

<i>SERFF Tracking Number:</i>	<i>SHLI-126759055</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Shelter Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>46415</i>
<i>Company Tracking Number:</i>	<i>03L10210</i>		
<i>TOI:</i>	<i>L04I Individual Life - Term</i>	<i>Sub-TOI:</i>	<i>L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life</i>
<i>Product Name:</i>	<i>Level Term Application</i>		
<i>Project Name/Number:</i>	<i>Paper App/L10210</i>		

Filing at a Glance

Company: Shelter Life Insurance Company

Product Name: Level Term Application

TOI: L04I Individual Life - Term

SERFF Tr Num: SHLI-126759055 State: Arkansas

SERFF Status: Closed-Approved-Closed
State Tr Num: 46415

Sub-TOI: L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life

Co Tr Num: 03L10210

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Linda Bird

Authors: Dina Krofta, Berdetta Moore

Disposition Date: 08/10/2010

Date Submitted: 08/06/2010

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Paper App

Project Number: L10210

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 08/10/2010

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Individual

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 08/10/2010

Created By: Berdetta Moore

Corresponding Filing Tracking Number:
03L10210

Deemer Date:

Submitted By: Berdetta Moore

Filing Description:

This application is for fully underwritten life insurance.

Company and Contact

Filing Contact Information

SERFF Tracking Number: SHLI-126759055 State: Arkansas
 Filing Company: Shelter Life Insurance Company State Tracking Number: 46415
 Company Tracking Number: 03L10210
 TOI: L041 Individual Life - Term Sub-TOI: L041.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life

Product Name: Level Term Application
 Project Name/Number: Paper App/L10210

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

Filing Company Information

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

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	\$50.00	08/06/2010	38576019

<i>SERFF Tracking Number:</i>	<i>SHLI-126759055</i>	<i>State:</i>	<i>Arkansas</i>
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<i>Company Tracking Number:</i>	<i>03L10210</i>		
<i>TOI:</i>	<i>L041 Individual Life - Term</i>	<i>Sub-TOI:</i>	<i>L041.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life</i>
<i>Product Name:</i>	<i>Level Term Application</i>		
<i>Project Name/Number:</i>	<i>Paper App/L10210</i>		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved- Closed	Linda Bird	08/10/2010	08/10/2010

SERFF Tracking Number: *SHLI-126759055* *State:* *Arkansas*
Filing Company: *Shelter Life Insurance Company* *State Tracking Number:* *46415*
Company Tracking Number: *03L10210*
TOI: *L04I Individual Life - Term* *Sub-TOI:* *L04I.213 Specified Age or Duration -*
Product Name: *Level Term Application* *Fixed/Indeterminate Premium - Single Life*
Project Name/Number: *Paper App/L10210*

Disposition

Disposition Date: 08/10/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: SHLI-126759055 State: Arkansas
 Filing Company: Shelter Life Insurance Company State Tracking Number: 46415
 Company Tracking Number: 03L10210
 TOI: L041 Individual Life - Term Sub-TOI: L041.213 Specified Age or Duration -
 Fixed/Indeterminate Premium - Single Life
 Product Name: Level Term Application
 Project Name/Number: Paper App/L10210

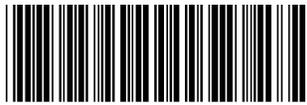
Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Life & Annuity - Acturial Memo		No
Form	Life Insurance Application		Yes

SERFF Tracking Number: SHLI-126759055 State: Arkansas
 Filing Company: Shelter Life Insurance Company State Tracking Number: 46415
 Company Tracking Number: 03L10210
 TOI: L041 Individual Life - Term Sub-TOI: L041.213 Specified Age or Duration -
 Fixed/Indeterminate Premium - Single Life
 Product Name: Level Term Application
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Form Schedule

Lead Form Number: L-309.41

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	L-309.41	Application/Life Insurance Enrollment Application Form	Initial		51.200	L-309.41.pdf



C O N T R A C T



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

LIFE INSURANCE APPLICATION

Agent Name _____
Agent # _____
Agent Telephone # _____
Applicant's Family # _____

PROPOSED INSURED

1. Name (Last) (First) (MI) (Suffix)		Soc. Sec. No.		<input type="checkbox"/> Male		
2. Marital Status		Hgt. ' "	Wgt. lbs.	Birth Date	Age	State of Birth
3. Physical Address (Street)		(City)	(County)	(State)	(Zip)	
3a. Mailing Address If Different						
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 to 100 <input type="checkbox"/> Whole Life <input type="checkbox"/> YRT to 85		Face Amount \$
<input type="checkbox"/> 20 Yr. Level Term to 100 <input type="checkbox"/> 20 Pay Whole Life <input type="checkbox"/>		Mode Premium \$
<input type="checkbox"/> 30 Yr. Level Term to 100 <input type="checkbox"/> Secure Whole Life <input type="checkbox"/>		
10. Rate Class: (LT) <input type="checkbox"/> T <input type="checkbox"/> PRF/T <input type="checkbox"/> NT <input type="checkbox"/> PRF/NT <input type="checkbox"/> ULT PRF/NT (YRT) <input type="checkbox"/> STD <input type="checkbox"/> STD/NT <input type="checkbox"/> PRF/NT (All other) <input type="checkbox"/> STD <input type="checkbox"/> NT		
11. WP <input type="checkbox"/> Yes <input type="checkbox"/> No AD <input type="checkbox"/> Yes Amount \$ _____ <input type="checkbox"/> No Auto Prem Loan <input type="checkbox"/> Yes <input type="checkbox"/> No (Not available on term insurance)		
12. Dividend Options: (WL & WL 20 Pay Only) <input type="checkbox"/> Pd. Up. Adds <input type="checkbox"/> Accum. at Interest <input type="checkbox"/> Cash <input type="checkbox"/> Reduce Premium (N/A 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"/> NT		<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) \$ _____ 1035 Exchange <input type="checkbox"/> Yes <input type="checkbox"/> No									
17. <input type="checkbox"/> Guaranteed Insurability Rider - Amount \$		18. <input type="checkbox"/> Payor Death or Disability Benefit (WL, 20 Pay WL, Secure WL)							
19. Payor To Be Insured	Relationship	Sex	Hgt	Wgt	Birth Date	Age	US Cit?	Birth St.	SS No.
Payor's Occupation					Payor's Address				

PREMIUM

20. <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Payroll Deduction	
<input type="checkbox"/> PAC - 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. Do you have existing life insurance policies or contracts? Yes No
(If yes, send Replacement Form L-243.29 with application.)

Will this application replace an existing policy or contract? Yes No
(If yes, send Replacement Memorandum L-243.33 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?

b. died before age 60? If yes, list relationship, age & cause of death in question 32

26. Have you engaged in or do you anticipate engaging in:

a. Aviation activities, including ultralight flying, hang gliding or parachute jumping?.....

b. Rodeo riding, underwater diving, racing of any motor powered vehicle or any other hazardous sport or hobby?.....

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?

28. Are you planning travel, residence or employment outside the United States?.....

29. Do you now use or have you ever used any form of tobacco or nicotine substitutes?

If yes, give date last used in question 32.

30. Are you in the National Guard or Reserves?

31. Have you been charged with any Misdemeanor or Felony?

If yes, give details such as type of offense, date, and whether or not convicted in question 32.

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? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. cancer, tumor or other growth or malignancy of any kind?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. bronchitis, emphysema, shortness of breath or any other disease or disorder of the lungs or respiratory system? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. depression, anxiety or any other behavioral, mental or nervous disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. epilepsy, seizures, sleep apnea or any other disease or disorder of the brain or nervous system?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| f. diabetes, hepatitis, anemia or any other disease or disorder of the blood or glands?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| g. arthritis, gout, or any other disease or disorder of the bones, muscles, joints, eyes or skin?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| h. any disease or disorder of the stomach, intestines, colon, rectum, liver, pancreas or digestive system? | <input type="checkbox"/> | <input type="checkbox"/> |
| i. any disease or disorder of the kidney, bladder, prostate, urinary system or genital organs including complication of pregnancy? | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Acquired Immune Deficiency Syndrome (AIDS), positive HIV test, or other immunological disorder?..... | <input type="checkbox"/> | <input type="checkbox"/> |

34. If female, are you now pregnant? If yes, give approximate delivery date in question 40. Yes No

35. Are you currently receiving treatment, taking medication, or scheduled to have surgery? Yes No

36. Weight loss of more than 10 lbs. in past year? If yes, list # of lbs. and reason in question 40. Yes No

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 question 40..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. used or do you now use alcoholic beverages? If Yes, provide type, frequency and amount in question 40..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. sought or received treatment or counseling for alcohol or drug use?..... | <input type="checkbox"/> | <input type="checkbox"/> |

38. Have you received or do you now receive disability benefits or do you currently have a disability of any kind?..... Yes No

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?..... Yes No

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

UNDERWRITING INFORMATION

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 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.

(Signature of Writing Agent)

(Print Name 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? Yes No (UL, PUA Only) 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, Inc., formerly known as Medical Information Bureau**, a not-for-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 about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the information in 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 MIB's information office is **50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734**.

Shelter Life Insurance Company, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. **Information for consumers about MIB may be obtained on its website at www.mib.com.**

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.

SERFF Tracking Number: SHLI-126759055 State: Arkansas
Filing Company: Shelter Life Insurance Company State Tracking Number: 46415
Company Tracking Number: 03L10210
TOI: L041 Individual Life - Term Sub-TOI: L041.213 Specified Age or Duration -
Fixed/Indeterminate Premium - Single Life
Product Name: Level Term Application
Project Name/Number: Paper App/L10210

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification		
Comments:		
Attachment: AR Flesch Certification.pdf		

	Item Status:	Status Date:
Satisfied - Item: Application		
Comments:		
Attachment: L-309.41.pdf		



**SHELTER
INSURANCE
COMPANIES**

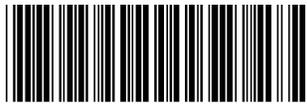
SHELTER MUTUAL
SHELTER GENERAL
SHELTER LIFE

CERTIFICATION

This is to certify that the following forms have achieved the indicated Flesch Reading Ease Scores. They do not comply with the requirements of Ark. Stat. Ann. 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act, due to required wording.

<u>Form No.</u>	<u>Name</u>	<u>Score</u>
L-309.41	Individual Life Insurance Application	51.2

Signed _____
Robert W. Omdal, FSA, MAAA
Chief Actuary – Life and Health
Shelter Life Insurance Company



C O N T R A C T



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

LIFE INSURANCE APPLICATION

Agent Name _____
Agent # _____
Agent Telephone # _____
Applicant's Family # _____

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. Physical Address		(Street)	(City)	(County)	(State)	(Zip)			
3a. Mailing Address If Different									
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 to 100		<input type="checkbox"/> Whole Life		<input type="checkbox"/> YRT to 85		Face Amount \$			
<input type="checkbox"/> 20 Yr. Level Term to 100		<input type="checkbox"/> 20 Pay Whole Life		<input type="checkbox"/>		Mode Premium \$			
<input type="checkbox"/> 30 Yr. Level Term to 100		<input type="checkbox"/> Secure Whole Life		<input type="checkbox"/>					
10. Rate Class: (LT) <input type="checkbox"/> T <input type="checkbox"/> PRF/T <input type="checkbox"/> NT <input type="checkbox"/> PRF/NT <input type="checkbox"/> ULT PRF/NT (YRT) <input type="checkbox"/> STD <input type="checkbox"/> STD/NT <input type="checkbox"/> PRF/NT (All other) <input type="checkbox"/> STD <input type="checkbox"/> NT									
11. WP <input type="checkbox"/> Yes <input type="checkbox"/> No AD <input type="checkbox"/> Yes Amount \$ _____ <input type="checkbox"/> No Auto Prem Loan <input type="checkbox"/> Yes <input type="checkbox"/> No (Not available on term insurance)									
12. Dividend Options: (WL & WL 20 Pay Only) <input type="checkbox"/> Pd. Up. Adds <input type="checkbox"/> Accum. at Interest <input type="checkbox"/> Cash <input type="checkbox"/> Reduce Premium (N/A 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"/> NT		<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) \$ _____ 1035 Exchange <input type="checkbox"/> Yes <input type="checkbox"/> No										
17. <input type="checkbox"/> Guaranteed Insurability Rider - Amount \$					18. <input type="checkbox"/> Payor Death or Disability Benefit (WL, 20 Pay WL, Secure WL)					
19. Payor To Be Insured		Relationship	Sex	Hgt	Wgt	Birth Date	Age	US Cit?	Birth St.	SS No.
Payor's Occupation					Payor's Address					

PREMIUM

20. <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Payroll Deduction									
<input type="checkbox"/> PAC - 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. Do you have existing life insurance policies or contracts? Yes No
(If yes, send Replacement Form L-243.29 with application.)

Will this application replace an existing policy or contract? Yes No
(If yes, send Replacement Memorandum L-243.33 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?

b. died before age 60? If yes, list relationship, age & cause of death in question 32

26. Have you engaged in or do you anticipate engaging in:

a. Aviation activities, including ultralight flying, hang gliding or parachute jumping?.....

b. Rodeo riding, underwater diving, racing of any motor powered vehicle or any other hazardous sport or hobby?.....

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?

28. Are you planning travel, residence or employment outside the United States?.....

29. Do you now use or have you ever used any form of tobacco or nicotine substitutes?

If yes, give date last used in question 32.

30. Are you in the National Guard or Reserves?

31. Have you been charged with any Misdemeanor or Felony?

If yes, give details such as type of offense, date, and whether or not convicted in question 32.

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? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. cancer, tumor or other growth or malignancy of any kind?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. bronchitis, emphysema, shortness of breath or any other disease or disorder of the lungs or respiratory system? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. depression, anxiety or any other behavioral, mental or nervous disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. epilepsy, seizures, sleep apnea or any other disease or disorder of the brain or nervous system?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| f. diabetes, hepatitis, anemia or any other disease or disorder of the blood or glands?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| g. arthritis, gout, or any other disease or disorder of the bones, muscles, joints, eyes or skin?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| h. any disease or disorder of the stomach, intestines, colon, rectum, liver, pancreas or digestive system? | <input type="checkbox"/> | <input type="checkbox"/> |
| i. any disease or disorder of the kidney, bladder, prostate, urinary system or genital organs including complication of pregnancy? | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Acquired Immune Deficiency Syndrome (AIDS), positive HIV test, or other immunological disorder?..... | <input type="checkbox"/> | <input type="checkbox"/> |

34. If female, are you now pregnant? If yes, give approximate delivery date in question 40. Yes No

35. Are you currently receiving treatment, taking medication, or scheduled to have surgery? Yes No

36. Weight loss of more than 10 lbs. in past year? If yes, list # of lbs. and reason in question 40. Yes No

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 question 40..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. used or do you now use alcoholic beverages? If Yes, provide type, frequency and amount in question 40..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. sought or received treatment or counseling for alcohol or drug use?..... | <input type="checkbox"/> | <input type="checkbox"/> |

38. Have you received or do you now receive disability benefits or do you currently have a disability of any kind?..... Yes No

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?..... Yes No

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

UNDERWRITING INFORMATION

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 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.

(Signature of Writing Agent)

(Print Name 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? Yes No (UL, PUA Only) 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, Inc., formerly known as Medical Information Bureau**, a not-for-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 about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the information in 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 MIB's information office is **50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734**.

Shelter Life Insurance Company, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. **Information for consumers about MIB may be obtained on its website at www.mib.com.**

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.