET Scan**
  - $500 per Day of PET scan.

- **CT Scan**
  - $250 per Day of CT scan.

- **Lab Test Fees**
  - $50 per Day per lab-test Event. Limit 3 lab-test Events per Policy Year.

- **Conventional Pap smear screening**
  - $150 per Day of screening. Limit 1 screening per Policy Year.

- **Benefit for treatment of neck, back, or spine**
  - $50 per Policy Year.

- **X-ray or Radiological Exam Benefit**
  - $100 per Day of exam.

- **Other Outpatient Events not specifically described**
  - $100 per Day of OP Event. Limit 4 per Policy Year.

### OUTPATIENT EVENTS SUBJECT TO PARTICULAR MAXIMUMS

- **Ambulance Benefit**
  - $100 per Day when ambulance used. Limit $300 per Policy Year.

- **Common Carrier Transportation Benefit**
  - $300 for transport by common carrier or $.50/mile when common carrier unavailable, per Day of trip and per Period of Hospital Confinement. Limit $300 per Policy Year.

- **Home Recuperation Benefit**
  - $30 per Day immediately following covered Period of Hospital Confinement, up to the number of days Hospital confined. 3-day elimination period.

- **Immediate Family-Member’s Lodging Benefit**
  - $50 per Day. Limit 30 days per Period of Hospital Confinement.
Part 1 Read your policy carefully. This outline of coverage provides a very brief description of some of the important features of Your Policy. This is not the insurance contract and only the actual Policy provisions will control. The Policy itself sets forth, in detail, the rights and obligations of both You and Your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY.

Part 2. Hospital confinement indemnity coverage is designed to provide you with a fixed daily benefit during periods of hospital confinement resulting from a covered injury or sickness. This policy also provides fixed daily indemnity coverage for expenses arising from certain medical and surgical events. Coverage is provided for the benefits outlined in PART THREE. The benefits described in PART THREE may be limited by PART FOUR.

Part 3. BENEFITS We will pay the benefits stated in this Policy for Events, services and materials stated herein which are:

a) Covered Expenses as defined in this Policy; and

b) Incurred as a result of a covered Sickness or Injury as defined in this Policy.

Benefits for Events, services and materials are not to exceed the maximum amounts set out in this Policy with respect to each Insured Person. Benefits will be payable only if:

a) the Events, services and materials are furnished by or at the direction and under the regular supervision of a duly licensed Physician;

b) such services and materials are considered Necessary Treatment as defined in this Policy; and

c) Expenses are incurred and services and materials are furnished while this Policy is in force.

For each Insured Person, benefits provided under all benefit provisions of this Policy shall not exceed the Aggregate per Policy Year and the Aggregate for Lifetime as shown on the Policy Benefit Schedule.

The Indemnity for Hospital Confinement is the daily Hospital Confinement benefit shown on the Policy Benefit Schedule, multiplied by the total number of Days an Insured Person is Hospital Confined for Necessary Treatment, which confinement occurs more than thirty [30] days after the Policy Effective Date and while this Policy is in effect, regardless of what the provider charges and regardless of any other insurance covering the Insured Person. Payment of benefits is subject to all terms, limitations, exclusions, waiting periods and aggregates in the Policy.
4. LIMITATIONS AND EXCLUSIONS - READ CAREFULLY

PRE-EXISTING CONDITIONS: Subject to all the terms of this Policy, after one year this Policy covers Pre-existing Conditions made known to the Company during the underwriting process and not specifically excluded from coverage. “Pre-Existing Condition” means the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment within a five year period preceding the Effective Date of coverage or a condition for which medical advice or treatment was recommended by a Physician or received from a Physician within a five-year period preceding the Effective Date of coverage.

REDUCTION OF BENEFITS AFTER AGE 65. If treatment for a covered sickness or injury commences after the Insured Person’s 65th birthday, all Benefits will be 50 percent of the amount otherwise payable.

WAITING PERIODS:

1. FOR SUCH INJURIES, SUCH SICKNESSES. This Policy provides benefits only for such Injuries occurring on or after the Policy Effective Date of Coverage, and only for such Sickness first manifesting itself more than thirty [30] days after the Effective Date of Coverage shown on the Policy Benefit Schedule.

2. FOR CERTAIN SICKNESSES. For the first six [6] months after the Effective Date of Coverage, this Policy does not provide any benefits for services or expenses resulting in or from hernia, disorder of reproductive organs, varicose veins, hemorrhoids, appendix, tonsils, adenoids, or gallbladder.

3. FOR COMPLICATIONS OF PREGNANCY. Complications of Pregnancy [see Definitions] will be covered as a Sickness if this Policy is in force a minimum of thirty [30] days before the inception of such pregnancy with respect to such Insured Person. We reserve the right to request that You furnish medical evidence from a Physician confirming the inception date of such pregnancy.

EXCLUSIONS: Benefits otherwise provided by this Policy will not be payable for Events, services, expenses or any Loss resulting from or in connection with: a) Dental treatment except that dental treatment caused by a covered injury within 90 days thereof; b) Accidental bodily injury or sickness caused by war or any act of war declared or undeclared; service in the armed forces or units auxiliary thereto; (Premium will be refunded on a pro-rata basis for any Insured Person who enters military service and all coverage for that Insured Person will be canceled.); c) Any intentional self-inflicted injury, suicide or attempted suicide; d) Addiction to, overdose of, or sickness or injury resulting from use of alcohol, drugs, narcotics, hallucinogens, or other drugs, controlled or uncontrolled substances; e) Termination of use or addiction to tobacco products; f) Intoxicants and Narcotics. We are not liable for any loss sustained or contracted in consequence of an Insured Person being intoxicated or under the influence of any narcotic unless the narcotic is administered on the advice of a Physician. This exclusion applies whether or not the Insured Person is charged with any violation in connection with a loss; further, there is no need to prove a loss was caused, contributed to, or resulted from excessive blood alcohol concentration; g) Any disease or disorder due to abuse of or addiction to alcohol or drugs; h) Cosmetic surgery, except operations necessary to repair disfigurement resulting from a covered injury and performed [1] within two years of the date of the covered injury, and [2] while this Policy is in force; i) Any Injury or Sickness arising out of, or in the course of, employment for wage or profit, provided the Insured Person is covered under any Workers’ Compensation Act, Occupational Disease Act, or similar act or law, unless the Insured Person is self-employed; j) Voluntary sterilization; in vitro fertilization, fertility drugs or any other expenses or services relating to or in connection with assisted reproductive technology; k) Normal pregnancy, except for Complications of Pregnancy as defined herein; l) Any routine physical examination except as provided herein; m) Elective abortion or any elective procedure or treatment; n) Aviation of any type, except as a fare-paying passenger on a regularly scheduled flight on a commercial airline; o) Services performed by an Insured Person on him- or herself.

p) Breast augmentation or reduction mammoplasty unless necessary in connection with breast reconstructive surgery following a mastectomy; q) Gastric segmentation, stapling, or any other surgical procedure or medical treatment for weight control, weight reduction or dietary control or any expenses of any kind to treat obesity, weight control, weight reduction or dietary control; r) Mental or nervous disorders without demonstrable organic disease; s) Prostheses of any kind; t) Occupational therapy; u) The detection and correction by manual or mechanical means of structural imbalance, distortion or subluxation of or in the neck, back, or vertebral column, unless otherwise provided by the Policy; v) Services which you are entitled to receive without incurring legal liability; w) Medical treatment incurred outside the United States of America. x) Charges for which there is no legal obligation to pay; charges which are compensated for or furnished by the United States government or any of its agencies; y) Expenses incurred which exceed the maximum benefits of this Policy; z) Corrective vision or hearing supplies or for the examination for prescribing or fitting such supplies, or any treatment of refractive disorders; aa) Confinement or treatment in any sanitarium, or in facilities for the aged, criminals, educational care, drug addiction or alcoholism; ab) Treatment of temporomandibular joint dysfunction (TMJ); ac) Transplants, unless otherwise provided by the Policy; ad) Rest cures, home hospice; ae) Treatment for foot conditions including, but not limited to: (i) flat foot conditions; (ii) foot supportive devices, including orthotics and corrective shoes; (iii) foot subluxation treatment; (iv) plantar fasciitis, corns, bunions, calluses, toenails, fallen arches, weak feet, chronic foot strain, or symp-
omatosic complaints of the feet; and (v) hygienic foot care that is routine; af) Confinement or treatment in any convalescent home, rest or nursing facility, unless specifically provided herein; ag) The cost of blood plasma or blood derivatives, cross matching, typing or transfusions; ah) Services for calibration of automated laboratory equipment and monitoring overall results from such equipment; aj) Treatment or services for behavioral or learning disorders, including but not limited to Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD); ak) Treatment of “quality of life” or “lifestyle” concerns including but not limited to: smoking cessation; obesity; hair loss; al) Sexual dysfunction including, but not limited to: sex transformations, penile implants or any complications thereof; aj) Treatment used to improve memory or to slow the normal process of aging; am) Illegal Occupation: We are not liable for any loss for which a contributing cause was the Insured Person’s commission of or attempt to commit a felony or for which a contributing cause was the Insured Person’s being engaged in an illegal occupation; an) Laser vision correction, radial keratotomy or any eye Surgery when the primary purpose is to correct nearsightedness, farsightedness, astigmatism, or any other refractive error; ao) Eye refractions; vision therapy; routine vision exams to assess the initial need for, or changes to prescription eyeglasses or contact lenses; the purchase, fitting or adjustment of eyeglasses or contact lenses; frames or contact lenses for the treatment of aphakia; ap) Transportation charges, except as provided elsewhere herein for Ambulance Transport Services and Common Carrier Transportation benefits; and aq) Treatment of complications arising from or connected in any way with a surgical or medical treatment or procedure that is not a covered surgical or medical treatment or procedure under the terms of this Policy, whether or not the covered person was insured under the Policy at the time of the non-covered treatment or procedure was performed.

FIVE. RENEWABILITY

This coverage is guaranteed renewable up to the age of 75, subject to the Company’s right to discontinue or terminate the coverage as provided in the Termination provisions below.

TERMINATION. Your coverage will terminate and no Benefits will be payable under this Policy: 1. On the date premiums are not received when due, subject to the Grace Period; 2. If Your mode of premium is monthly, at the end of the period through which premium has been paid following Our receipt of Your request of termination; 3. If Your mode of premium is other than monthly, upon the next monthly anniversary day following Our receipt of Your request for termination. Premium will be refunded for any amounts paid beyond the termination date; 4. At the end of the period through which premium has been paid in which: a) your spouse ceases to be a dependent, b) your children marry or reach age 26, or c) your disabled children are no longer disabled or de-
6. PREMIUM
If You are not satisfied that this coverage will meet Your insurance needs, You may return this Policy to the Company at Our administrative office in Fort Worth, Texas within 10 days after You receive it. If returned during this 10-day period, this Policy will be cancelled as of the Effective Date, any premiums paid on the Policy will be refunded and the Policy will be treated as if never issued.
The premiums for this Policy are shown on the premium rate sheet. The Family Premium rate is based on the age of the oldest family member. We reserve the right to change the applicable table of premium rate on a Class Basis. The premium for the Policy may change in amount by reason of an increase in the age of an Insured Person.
A Grace Period is provided for each premium payment. The Grace Period will be 10 days for monthly modes and 31 days for other premium modes. If a billing mode other than the monthly direct or monthly bank draft is selected, the rates will be in multiples of the monthly premium rate:

- [ ] Monthly
- [ ] Monthly Bank Draft
- [ ] Quarterly - 3 times the monthly rate
- [ ] Semi-Annual - 6 times the monthly rate
- [ ] Annual - 12 times the monthly rate

Plan applied for [check one]:
- [ ] Plan A
- [ ] Plan B
- [ ] Plan C

Per your application, your initial premium will be $___________.
This includes a one-time, nonrefundable application fee of $25.00.
The application fee must be submitted with Your application.
Subsequent premiums will be $___________.

DISCLOSURE OF LIMITED AUTHORITY Your agent does not have the authority to waive a complete answer to any question on your application, or to approve insurability nor the authority to make or alter any provisions of the outline of coverage, application or Policy. Your agent does not have the authority to waive any rights of the Company and You will not be insured until a policy is actually issued by the Company. The making of an application and the payment of an initial premium does not guarantee your insurability and does not mean that you are insured by the Company.

RECEIPT FOR ADVANCE PREMIUM PAYMENT
Received of ________________________________________$
for the first premium and application fee beginning with the date of the policy. These amounts will be returned if a policy is not issued. Please notify our office if the policy is not received within 45 days. It is very important that the complete medical history be recorded on the application. It is distinctly understood that the policy applied for is not effective until actually issued by the Company, and the Company is not liable for any loss whatsoever sustained before the policy is actually issued by the Company, and is then liable only as provided and limited in the policy. All benefits are subject to policy provisions. No oral statement by or to the soliciting representative shall be effective to alter any written provisions of the application of the insurance policy, if any, when same may be issued by the Company.

SOUTHWEST SERVICE LIFE INSURANCE COMPANY
Date ________________________________ 20 ______. Soliciting Representative ________________________________
License Number ________________________________________________________
Form No. HI-2015 CR
If "YES," which applicant?

❏

NAME OF COMPANY    Yes   No  When

applications applicant may have.     BE REPLACED?

4.  Beneficiary (for Life Insurance)   Relationship

Name of Spouse's Employer   Spouse's Occupation

3.  Name of Applicant's Employer   Applicant's Occupation

14.Name of Applicant's Doctor ________________________________________ Address ________________________________________________________________

13. Do you or any dependent listed above own or operate a motorcycle or trail bike; engage in weight lifting; underwater diving; auto or vehicle racing, rodeo activities or any other hazardous work or sport activity? ❑ YES ❑ NO If YES, which applicant(s) ____________________________________________ What sport or activity?

12. Have you or any member listed above been declined, restricted, rated up or postponed for any kind of personal insurance? ❑ YES ❑ NO

If "YES," Name of Company, Why?

APPLICANT OR SPOUSE MUST ANSWER ALL QUESTIONS IN FULL - YOUR REPRESENTATIVE DOES NOT HAVE AUTHORITY TO WAIVE OR OMIT ANY INFORMATION FROM YOUR APPLICATION

8. Are you and all the other members listed above now in good health and without physical or mental defect or deformity? ………………… ❑ YES ❑ NO

9. HAVE ANY OF YOU EVER HAD ANY OF THE FOLLOWING?

(a) High Blood Pressure, Disease of the Heart, Circulatory System, Veins and Arteries or Stroke? ………………… ❑ YES ❑ NO

(b) Chest Pain? ………………… ❑ YES ❑ NO

(c) Hypercholesterolemia or Hypertriglyceridemia? ………………… ❑ YES ❑ NO

(d) Tuberculosis, Emphysema, COPD, Bronchitis or any other Lung Disease? ………………… ❑ YES ❑ NO

(e) Asthma? ………………… ❑ YES ❑ NO

(f) Allergy, Hayfever, Sinusitis or Deviated Nasal Septum? ………………… ❑ YES ❑ NO

(g) Hernia? ………………… ❑ YES ❑ NO

(h) Hemorrhoids, Anal Fistula or Disease of the Rectum or Colon? ………………… ❑ YES ❑ NO

(i) Disease of the Esophagus, Stomach, Pylorus or Duodenum? ………………… ❑ YES ❑ NO

(j) Disease of the Intestines, Gall Bladder or Liver? ………………… ❑ YES ❑ NO

(k) Diabetes, Hyperglycemia or Disease of the Pancreas? ………………… ❑ YES ❑ NO

(l) Disease of the Kidneys, Ureters, Bladder or Urethra? ………………… ❑ YES ❑ NO

(m) Any Venerable Disease? ………………… ❑ YES ❑ NO

(n) Any Disease of the Thyroid or Parathyroid? ………………… ❑ YES ❑ NO

(o) Any Neck, Back, Spine, or Hip Disease or Disorder? ………………… ❑ YES ❑ NO

(p) Arthritis, Rheumatism, Gout or Joint Disorder? ………………… ❑ YES ❑ NO

(q) Cancer ………………… ❑ YES ❑ NO

(t) Glaucoma, Cataracts or any other Disorder of the Eyes? ………………… ❑ YES ❑ NO

(s) Depression, Anxiety, Phobia, Alzheimer's Disease or any other Mental or Nervous Disease or Disorder? ………………… ❑ YES ❑ NO

(u) Alcohol, Drug or any Chemical Abuse? ………………… ❑ YES ❑ NO

(v) Any Injury to, or Disease or Disorder of, the knee(s)? ………………… ❑ YES ❑ NO

(w) Any jaw disproportions or malocclusions? ………………… ❑ YES ❑ NO

(x) Any other Disease or Disorder not specifically listed in (a) through (w) above? ………………… ❑ YES ❑ NO

10. (a) Has any male Family Member ever had any Disease or Disorder of the Prostate or any other reproductive organ? ………………… ❑ YES ❑ NO

Has any female Family Member ever had any of the following?

(b) Any Disease or Disorder of either or both breasts? ………………… ❑ YES ❑ NO

(c) Any Breast Implant or Prosthesis? ………………… ❑ YES ❑ NO

(d) Any hormone imbalance? ………………… ❑ YES ❑ NO

(e) Caesarean section? ………………… ❑ YES ❑ NO

(f) Any complication of a pregnancy? ………………… ❑ YES ❑ NO

(g) Is any Family Member currently pregnant? ………………… ❑ YES ❑ NO

11. Have you or any member listed above ever been told or advised to have a surgical operation which has not been performed? (If "YES," give full details below) ………………… ❑ YES ❑ NO

12. Has any proposed insured been diagnosed HIV positive by a member of the medical profession or diagnosed as having AIDS or ARC? ………………… ❑ YES ❑ NO

(OVER, QUESTION #15 CONTINUES ON BACK)

APP HI-2015
ADDITIONAL MEDICAL INFORMATION (CONTINUED)

15. If Question No. 8 was answered "NO," or any part of 9, 10, 11, or 12 was answered "YES," give full details below, and details of any other ailments about which any Doctor was consulted IN THE LAST 10 YEARS by you or any dependent listed above. If none, state "NONE." LIST ALL HOSPITAL CONFINEMENTS OR OUTPATIENT SURGERIES IN LAST 10 YEARS (ROUTINE CONFINEMENTS, WITHOUT COMPLICATIONS, FOR CHILDBIRTH NEED NOT BE LISTED).

Name of Person | Nature of Illness or Injury | Dates(s) | Names and Addresses of Doctor(s) and Hospitals | Recovery Complete?
--- | --- | --- | --- | ---

16. List all prescriptions currently being taken by:

Applicant

Spouse

Children

17. I hereby apply to Southwest Service Life Insurance Company for a policy to be issued solely and entirely in reliance on the written answers to the questions in this application. I understand and agree that (1) the insurance shall not take effect unless the application has been accepted and approved by the Company; and until the Effective Date of the Policy and (2) the agent does not have the authority to waive a complete answer as to any question in the application, pass on insurability, make or alter any contract, or waive any of the Company's other rights or requirements. I understand and agree that the falsity of any answer or statement in this application may bar the right to recover thereunder if such answer materially affects the acceptance of the risk or hazard assumed by the Company. The Company may rely upon this application and all of the information contained herein. This is an authorization under the Privacy Rules of the Health Insurance Portability and Accountability Act of 1996, 45 CFR §164.508. It authorizes Southwest Service Life Insurance Co., to use my complete medical records, and those of my family members whose names appear in my application for health insurance, for the purposes of insurance underwriting, risk review, claims adjudication and other health plan insurance operations. The person/people/entities authorized to make this disclosure to Southwest Service Life Insurance Co. are my physicians, medical practitioners, hospitals, clinics, medical facilities of other health care providers having records or knowledge of my health, and those of my family members whose names appear in my application for health insurance. The confidentiality of my health care information is waived by this authorization, which permits disclosure of any and all requested parts of my medical records. I understand this may include drug, alcohol, mental health, HIV and AIDS information. Southwest Service Life Insurance Co. will, within sixty days from the date written below, send me a copy of this authorization form as completed by me. This authorization is valid for two years following the date written below and will then expire. Under the Privacy Rules, I have a right to revoke this authorization at any time, and Southwest Service Life Insurance Co. must cease using this authorization. However, Southwest Service Life Insurance Co. may complete any actions it initiated prior to my revocation and which rely on my complete medical records for completion. I must revoke this authorization in writing and send the revocation to Southwest Service Life Insurance Co., P.O. Box 982005, Fort Worth, Texas 76182-8005. A photocopy of this authorization is to be considered as valid as the original. This application for insurance is medically underwritten. My policy may be issued as applied for or with either an exclusionary rider or a premium rating for a treated medical condition. I have received an outline of coverage for the policy applied for.

I certify I have accurately recorded herein the information supplied by the applicant and that an outline of coverage has been given the applicant.

X

Representative's Signature

Address:

Amount paid for Policy form HI-2015 $ for initial and First Months Premium
Amount paid for Policy form SWLT-10 & CCLB-Rider $ for initial and First Months Premium
Amount paid for Policy form AO $ for initial and First Months Premium
Amount paid for Policy form AC-502 $ for initial and First Months Premium
Amount paid for Policy form HI-2010-HC $ for initial and First Months Premium
Amount paid for Policy form H&S-1 $ for initial and First Months Premium
Amount paid for additional coverage $ for initial and First Months Premium

ADDITIONAL FAMILY MEMBERS

<table>
<thead>
<tr>
<th>PRINT</th>
<th>Names of Additional Family Members to be Insured</th>
<th>Relationship to Applicant</th>
<th>Age</th>
<th>Sex</th>
<th>Date of Birth Mo. Day Yr.</th>
<th>Hi. Wt.</th>
<th>Amount of Life Insurance</th>
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AUTHORIZATION TO HONOR CHECKS DRAWN BY THE SOUTHWEST SERVICE LIFE INSURANCE COMPANY, FORT WORTH, TEXAS 76182

TO: (BANK) ________________________________________________________________________________________________________
Checking or Savings
Routing Number:

As a convenience to me, I hereby request and authorize you to pay and charge to my account checks drawn on my account by and payable to the order of the Southwest Service Life Insurance Company, Fort Worth, Texas. I agree that your rights in respect to each such check shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such check.

I further agree that if any such check 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.

Date of Birth

Account No.

Signature EXACTLY as it appears on Bank Records

APP HI-2015
APPLICANT’S ACKNOWLEDGMENT OF UNDERSTANDING
and DESCRIPTION OF AGENT’S AUTHORITY

Insurance agent, ____________________________, talked with me about applying for insurance with Southwest Service Life Insurance Company and gave me an outline of coverage for the policy that I am applying for. The agent showed me on the outline of coverage the description of the policy benefits, the waiting periods and the limitations and exclusions, which I read and understand. I also understand that the policy I am applying for contains limited benefits, and any benefits payable will always be paid in accordance with policy provisions.

I have personally answered each question on the application, including the health history questions, and I read the application before signing it to make sure all the questions were answered correctly. No one told me to leave out any information asked for in the application.

I understand the agent taking this application does not have any authority to leave out any information that is asked for in the application. All the information I told the agent about my health history, and the health history of any other applicant, is written on the application. The agent explained that the company will rely on my answers in the application in deciding whether or not to issue a policy to me.

I understand that no insurance will become effective until a policy is actually issued by the company and that making this application and paying the initial premium does not guarantee that a policy will be issued. I understand the agent taking my application has no authority to guarantee me that a policy will be issued.

I HAVE READ AND UNDERSTOOD THE ABOVE STATEMENTS BEFORE SIGNING THIS DOCUMENT.

Signed:

Agent ____________________________  Applicant ____________________________

Co-Applicant ____________________________

Date ____________________________  Date ____________________________

SOUTHWEST SERVICE LIFE INSURANCE CO.
A Stipulated Premium Company • Administrative Office: Fort Worth, Texas

I CERTIFY THAT ____________________________ IS A DEPENDENT, UNMARRIED CHILD.

____________________________________________  ______________________________________________
INSTRUCTIONS TO AGENT: This form is provided for the purpose of compliance with regulations regarding the replacement of accident and sickness insurance.

When the replacement questions on the application is answered YES, this form must be dated, signed by applicant, and submitted with the application, AND a copy of this form must be left with the applicant.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

According to your application, you, intend to lapse or otherwise terminate existing accident and sickness insurance replace it with a policy to be issued by Southwest Service Life Insurance Co.

For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have, pre-existing conditions, may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.

3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may prove a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.

The above “Notice to applicant” was delivered to me on: ________________________________

Applicant’s Signature ____________________________________________________________________
SOUTHWEST SERVICE LIFE INSURANCE CO.

IMPORTANT NOTICE
This Medical Records Authorization Form must be completed, signed and submitted with the initial application.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)
COMPLIANT MEDICAL RECORDS AUTHORIZATION FORM

Patient/Primary Proposed Insured __________________________________________________________

Address: ___________________________ City: ______________________ Zip: __________ Date of Birth: ____ / ____ / ____

This is an authorization under the Privacy Rules of the Health Insurance Portability and Accountability Act of 1996; 45 CFR §164.508. It authorizes Southwest Service Life Insurance Co. to use my complete medical records, and those of my family members whose names appear in my application for health insurance, for the purposes of insurance underwriting, risk review, claims adjudication and other health plan insurance operations.

The person/people/entities authorized to make this disclosure to Southwest Service Life Insurance Co. is/are my physicians, medical practitioners, hospitals, clinics, medical facilities, the Pharmacy Benefit Manager, or other health care providers having records or knowledge of my health, and those of my family members whose names appear in my application for health insurance.

The confidentiality of my health care information is waived by this authorization, which permits disclosure of any and all requested parts of my medical records. I understand that re-disclosure may not be protected by the federal privacy regulations. I also understand this may include drug, alcohol, mental health, HIV or AIDS information.

This authorization is valid for two years following the date written below and will then expire. Under the Privacy Rules, I have the right to revoke this authorization at any time, and Southwest Service Life Insurance Co. must cease using this authorization. However, Southwest Service Life Insurance Co. may complete any actions it initiated prior to my revocation and which rely on my complete medical records for completion. I must revoke this authorization in writing and send the revocation to Southwest Service Life Insurance Co., P.O. Box 982005, Fort Worth, Texas 76182-8005.

Notice to my health care provider(s): An electronic signature on this HIPAA Compliant Medical Records Authorization Form has the same legal authority as a hand-written signature under both state and federal law. Please accept my e-signature as if it were my original hand-written signature.

Signature of Patient/
Primary Proposed Insured
_______________________________________________ Date ____ / ____ / ____ Date of Birth: ____ / ____ / ____

Signature of Patient/Spouse
(if proposed to be insured)
_______________________________________________ Date ____ / ____ / ____ Date of Birth: ____ / ____ / ____

Signatures of other
Patients/Dependents 18 or over
(if proposed to be insured)
_______________________________________________ Date ____ / ____ / ____ Date of Birth: ____ / ____ / ____
_______________________________________________ Date ____ / ____ / ____ Date of Birth: ____ / ____ / ____
_______________________________________________ Date ____ / ____ / ____ Date of Birth: ____ / ____ / ____

Please Complete if Applicable: Print name[s] of covered children
_______________________________________________ Date of Birth: ____ / ____ / ____
_______________________________________________ Date of Birth: ____ / ____ / ____
_______________________________________________ Date of Birth: ____ / ____ / ____
You have applied for an insurance policy with the Southwest Service Life Insurance Company (“Company”). Please understand that:

1. The policy is an individual fixed indemnity policy and not a group, blanket, franchise or Small Employer type coverage, even though your employer may be remitting a premium on your behalf to the Company. Benefits are limited, as shown in your Outline of Coverage.

2. The Company assumes no responsibility for compliance with the Employee Retirement Income Security Act of 1974 and amendments thereto, nor does it maintain that the policy is designed or marketed to comply with the requirements contained therein. In particular, the policy provides no benefits for normal pregnancy and delivery and/or coverage for any individual, newborn, fetus or otherwise that was not extended coverage at the time the policy was originally issued and is subject to Company underwriting in (3) below. The Company also assumes no responsibility for compliance with any State Small Employer Health Insurance Law.

3. The policy is not guaranteed issue and will be fully underwritten by the Company. This may result in the exclusion from coverage of certain family members (if applicable), and/or health conditions. Southwest Service assumes no responsibility for the collection of premiums and/or the failure of same to be remitted on a timely basis.

4. I further acknowledge that the policy Benefits - Limitations & Exclusions have been explained to me individually and that an Outline of Coverage which explains the coverage which I have applied for has been left with me for my examination.

5. If my employer is remitting the premium to the Company, I understand any policy issued on my behalf is on the premium paying mode requested by me. In the event the employer ceases to remit the required premium, for any reason, the policy coverage will terminate at such date and any further coverage after such date of termination of premium payment will become null and void.

Because this is an individual fixed indemnity benefit policy, I understand I may continue the policy if I personally desire to remit the premium required by the Company within the grace period provided in the policy.

I also understand that it is my personal obligation and responsibility to notify the Company in writing of my desire to arrange for the proper premium to be paid within the time period allowed. If such election is made after expiration of the grace period, the policy is subject to reinstatement review by the Company and coverage may or may not be allowed to remain in force. Any failure to request the privilege for this continuation of coverage will result in the policy being null and void. I understand the Company assumes no responsibility for notifying me that my employer has elected and/or is not remitting a premium on my behalf.

I hereby acknowledge my full understanding of the contents of this disclaimer.

Applicant Signature _____________________________ Agent's Signature _______________________________

Date __________________________________________ Date __________________________________________