











SERFF Tracking Number: *STFH-126892785* State: *Arkansas*  
 Filing Company: *State Farm Mutual Automobile Insurance Company* State Tracking Number: *47279*  
 Company Tracking Number:  
 TOI: *CR02I Individual Credit - Credit Disability* Sub-TOI: *CR02I.003 Single Premium*  
 Product Name: *ICDI*  
 Project Name/Number: *ICDI POLICY, et al /*

<b>Schedule</b>	<b>Schedule Item</b>	<b>Schedule Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Flesch Certification	Approved-Closed	Yes
<b>Supporting Document</b>	Application	Approved-Closed	Yes
<b>Supporting Document</b>	Life & Annuity - Acturial Memo	Approved-Closed	Yes
<b>Form</b>	ICDI policy	Approved-Closed	Yes
<b>Form</b>	Application for ICDI	Approved-Closed	Yes
<b>Form</b>	Outline of Coverage for ICDI	Approved-Closed	Yes
<b>Rate</b>	Rate Table	Approved-Closed	Yes



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 Filing Company: State Farm Mutual Automobile Insurance State Tracking Number: 47279  
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 TOI: CR02I Individual Credit - Credit Disability Sub-TOI: CR02I.003 Single Premium  
 Product Name: ICDI  
 Project Name/Number: ICDI POLICY, et al /

## Form Schedule

Lead Form Number: 97021 Z

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 11/18/2010	97021 Z	Policy/Contract/Fraternal Certificate	ICDI policy	Initial			97021 Z.pdf
Approved-Closed 11/18/2010	1003449	Application/Enrollment Form	Application for ICDI	Initial			App 1003449.pdf
Approved-Closed 11/18/2010	1003645	Outline of Coverage	Outline of Coverage for ICDI	Initial			Outline of Coverage 1003645.pdf



# STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY

One State Farm Plaza, Bloomington, Illinois 61710-0001  
866-855-1212

INSURED

POLICY DATE

POLICY NUMBER

TERMINATION DATE

We are pleased to issue this Individual Credit Disability Insurance policy to You. It was issued in consideration of Your application and payment of the required premium.

## THIRTY (30) DAY RIGHT TO EXAMINE POLICY

If You feel this policy does not meet Your insurance need, return it to Us or Your agent within thirty (30) days after You have received it. We will return Your premium and consider the policy never to have been issued.

## THIS POLICY IS NON RENEWABLE

Countersigned

\_\_\_\_\_  
Licensed Resident Agent

## INDIVIDUAL CREDIT DISABILITY INSURANCE (Credit Health and Accident Insurance)

**GUIDE TO YOUR MEDICARE SUPPLEMENT POLICY  
TABLE OF CONTENTS**

The following is a Guide to Your Individual Credit Disability Insurance Policy. It tells You what is included in Your policy and on what page(s) You can find it.

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POLICY SCHEDULE

INSURED	[DOE, JOHN D.]	[DECEMBER 1, 2010]	POLICY DATE
POLICY NUMBER	[H100000 0000]	[DECEMBER 1, 2011]	TERMINATION DATE

PREMIUM [\$XXX.XX]

COVERAGE INFORMATION

-----  
TOTAL DISABILITY BENEFIT

MONTHLY INCOME AMOUNT           [\$XXX]

WAITING PERIOD                    30 DAYS

**\*\*This page is intentionally left blank\*\***

## SECTION 1: IMPORTANT DEFINITIONS

**Many words in Your policy have specific definitions. We define some words to shorten the policy. Defined words have been capitalized throughout Your policy for easy identification. This section defines these important terms.**

Wherever used in this policy:

**Agent** means licensed insurance producer.

**Credit Accident and Health Insurance** means insurance on a Debtor to provide indemnity for payments or debt becoming due on a specific loan or other Credit Transaction while the Debtor is Totally Disabled as defined in the policy.

**Creditor** means the financing institution who is the lender of money for which payment is arranged through a Credit Transaction.

**Credit Transaction** means any transaction by the term of which the repayment of money loaned is to be repaid.

**Debtor** means You, the borrower of money through a Credit Transaction.

**Effective Date of Coverage** means the date when coverage starts under Your policy and is shown on the Policy Schedule. Coverage begins at 12:01 A.M. in the area of Your residence.

**Injury** means accidental bodily Injury.

**Occupation** means, during the first thirty-six (36) months of Total Disability, Your Occupation at the time such Total Disability began; thereafter it means any Occupation for which You are or become reasonably able to perform by Your education, training or experience.

If You are not working at the time your Total Disability begins, Your Occupation shall then mean any Occupation (s) for which You are reasonably able to perform by Your education, training or experience.

**Physician** means a licensed practitioner of the healing arts performing services within the scope of his/her license as provided by the laws of the state in which his/her services are performed. The Physician cannot be You, any person related to You by blood or marriage, a business or professional partner or associate, or any person who has a financial affiliation or business interest with You.

**Policy Schedule** means the section of Your policy beginning on page 3. It includes important facts regarding Your coverage.

**Pre-existing Sickness or Physical Condition** means an Injury or Sickness for which You received medical advice, consultation or treatment within six (6) months before the Effective Date of Coverage and from which You become Totally Disabled within six (6) months after the Effective Date of Coverage.

**Sickness** means any Sickness or disease.

**Total Disability or Totally Disabled** means, as the result of Injury or Sickness, You are unable to perform the substantial and material duties of an Occupation for pay or profit and You are not working.

**Waiting Period** means the first thirty (30) days of a period of continuous Total Disability, for which no payment shall be made unless such Total Disability continues beyond such thirty (30) days.

**We, Our, Us** means the insurer, State Farm Mutual Automobile Insurance Company, One State Farm Plaza, Bloomington, Illinois 61710-0001.

**You, Your, Yourself** means the insured named on the Policy Schedule.

## SECTION 2: BENEFITS OF YOUR POLICY

**This section describes the policy benefits and how they are payable.**

### Monthly Income for Total Disability

If Injury or Sickness results in Your Total Disability, and if such Total Disability commences while this policy is in force, continues beyond the Waiting Period, and requires the regular care and attendance of a licensed Physician, We will periodically pay the monthly income amount specified in the Policy Schedule, for each month during which such Total Disability continues, but not for any period of Total Disability beyond the policy termination date. This benefit shall be computed retroactively from the first day of Total Disability.

Any monthly income payable for a period of less than a month following the Waiting Period shall be computed at a daily rate equal to one-thirtieth of the monthly income amount.

We reserve the right to require medical evidence of the continuance of Total Disability at reasonable intervals in order to justify continued payments of benefits.

### Recurrent Disability

If monthly income for Total Disability has become payable under this policy and if You suffer a recurrence of Total Disability from the same or related cause or causes while this policy is in force, the subsequent period of such Total Disability will be deemed a continuation of the prior period unless between such periods You have performed the duties of Your Occupation on a full-time basis for a period of at least six (6) consecutive months, in which event, such subsequent period of Total Disability shall be deemed a new period of Total Disability subject to a new Waiting Period.

## SECTION 3: EXCLUSIONS, EXCEPTIONS AND LIMITATIONS

**This section describes situations and conditions in which payment will be limited or denied even if you otherwise qualify for benefits.**

1. If Total Disability results from two (2) or more causes, the monthly income amount payable for Total Disability shall be limited to that amount payable for Total Disability resulting from a single cause.
2. This policy does not cover Total Disability caused by or resulting from:
  - a. Pre-existing Sickness or Physical Condition as defined herein, subject to the Time Limit on Certain Defenses provision; or
  - b. Any intentionally self-inflicted Injury; or
  - c. Normal pregnancy and childbirth; however, Total Disability caused by complications of pregnancy will be covered.

## SECTION 4: CLAIMS

**This section describes how to notify Us of a claim, how to file a claim, how and when Your claim is paid and other rights and responsibilities under the policy.**

### **Notifying Us of a Claim**

You must notify Us or Your agent in writing of a claim within thirty (30) days after a covered loss begins, or as soon as reasonably possible. Notice given by You, or on behalf of You or Your beneficiary, to Us or Your agent, with information sufficient to identify You, shall be deemed notice.

### **How to File a Claim**

We will send You appropriate claim forms within fifteen (15) days of receiving notice of Your claim. If We do not, You will meet the requirements of providing Us with written proof of loss if You send Us a written statement describing the nature and extent of Your loss within the time limit stated in the When to File a Claim provision.

### **When to File a Claim**

You should send Us written proof of loss within ninety (90) days after the end of the time period for which We are liable. If it is not reasonably possible to provide written proof in such time, We will not reduce or deny Your claim as long as proof is provided as soon as reasonably possible. In any event, unless You were legally incapacitated, written proof must be provided not later than twelve (12) months from the time proof is otherwise required.

### **Our Right to Obtain Information**

At Our expense, We have the right to have You examined as often as reasonably necessary while a claim is pending. Any such examinations will be conducted by one or more Physicians or vocational specialists of Our choice.

We have the right to suspend payment of benefits if You fail to attend an examination or fail to cooperate with the person conducting the examination. In such a case Total Disability benefits may be resumed, provided that the required examination occurs within a reasonable time and benefits are otherwise payable.

Upon death We may also have an autopsy done unless prohibited by law.

### **When Your Claim is Paid**

Benefits payable under this policy will be paid immediately after receipt of proper written proof of such loss.

### **How Your Claim is Paid**

All benefits of this policy shall be payable to the financing institution named in the application. Such payments shall be applied to reduce or extinguish Your unpaid indebtedness.

In the event benefits exceed the unpaid debt, any excess will be payable to a beneficiary, other than the Creditor, named by the Debtor, or to the Debtor's estate.

If benefits are payable to Your estate, We may pay up to \$1,000 to a person related to You by blood or marriage whom We consider to be entitled to the benefits. Any payments made in good faith will discharge Us to the extent of the payment.

### **Misstatement of Your Age**

In the event Your age has been misstated and if, according to Your correct age, the coverage provided by this policy would not have become effective, then Our liability shall be limited to the refund of all premiums paid.

## Limitations on Legal Actions

No legal action may be brought to recover on this policy within sixty (60) days after written proof of loss has been given as required by this policy. No such action may be brought after thirty-six (36) months from the time written proof of loss is required to be given.

## SECTION 5: THE CONTRACT

**This section identifies the documents which describe all contractual agreements, the importance of accurate and truthful application completion, and other basic rights, obligations, and features of the policy.**

### Entire Contract

This policy, (with the application and attached papers) is the entire contract between You and Us. No change in this policy will be effective until approved by one of Our officers. This approval must be noted on or attached to this policy. No agent may change this policy or waive any of its provisions.

### Importance of Information on the Application/Time Limit on Certain Defenses:

1. **Misstatements in the Application.** After twelve (12) months from the policy date only fraudulent misstatements in the application may be used to void the policy or deny any claim for loss incurred after such twelve (12) month period.
2. **Pre-existing Conditions.** No claim for loss incurred or Total Disability commencing after six (6) months from the policy date shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the policy date.

### Policy Cancellation

1. You have the right to cancel this policy at any time by written notice delivered or mailed to Us. Such cancellation will be effective upon receipt or on such later date as You state in such notice.
2. If You are receiving monthly income for Total Disability at the time of prepayment of the loan, the amount of refund will be determined as if the prepayment did not occur until the payment of benefits terminates.
3. You must cancel this policy if you refinance, consolidate or extend the term of the original loan. Should Your policy be cancelled for any of these reasons, We will promptly return the unused portion of the insurance premium paid.

You may apply for a new policy to cover the new term and loan amount. If you apply for another Individual Credit Disability Insurance policy issued by Us, the pre-existing provision, incontestability and waiting provisions will be waived to the extent it has been satisfied under this policy.

If you are Totally Disabled and receiving benefits at the time of refinancing:

- a. The amount of the new insurance coverage will be at least equal to the amount of coverage remaining at the time of the refinancing or consolidation.
- b. The term of the new insurance coverage will be at least equal to the term of coverage remaining at the time of the refinancing or consolidation.

If You do not complete a new application for Individual Credit Disability Insurance covering the refinanced/consolidated loan, coverage under this policy will terminate effective upon the termination date of the loan.

4. If You default on the indebtedness, the insurance in force will be terminated as of the date of default.

Should it ever be necessary for Us to return the unearned portion of the insurance premiums paid, the amount will be computed by the "sum of the digits" formula commonly known as the "Rule of 78". The unearned portion of the insurance premium will be refunded to the financing institution or the person entitled thereto. No refund shall be made if the amount thereof is less than one dollar.

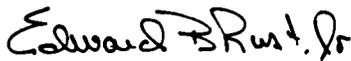
### Conformity with State Statutes

Any provision of this policy which, on the Effective Date of Coverage, is in conflict with the statutes of the state in which You reside on such date is amended to conform to such statutes.

### SECTION 6: MUTUAL CONDITIONS

1. **Membership.** While this policy is in force, You are entitled to vote at all meetings of members and to receive dividends the Board of Directors in its discretion may declare in accordance with reasonable classifications and groupings of policyholders established by such Board.
2. **No Contingent Liability.** This policy is non-assessable.
3. **Annual Meeting.** The annual meeting of the members of the company shall be held at its home office at Bloomington, Illinois, on the second Monday of June at the hour of 10:00 A.M., unless the Board of Directors shall elect to change the time and place of such meeting, in which case, but not otherwise, due notice shall be mailed each member at the address disclosed in this policy at least ten (10) days prior thereto.

In Witness Whereof, the State Farm Mutual Automobile Insurance Company has caused this policy to be signed by its President and Secretary of Bloomington, Illinois.



President



Secretary



## Application for Individual Credit Disability Insurance Policy

### 1. Proposed Insured (Debtor)

LAST NAME		
FIRST NAME		MIDDLE INITIAL
SEX	AGE	BIRTH DATE MONTH-DAY-YEAR
RESIDENCE ADDRESS		
RESIDENCE ADDRESS		
CITY		STATE
ZIP CODE	COUNTY	
ARE YOU ACTIVELY WORKING 30 HOURS OR MORE EACH WEEK FOR PAY OR PROFIT? <input type="radio"/> YES <input type="radio"/> NO		

### 3. Financing Institution (Creditor)

NAME OF INSTITUTION		
MAILING ADDRESS		
CITY	STATE	ZIP CODE
MONTHLY PAYMENT	LOAN TERM (Months)	LOAN EFFECTIVE DATE
\$		LOAN TERMINATION DATE

### 2. Coverage

MONTHLY BENEFIT (Benefit Applied For)	TOTAL OF PAYMENTS (Includes Principal, Interest & Financed Premium)	COVERAGE EFFECTIVE DATE
\$	\$	COVERAGE TERMINATION DATE
TERM OF INSURANCE (Months)	WAITING PERIOD 30 DAYS RETROACTIVE	TOTAL PREMIUM (Submit With App)
	\$	IS THE PREMIUM BEING FINANCED IN THE LOAN? <input type="radio"/> YES <input type="radio"/> NO

I understand and agree that under the terms of the policy hereby applied for, Benefits are payable to the financing institution for Total Disability of the Insured resulting from Injury or Sickness in accordance with the Payment of Claims provision of the policy, but no Benefits are payable for: (a) the first 30 days of Total Disability unless such disability continues for more than 30 days, and (b) any disability resulting, within a period of six months from the policy effective date, from any Pre-Existing Sickness or Physical Condition for which I received medical advice, consultation or treatment within six months prior to the policy effective date.

### Beneficiary (optional)

Should the indemnities exceed the unpaid indebtedness, such excess shall be paid to the Insured, if living; otherwise to the beneficiary named below by the Insured; otherwise to the estate of the Insured.

FULL NAME	
AGE	RELATIONSHIP

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.

**THE CONDITIONAL RECEIPT HAS BEEN EXPLAINED TO ME. I UNDERSTAND THAT I WILL NOT RECEIVE ANY INSURANCE COVERAGE FOR MY MONEY UNLESS A POLICY IS ISSUED AS APPLIED FOR AND DELIVERED.**

<p>The Conditional Receipt has been explained and given to the Proposed Insured. An Outline of Coverage has been furnished to the Proposed Insured.</p>	<p>Dated on _____  MONTH DAY YEAR</p> <p>at _____  CITY STATE</p>
<p>X Signature of Agent</p>	<p>X Signature of Proposed Insured</p>
<p>Agent's Code Stamp</p>	<p>Mailing Address if different from Residence Address:</p>

**Financing Institution Use Only**

(NOTE TO FINANCING INSTITUTION) If loan terminated prior to scheduled maturity date, complete the area below and return this copy to: State Farm Mutual Automobile Insurance Company, Greeley Health Operations Center, P.O. Box 339404, Greeley, Colorado 80633-9404

**LOAN TERMINATED EFFECTIVE** \_\_\_\_\_  
MONTH DAY YEAR



State Farm Mutual Automobile Insurance Company  
Home Office, Bloomington, IL 61710  
(309) 766-2311

Retain this for your records.

## Individual Credit Disability Insurance Policy Outline of Coverage Policy Form 97021 Z Series

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**PURCHASE OF CONSUMER CREDIT INSURANCE IS OPTIONAL AND NOT A CONDITION OF OBTAINING CREDIT APPROVAL. YOU MAY NOT NEED CONSUMER CREDIT INSURANCE IF YOU HAVE OTHER INSURANCE THAT COVERS THE RISK.**

**IF MORE THAN ONE TYPE OF CONSUMER CREDIT INSURANCE IS MADE AVAILABLE TO YOU, YOUR CREDITOR WILL ADVISE YOU THAT YOU MAY PURCHASE EACH SEPARATELY OR ONLY AS A PACKAGE.**

- 1. READ YOUR POLICY CAREFULLY.** This outline of coverage provides a very brief description of the important features of your policy. This outline 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!**
- 2. TERMS UNDER WHICH THE POLICY MAY BE RETURNED AND PREMIUM REFUNDED.** It is important that you understand your policy and are satisfied with it. Please read it carefully. If you are not satisfied with it for any reason, return it to us at our Home Office at One State Farm Plaza, Bloomington, Illinois 61710-0001 or our agent through whom it was purchased.

You may cancel coverage at any time during the term of the loan. If the cancellation request is received within 30 days after you receive the policy, your premium will be refunded and the policy will be considered to never have been issued.

If the cancellation request is received after 30 days any unearned premium will be refunded.

If insurance is required for an extension of credit, you may be required to show evidence of alternative insurance acceptable to the creditor.

### 3. THE CONDITIONS FOR ELIGIBILITY ARE AS FOLLOWS:

- (a) Eligible applicants are 16 through 64 years of age.
- (b) The principal obligor of the loan is eligible to apply for coverage.
- (c) The applicant must be actively working 30 hours or more each week for pay or profit.
- (d) Persons currently disabled or contemplating hospitalization are ineligible.
- (e) New credit disability insurance may not be written on a refinanced or renewed loan unless all credit insurance on the previous loan has expired or been canceled.
- (f) Must be a loan payable on an equal monthly basis and a maximum term of 120 months.
- (g) The monthly loan payment must be at least \$40.
- (h) The maximum issue limit for each applicant is \$1,200/month or a total maximum indemnity amount up to \$100,000, whichever is less. If either maximum is exceeded, no coverage is available.

### 4. BENEFITS OF THIS POLICY

**Monthly Income Amount:** We will pay the financing institution this amount if you are totally disabled from injury or sickness. The payment begins after the Waiting Period retroactive to the first day of Total Disability. We pay as long as the Total Disability continues, but no longer than the Termination Date shown on the Policy Schedule.

**Total Disability:** During the first three years of disability this means you are completely unable, due to injury or sickness, to perform the duties of the job you have at the time Total Disability begins. After you have been disabled for three years, it means you are completely unable to do any job for which you are able to perform by your education, training or experience.

If you are not working at the time your Total Disability begins, your Occupation shall then mean any Occupation (s) for which you are reasonably able to perform by your education, training or experience.

### 5. EXCLUSIONS AND LIMITATIONS

This policy does not cover Total Disability caused by or resulting from:

- (a) A pre-existing sickness or physical condition as defined herein, subject to the Time Limit on Certain Defenses provision;
- (b) Any intentionally self-inflicted injury; or
- (c) Normal pregnancy and childbirth; however, total disability caused by complications of pregnancy will be covered.

If Total Disability results from two or more causes, the Monthly Income Amount payable for total disability shall be limited to the amount payable for Total Disability resulting from a single cause.

**6. DESCRIPTION**

Waiting Period	<b>30 days</b> _____
Monthly Benefit Amount	\$ _____
Term of Loan (months)	_____
Term of Insurance (months)	_____
Coverage Effective Date	_____
Premium*	\$ _____

\*If the premium is financed, it will be subject to finance charges at the rate applicable to the credit transaction.

An individual policy of insurance will be delivered to you if your application is accepted. If the application of insurance is not accepted, any monies paid toward this insurance shall be fully refunded.





SERFF Tracking Number: STFH-126892785 State: Arkansas  
 Filing Company: State Farm Mutual Automobile Insurance State Tracking Number: 47279  
 Company  
 Company Tracking Number:  
 TOI: CR02I Individual Credit - Credit Disability Sub-TOI: CR02I.003 Single Premium  
 Product Name: ICDI  
 Project Name/Number: ICDI POLICY, et al /

## Supporting Document Schedules

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b>	Flesch Certification	Approved-Closed	11/18/2010
<b>Comments:</b>			
<b>Attachment:</b>			
	READABILITY SCORE AND CERTIFICATION.pdf		

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b>	Application	Approved-Closed	11/18/2010
<b>Comments:</b>			
<b>Attachment:</b>			
	App 1003449.pdf		

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b>	Life & Annuity - Acturial Memo	Approved-Closed	11/18/2010
<b>Bypass Reason:</b>	N/A		
<b>Comments:</b>			

## READABILITY SCORE AND CERTIFICATION

The Flesch reading ease test score for the following forms are:

Individual Credit Disability Insurance Policy, 97021 Z – 50.4

Application for Individual Credit Disability Insurance Policy, 1003449 – 55.3

This meets the minimum reading ease test score required in this state.



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Mary F. Keim  
Assistant Secretary/Treasurer



## Application for Individual Credit Disability Insurance Policy

### 1. Proposed Insured (Debtor)

LAST NAME		
FIRST NAME		MIDDLE INITIAL
SEX	AGE	BIRTH DATE MONTH-DAY-YEAR
RESIDENCE ADDRESS		
RESIDENCE ADDRESS		
CITY		STATE
ZIP CODE	COUNTY	
ARE YOU ACTIVELY WORKING 30 HOURS OR MORE EACH WEEK FOR PAY OR PROFIT? <input type="radio"/> YES <input type="radio"/> NO		

### 3. Financing Institution (Creditor)

NAME OF INSTITUTION		
MAILING ADDRESS		
CITY	STATE	ZIP CODE
MONTHLY PAYMENT	LOAN TERM (Months)	LOAN EFFECTIVE DATE
\$		
		LOAN TERMINATION DATE

### 2. Coverage

MONTHLY BENEFIT (Benefit Applied For)	TOTAL OF PAYMENTS (Includes Principal, Interest & Financed Premium)	COVERAGE EFFECTIVE DATE
\$	\$	
		COVERAGE TERMINATION DATE
TERM OF INSURANCE (Months)	WAITING PERIOD 30 DAYS RETROACTIVE	TOTAL PREMIUM (Submit With App)
		\$
		IS THE PREMIUM BEING FINANCED IN THE LOAN? <input type="radio"/> YES <input type="radio"/> NO

I understand and agree that under the terms of the policy hereby applied for, Benefits are payable to the financing institution for Total Disability of the Insured resulting from Injury or Sickness in accordance with the Payment of Claims provision of the policy, but no Benefits are payable for: (a) the first 30 days of Total Disability unless such disability continues for more than 30 days, and (b) any disability resulting, within a period of six months from the policy effective date, from any Pre-Existing Sickness or Physical Condition for which I received medical advice, consultation or treatment within six months prior to the policy effective date.

### Beneficiary (optional)

Should the indemnities exceed the unpaid indebtedness, such excess shall be paid to the Insured, if living; otherwise to the beneficiary named below by the Insured; otherwise to the estate of the Insured.

FULL NAME	
AGE	RELATIONSHIP

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.

**THE CONDITIONAL RECEIPT HAS BEEN EXPLAINED TO ME. I UNDERSTAND THAT I WILL NOT RECEIVE ANY INSURANCE COVERAGE FOR MY MONEY UNLESS A POLICY IS ISSUED AS APPLIED FOR AND DELIVERED.**

<p>The Conditional Receipt has been explained and given to the Proposed Insured. An Outline of Coverage has been furnished to the Proposed Insured.</p>	<p>Dated on _____  MONTH DAY YEAR</p> <p>at _____  CITY STATE</p>
<p>X Signature of Agent</p>	<p>X Signature of Proposed Insured</p>
<p>Agent's Code Stamp</p>	<p>Mailing Address if different from Residence Address:</p>

**Financing Institution Use Only**

(NOTE TO FINANCING INSTITUTION) If loan terminated prior to scheduled maturity date, complete the area below and return this copy to: State Farm Mutual Automobile Insurance Company, Greeley Health Operations Center, P.O. Box 339404, Greeley, Colorado 80633-9404

**LOAN TERMINATED EFFECTIVE** \_\_\_\_\_  
MONTH DAY YEAR