

SERFF Tracking Number:	SHLI-125804664	State:	Arkansas
Filing Company:	Shelter Life Insurance Company	State Tracking Number:	40173
Company Tracking Number:	03L10508		
TOI:	L09I Individual Life - Flexible Premium Adjustable Life	Sub-TOI:	L09I.001 Single Life
Product Name:	Waiver of Premium Rider		
Project Name/Number:	WP/10508		

Filing at a Glance

Company: Shelter Life Insurance Company

Product Name: Waiver of Premium Rider

TOI: L09I Individual Life - Flexible Premium

Adjustable Life

Sub-TOI: L09I.001 Single Life

Filing Type: Form

SERFF Tr Num: SHLI-125804664

SERFF Status: Closed

Co Tr Num: 03L10508

Co Status:

Authors: Dina Krofta, Berdetta
Moore

Date Submitted: 09/05/2008

State: ArkansasLH

State Tr Num: 40173

State Status: Approved-Closed

Reviewer(s): Linda Bird

Disposition Date: 09/15/2008

Disposition Status: Approved

Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

General Information

Project Name: WP

Project Number: 10508

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 09/15/2008

State Status Changed: 09/15/2008

Corresponding Filing Tracking Number: 03L10508

Filing Description:

This form provides a premium waiver benefit for recently submitted for approval form L-705.15. It is substantially similar to previously approved form L-707.4. The rider provides the premium waiver benefit upon disability for the life of the universal life policy or to age 65 if the insured becomes disabled after age 60. The issues ages are 0-59. There are male and female rates for this rider.

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Individual

Group Market Size:

Group Market Type:

Deemer Date:

SERFF Tracking Number: SHLI-125804664 State: Arkansas
 Filing Company: Shelter Life Insurance Company State Tracking Number: 40173
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We have reviewed our processes regarding Ark. Code Ann. 23-79-138, Bulletin 6-87 and Bulletin 11-88 and found them to be in compliance. We have also reviewed our procedures and are in compliance with Regulation 49 and Regulation 19§10B.

Company and Contact

Filing Contact Information

Berdetta Moore, Actuarial Administrative Assistant
 1817 W. Broadway
 Columbia, MO 65203
 blmoore@shelterinsurance.com
 (573) 214-4832 [Phone]
 (573) 214-6942[FAX]

Filing Company Information

Shelter Life Insurance Company
 1817 W. Broadway Street
 Columbia, MO 65203
 (800) 743-5837 ext. [Phone]
 CoCode: 65757
 Group Code: 123
 Group Name:
 FEIN Number: 43-0740882
 State of Domicile: Missouri
 Company Type: Life and Health
 State ID Number:

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? No
 Fee Explanation:
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Shelter Life Insurance Company	\$0.00	09/05/2008	

CHECK NUMBER	CHECK AMOUNT	CHECK DATE
1563567	\$50.00	08/22/2008

SERFF Tracking Number: SHLI-125804664 State: Arkansas
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	09/15/2008	09/15/2008

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Disposition

Disposition Date: 09/15/2008

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice		Yes
Supporting Document	Application		Yes
Supporting Document	Health - Actuarial Justification		No
Supporting Document	Outline of Coverage		No
Form	waiver of Monthly Deduction Rider		Yes

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Form Schedule

Lead Form Number: L-707.6

Review Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	L-707.6	Policy/Cont waiver of Monthly ract/Fratern Deduction Rider al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		47	L-707.6.pdf



WAIVER OF MONTHLY DEDUCTION RIDER

BENEFIT

When we receive proof that the Insured has been totally disabled for at least 6 consecutive months, we will waive the monthly deduction under one of the following methods:

- (1) If total disability began before the policy anniversary following the Insured's 60th birthday, all monthly deductions which fall due will be waived.
- (2) If total disability began after the policy anniversary following the Insured's 60th birthday and before the policy anniversary following the Insured's 65th birthday, only monthly deductions which fall due before the policy anniversary following the Insured's 65th birthday will be waived.

All monthly deductions to be waived must fall due while total disability continues. However, we will not waive any monthly deduction if its due date was more than one year before the date we received written notice of claim.

TOTAL DISABILITY DEFINED - Total disability means that, as a result of injury or sickness, the Insured is unable to perform the material duties of:

- (1) his or her occupation during the first 12 months of disability; or
- (2) any occupation for which he or she is or could be suited because of education, training or experience after the first 12 months of disability.

Being a homemaker or a student is considered engaging in an occupation for purposes of this Rider.

THE CONTRACT

CONSIDERATION - The consideration for issuing this Rider is:

- (1) the application; and
- (2) deduction of the first months cost of insurance.

The annual cost of insurance rates for each \$1,000 of specified amount is shown in the Policy Schedule. To convert these rates to monthly, divide them by twelve. The monthly cost of insurance for this Rider is derived by $W \times (R-S)$. R and S are as defined in the "Cost of Insurance" provision of the policy and W is the rate found in the Policy Schedule.

The provisions and conditions of the Policy apply to this Rider, unless otherwise stated.

SPECIFIED AMOUNT - OPTION A: If coverage Option A is in effect at the beginning of disability, it will automatically be changed to Option B as of the date the Insured became totally disabled. The new specified amount will be reduced to equal the death benefit less the policy account value on that date. When total disability stops, you may request to change to Option A under the terms of Policy Change Provisions.

OPTION B: If coverage Option B is in effect at the beginning of disability, it will remain Option B during the continuance of disability. The specified amount will remain unchanged for the duration of total disability or until the Policy terminates, unless otherwise provided by rider.

EFFECTIVE DATE - The effective date of this Rider will be as follows:

- (1) The policy date if this Rider is applied for in the original application for the Policy.
- (2) If this Rider is applied for after the policy date, evidence of insurability will be required. The effective date will be the first monthly anniversary day on or after the date we determine the evidence to be satisfactory.

This Rider has no cash or loan values.

CONDITIONS AFFECTING CLAIMS

INCONTESTABILITY - We will not contest this rider after it has been in force during the lifetime of the Insured for 2 years from its issue date unless the Insured becomes totally disabled within that period.

RISK NOT COVERED - We will not waive the monthly deduction if total disability results from:

- (1) intentionally self-inflicted injury;
- (2) service in the military of any country at war; or
- (3) war, declared or undeclared.

NOTICE AND PROOF OF CLAIM - We must receive written notice and proof of total disability:

- (1) while the Insured is living;
- (2) while total disability continues; and
- (3) no later than one year after this Rider terminates.

As part of any proof, we at our expense, may require medical examinations by physicians of our choice.

We will not reject a claim because notice and proof were not given within the stated times if you show that notice was sent as soon as reasonably possible.

Waiver will begin with the first monthly deduction due after total disability begins. However, any monthly deduction due more than one year before notice was received will not be waived.

If the policy account value is not sufficient to provide for monthly deductions, but notice of claim is given within one year after lapse of this Policy, waiver will be allowed if total disability is shown to have begun:

- (1) before the date the monthly deduction was due; or
- (2) within the grace period.

PROOF OF CONTINUED DISABILITY - We may require proof at reasonable intervals that total disability continues. After two years, proof will not be required more than once a year.

Waiver will not be allowed after the earlier of:

- (1) 90 days after the date of request for any proof which is not furnished; or
- (2) the date total disability ceases.

TERMINATION

This Rider will terminate on the earliest of:

- (1) the next policy anniversary after the Insured's 65th birthday, but without prejudice to any claim starting before that date;
- (2) the end of the grace period of the Policy;
- (3) the date of termination, maturity or expiry of the Policy; or
- (4) the monthly anniversary day on or after the day we receive your request to cancel.


Secretary


President and CEO

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Supporting Document Schedules

Review Status:
Satisfied -Name: Certification/Notice 09/05/2008
Comments:
Attachment:
CERTIFICATION-FLESCH-ARK.pdf

Review Status:
Satisfied -Name: Application 09/05/2008
Comments:
Attachment:
L-309.17.pdf



**SHELTER
INSURANCE
COMPANIES**

SHELTER MUTUAL
SHELTER GENERAL
SHELTER LIFE

CERTIFICATION

This is to certify that the following forms have achieved the indicated Flesch Reading Ease Scores and comply with the requirements of Ark. Stat. Ann. 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

<u>Form No.</u>	<u>Name</u>	<u>Score</u>
L-707.6	Waiver of Monthly Deduction Rider	46.7

Signed _____
Dina Krofta, FSA, MAAA
Senior Life Actuary
Shelter Life Insurance Company



C O N T R A C T



SHELTER LIFE INSURANCE COMPANY
1817 WEST BROADWAY, COLUMBIA, MISSOURI 65218-0001

Agent Name _____

Agent # _____

Applicant's Family # _____

LIFE INSURANCE APPLICATION

PROPOSED INSURED

1. Name		(Last)	(First)	(MI)	(Suffix)	Soc. Sec. No.	<input type="checkbox"/> Male	<input type="checkbox"/> Female
2. Marital Status	Hgt.	'	"	Wgt.	lbs.	Birth Date	Age	State of Birth
3. Address		(Street)	(City)	(County)	(State)	(Zip)		
4. Home Phone	Cell Phone		Best Time to Contact					
5. Driver's License No.	State							
6. Country of Citizenship:		<input type="checkbox"/> US	<input type="checkbox"/> Other	If Other, provide the following:		Country of Citizenship _____	Length of Residency in US _____	
Visa Type:		<input type="checkbox"/> Permanent	<input type="checkbox"/> Temporary	If Temporary, Category _____		Expiration Date _____		
7. Occupation	Name of Employer			Date Employed				
Annual Earned Income \$				Income All Sources \$				

BENEFICIARY

8. Primary (List name, address, age, relationship, Payment Option) (If a trust, list name of Trustee, name & date of Trust)
Contingent

TERM / TRADITIONAL

9. <input type="checkbox"/> 10 Yr. Level Term	<input type="checkbox"/> SYRT to 75	<input type="checkbox"/> Whole Life	Face Amount \$
<input type="checkbox"/> 20 Yr. Level Term	<input type="checkbox"/> YRT to 85	<input type="checkbox"/> 20 Pay Whole Life	Mode Premium \$
<input type="checkbox"/> 30 Yr. Level Term	<input type="checkbox"/> 5 Yr R & C Term	<input type="checkbox"/>	
10. Rate Class: (Level Term, SYRT & YRT) <input type="checkbox"/> STD <input type="checkbox"/> STD/NT <input type="checkbox"/> PRF/NT (All other policies) <input type="checkbox"/> STD <input type="checkbox"/> PRF			
11. WP <input type="checkbox"/> Yes <input type="checkbox"/> No AD <input type="checkbox"/> Yes <input type="checkbox"/> No Automatic Premium Loan <input type="checkbox"/> Yes <input type="checkbox"/> No (Not available on term insurance)			
12. Dividend Option: <input type="checkbox"/> Paid-Up Additions <input type="checkbox"/> Accumulate at Interest <input type="checkbox"/> Cash <input type="checkbox"/> *Reduce Premium *(Not available on Special Monthly)			

UNIVERSAL

13. <input type="checkbox"/> Specified Amount - New Policy \$	Target Prem \$	Planned Prem (If more than Target) \$
14. <input type="checkbox"/> Specified Amount - Increase \$	to UL Policy #	Planned Prem after Increase \$
15. Rate Class: <input type="checkbox"/> STD <input type="checkbox"/> PRF	<input type="checkbox"/> Option A (Level) <input type="checkbox"/> Option B (Increasing)	WMD <input type="checkbox"/> Yes <input type="checkbox"/> No AD <input type="checkbox"/> Yes <input type="checkbox"/> No

RIDERS

16. <input type="checkbox"/> Paid Up Additional Insurance Rider Premium Amount (WL and 20 Pay WL) \$									
17. <input type="checkbox"/> Guaranteed Insurability Rider - Amount \$					<input type="checkbox"/> Payor Death and Disability Benefit (WL and 20 Pay WL)				
18. <input type="checkbox"/> Spouse's Term Rider (UL) - <input type="checkbox"/> STD <input type="checkbox"/> PRF - Amount \$					<input type="checkbox"/> Children's Term Rider (UL) - Amount \$				
19. Family Members/Payor to be Insured	Relationship	Sex	Hgt	Wgt	Birth Date	Age	US Cit?	Birth St.	SS No.
Occupation (Spouse/Payor)	Address (Payor)								

PREMIUM

20. <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly (WL and 20 Pay WL only) <input type="checkbox"/> Payroll Deduction	
<input type="checkbox"/> MPP - Withdrawal Day of Month _____ Send Form & Void Check <input type="checkbox"/> Government Allotment (Except YRT)	
<input type="checkbox"/> Special Billing - Name & Address of Company _____	
Remarks _____	
<input type="checkbox"/> Prem included with application \$	<input type="checkbox"/> COD <input type="checkbox"/> Paid Up Additional Insurance Rider Prem Collected \$
21. Name and address of person paying premium only if other than proposed insured or owner	

IN FORCE

22. a. Total individual life insurance and accidental death coverage in force or pending (excluding this application) in all companies including Shelter Life:	(Life) \$	(Accidental Death) \$	
b. If Proposed Insured is under 16, show amount of life insurance on:	(Father) \$	(Mother) \$	(Sibling[s]) \$

REPLACEMENT

23. Will this insurance replace or change any existing life insurance policy or annuity contract with any company including Shelter Life?
 Yes No If Yes, list name of company, policy number, face amount and send replacement form(s) with application.

QUESTIONS 24 THROUGH 40 MUST BE ANSWERED FOR EACH PERSON TO BE INSURED INCLUDING APPLICANTS FOR SPOUSE'S TERM RIDER, CHILDREN'S TERM RIDER & PAYOR BENEFIT.

UNDERWRITING INFORMATION

24. List attending physician(s) for proposed insured(s) and provide name, address, phone number, date and reason for most recent consultation(s), treatment received and medications prescribed:	
Physicians name, address and telephone number	Date/Reason/Diagnosis/Treatment/Medications Prescribed

25. Do you have a parent, brother or sister who:	Yes	No
a. has a history of diabetes, heart or kidney disease, or hypertension?	<input type="checkbox"/>	<input type="checkbox"/>
b. died before age 60? If yes, list relationship, age & cause of death in qt. 32.....	<input type="checkbox"/>	<input type="checkbox"/>

26. Have you engaged in or do you anticipate engaging in:	Yes	No
a. Aviation activities, including ultralight flying, hang gliding or parachute jumping?.....	<input type="checkbox"/>	<input type="checkbox"/>
b. Rodeo riding, underwater diving, racing of any motor powered vehicle or any other hazardous sport or hobby?.....	<input type="checkbox"/>	<input type="checkbox"/>

27. In the past 5 years have you been charged with any Motor Vehicle violations or violations for driving while intoxicated from alcohol or drugs?	Yes	No
	<input type="checkbox"/>	<input type="checkbox"/>

28. Are you planning travel, residence or employment outside the United States?.....	Yes	No
	<input type="checkbox"/>	<input type="checkbox"/>

29. Do you now use or have you ever used any form of tobacco or nicotine substitutes?	Yes	No
If yes, give date last used in qt. 32.	<input type="checkbox"/>	<input type="checkbox"/>

30. Are you in the National Guard or Reserves?	Yes	No
	<input type="checkbox"/>	<input type="checkbox"/>

31. Have you been charged with any Misdemeanor or Felony?	Yes	No
If yes, give details such as type of offense, date, and whether or not convicted in qt. 32.	<input type="checkbox"/>	<input type="checkbox"/>

32. FOR ALL YES ANSWERS TO QUESTIONS 25 THRU 31. GIVE FULL DETAILS BELOW.

Question No.	Name of Person	Date	Details

QUESTIONS 33 THROUGH 40 MAY BE OMITTED IF A MEDICAL EXAM IS REQUIRED.

33. To the best of your knowledge and belief, have you ever been diagnosed or treated by a medical professional for: Yes No
- a. hypertension, coronary artery disease, stroke, heart attack, chest pain, irregular heartbeat, or any other disease of the heart or blood vessels?
 - b. cancer, tumor or other growth or malignancy of any kind?
 - c. bronchitis, emphysema, shortness of breath or any other disease or disorder of the lungs or respiratory system?
 - d. depression, anxiety or any other behavioral, mental or nervous disorder?
 - e. epilepsy, seizures, sleep apnea or any other disease or disorder of the brain or nervous system?
 - f. diabetes, hepatitis, anemia or any other disease or disorder of the blood or glands?
 - g. arthritis, gout, or any other disease or disorder of the bones, muscles, joints, eyes or skin?
 - h. any disease or disorder of the stomach, intestines, colon, rectum, liver, pancreas or digestive system?
 - i. any disease or disorder of the kidney, bladder, prostate, urinary system or genital organs including complication of pregnancy?
 - j. Acquired Immune Deficiency Syndrome (AIDS), positive HIV test, or other immunological disorder?
34. If female, are you now pregnant? If yes, give approximate delivery date in qt. 40.
35. Are you currently receiving treatment, taking medication, or scheduled to have surgery?
36. Weight loss of more than 10 lbs. in past year? If yes, list # of lbs. and reason in qt. 40.
37. Have you:
- a. used or do you now use cocaine, methamphetamines, marijuana or any other drugs? If Yes, list type, amount, frequency and date last used in qt. 40.
 - b. used or do you now use alcoholic beverages? If Yes, provide type, frequency and amount in qt. 40
 - c. sought or received treatment or counseling for alcohol or drug use?
38. Have you received or do you now receive disability benefits or do you currently have a disability of any kind?
39. In the past five years, have you consulted any physician or health care facility, been hospitalized, had any abnormal diagnostic tests or been advised to have treatment for any reason not explained above?

UNDERWRITING INFORMATION

40. FOR ALL YES ANSWERS IN QUESTIONS 33 THRU 39 GIVE FULL DETAILS BELOW.

Question No.	Name of Person	Describe Illness or Injury and Medical Attention	Date Mo Day Yr	Duration	Details Including Any Remaining Effects	Names, Addresses, and Phone Numbers of Physicians & Hospitals

SIGNATURES/DECLARATION

41. List name, address, date of birth and relationship of OWNER if other than Proposed Insured.

42. List name, address and relationship of SUCCESSOR OWNER. (A successor owner is not required.)

43. Special Requests.

44. The Owner and Proposed Insured, if other than the Owner, each declares that he or she has read the answers recorded in this application and that they are complete and true to the best of his or her knowledge and belief, and agrees that:
a. this application and any amendments to it and any statements made and recorded on the medical examination form shall become the basis for and be a part of any contract of insurance;
b. any policy or rider issued on the basis of this application will belong to and be solely under the control of the Owner;
c. only the Shelter Life Insurance Company, at its Home Office, may make or modify contracts or waive any of its rights or requirements, and then only in writing;
d. no Agent of Shelter Life Insurance Company and no Medical Examiner is authorized to accept or pass upon insurability; and
e. except as provided in the Conditional Coverage Receipt, if issued, insurance will not be effective unless:
(1) a policy is delivered to the owner during the lifetime of all persons proposed for insurance; and
(2) to the best of the owner's and proposed insured's knowledge there has been no material change in the answers herein since the date of this application or the completion of all medical examination requirements.

45. THE OWNER DECLARES THAT THE CONDITIONAL COVERAGE RECEIPT HAS BEEN DETACHED FROM THIS APPLICATION AND GIVEN TO HIM OR HER Yes No
IF "YES" THE OWNER FURTHER DECLARES THAT THE TERMS AND CONDITIONS OF THE CONDITIONAL COVERAGE RECEIPT HAVE BEEN BROUGHT SPECIFICALLY TO HIS OR HER ATTENTION AND THAT HE OR SHE UNDERSTANDS AND ACCEPTS THEM.

THE PROPOSED INSURED ACKNOWLEDGES RECEIPT OF THE NOTICE OF CONSUMER REPORT AND MIB PRE-NOTICE AS REQUIRED BY THE CONSUMER PROTECTION AGENCY.

THIS APPLICATION IS A LEGAL DOCUMENT. THE POLICY MAY BE ALTERED OR RESCINDED IF THE QUESTIONS ARE NOT ANSWERED CORRECTLY AND TRUTHFULLY.

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 IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

Dated this _____ day of _____, _____ at _____ A.M. P.M. in the city of _____ State of _____
Month Year Time

Signature of Proposed Insured or of Parent or Legal Guardian if Under Age 18

Signature of spouse, if applying

Signature of Owner, if other than Proposed Insured, or of Parent or Grandparent Owner if Proposed Insured is Under Age 18

Owner's Social Security Number

I HEREBY CERTIFY THAT I PERSONALLY ASKED EVERY QUESTION OF THE OWNER, AND PROPOSED INSURED IF OTHER THAN OWNER, AND ACCURATELY RECORDED THE ANSWERS GIVEN AND THAT I WITNESSED THE SIGNATURE(S) ABOVE.

Print Name of Writing Agent

Signature of Writing Agent

Agent's Number

AGENT'S STATEMENT

- 1. Does proposed insured have other life insurance in force with Shelter Life?
 Yes No If yes, give policy numbers
- 2. Has a Medical Examination and/or other testing been arranged? Yes No. SEE MANUAL FOR REQUIREMENTS.
- 3. If blood profile is required, have you attached the special blood test authorization form if one is required in your state? Yes No
- 4. Do you know or have any reason to believe that replacement of existing Life insurance is involved? Yes No
If yes, give policy numbers, names and addresses of companies that issued such policies and expected date of lapse.
- 5. Does this application involve a 1035 exchange (UL Only)? Yes No If Yes, send appropriate form. External Internal
- 6. AS REQUIRED BY FEDERAL LAW, did you detach and give the NOTICE OF CONSUMER REPORT to the Proposed Insured (or Owner if the Proposed Insured is a juvenile)? YES.
- 7. Did you solicit this business? Yes No. If No, explain
- 8. Is any person applying for coverage related to you? Yes No. If Yes, give relationship

Signature of Writing Agent

Agent's Number

MEDICAL TEST AUTHORIZATION

I hereby authorize Shelter Life Insurance Company to obtain medical tests on blood, oral fluid or urine samples in connection with the underwriting of my application for insurance with Shelter Life Insurance Company.

I understand that such tests will be performed by laboratories selected by Shelter Life Insurance Company and may include, but are not limited to, test for cholesterol and related blood lipids, diabetes, hepatitis or other liver disorders, kidney disorders, infection by the Acquired Immune Deficiency Syndrome virus, immune disorders, or the presence of medications, drugs, nicotine, or their metabolites.

The results of these tests will be made known only to Shelter Insurance Companies and/or their reinsurers, and possibly the Medical Information Bureau as described in the Pre-Notice which was given to me as part of the application process. Positive HIV and hepatitis test results will be reported to your State Department of Health if we or the testing laboratory are required to do so by law. Test results will not be released to anyone else or any institution except as required by law, by court order or by written authorization from me to release it to a physician designated by me.

Date

Signature of Proposed Insured or Parent if Proposed Insured is a Juvenile

Date

Signature of Spouse, if applying

**Authorization for Use or Disclosure
Of Protected Health Information**

1. I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, MIB Group, Inc. or other organization, institution, or person, that has any records or knowledge of me or my health, to give to the Shelter Life Insurance Company, its Medical Director, its reinsurers, and Shelter Mutual Insurance Company, any and all such health information. I further authorize Shelter Life Insurance Company, and its reinsurers, to disclose such protected health information to MIB Group, Inc., a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members.
2. I understand that this protected health information will be used to locate or underwrite insurance for me, or to determine whether a valid claim for benefits has been made. The information may also be disclosed by Shelter Life Insurance Company to MIB, who, upon request, may disclose such information about me in its file to another member company with whom I apply for life or health insurance or to whom a claim for benefits may be submitted.
3. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations.
4. I understand that the information in my health record may include information that may be considered a communicable or venereal disease that may include, but is not limited to diseases such as hepatitis, syphilis, gonorrhea, and acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
5. This authorization is valid for 12 months from the date of signing. I understand that I may revoke this authorization at any time by sending written notification to Shelter Life Insurance Company, 1817 West Broadway, Columbia, MO 65218-0001, except to the extent that action has been taken in reliance on this authorization. A photographic copy of this authorization will be treated in the same manner as the original.

Print Name and Date of Birth of Proposed Insured

Signature of Proposed Insured or Parent if Proposed Insured is a Juvenile

Date

Print Name and Date of Birth of Spouse, If Applying

Signature of Spouse, If Applying

Date

A copy of this signed form will be provided to the individual upon request.

THIS AUTHORIZATION MEETS THE REQUIREMENTS SET FORTH IN THE HIPAA PRIVACY RULE (45 CFR 164.508).

Detach and leave with Proposed Insured or owner **ONLY IF** premium is collected with application.

CONDITIONAL COVERAGE RECEIPT

CONDITIONAL COVERAGE RECEIPT - void if altered or modified or if check given in payment is not honored.

NO INSURANCE WILL BE EFFECTIVE BEFORE POLICY DELIVERY TO PROPOSED INSURED OR OTHER OWNER UNLESS ALL THE CONDITIONS ON THIS RECEIPT ARE FULFILLED EXACTLY.

Premium received from _____ Amount \$ _____
in connection with the application for insurance made on this date to Shelter Life Insurance Company, 1817 West Broadway, Columbia, Missouri 65218-0001.

Policy Applied For _____ Face Amount \$ _____

by _____
Signature of Writing Agent Agent's Number Date

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO SHELTER LIFE INSURANCE COMPANY. DO NOT POSTDATE OR MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

If Shelter Life Insurance Company declines to issue the policy applied for, or issues it other than as applied for, which you do not accept, the payment will be returned.

CONDITIONS PRECEDENT - EFFECTIVE DATE OF INSURANCE

The insurance for which you (Proposed Insured) have applied, will be effective on the date of the application or the date a required medical examination and/or test(s) of any kind is completed, whichever is later, but only if the following conditions are met:

1. You have paid the full premium with the application;
2. You have completed all medical examination requirements;
3. We (Shelter Life Insurance Company), at our Home Office, have determined by our guidelines, that all persons for whom coverage is requested are qualified for the types and amounts of insurance requested at the premium paid.

If the above conditions are not met, no one for whom insurance is requested will be insured unless we offer and you accept the policy under modified terms. That modified policy will be effective on the date approved by us at our Home Office only if (1) we deliver your policy while all persons in the application are alive; (2) to your best knowledge there has been no material change in your answers on the application since the application date; and (3) you have paid any additional premium and/or signed any endorsements required.

CONDITIONAL COVERAGE AMOUNT AND LIMIT - The amount of insurance which may become effective on any person to be insured under the policy applied for prior to delivery will not exceed the lesser of: (a) \$250,000, including accidental death benefits, on all pending applications or (b) the amount applied for.

NO AGENT OF SHELTER LIFE INSURANCE COMPANY IS AUTHORIZED TO CHANGE ANY PROVISION OR CONDITION OF THIS RECEIPT.

Detach and leave with Proposed Insured when application is written.

MIB PRE-NOTICE

Information regarding your insurability will be treated as confidential. Shelter Life Insurance Company or its reinsurer(s) may, however, make a brief report thereon to the MIB, a non-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in the MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the MIB's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112.

Shelter Life Insurance Company or its reinsurer(s) may also release information in our files to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

NOTICE OF CONSUMER REPORT

As a part of our normal underwriting procedure, an investigative consumer report may be made to give us applicable information concerning character, general reputation and personal characteristics except as may be related directly or indirectly to the Insured's mode of living of persons to be insured. This information will be obtained through personal interviews primarily with you or your family, friends, neighbors, business associates and financial sources. Upon written request to the Life Underwriting Department at Shelter Life Insurance Company's home office in Columbia, Missouri, additional information as to the nature and scope of the Investigative Consumer Report, if one is made, will be furnished to you.