

<i>SERFF Tracking Number:</i>	<i>SHLI-126809060</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Shelter Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>46757</i>
<i>Company Tracking Number:</i>	<i>03L10610</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>Questionnaires</i>		
<i>Project Name/Number:</i>	<i>Questionnaires/L11110</i>		

Filing at a Glance

Company: Shelter Life Insurance Company

Product Name: Questionnaires

TOI: L04I Individual Life - Term

SERFF Tr Num: SHLI-126809060 State: Arkansas

SERFF Status: Closed-Approved-Closed
State Tr Num: 46757

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

Co Tr Num: 03L10610

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Linda Bird

Authors: Dina Krofta, Berdetta Moore

Disposition Date: 09/14/2010

Date Submitted: 09/10/2010

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Questionnaires

Project Number: L11110

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 09/14/2010

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: 09/14/2010

Created By: Berdetta Moore

Corresponding Filing Tracking Number:
03L10610

Filing Description:

These are questionnaires that will be used supplemental to our life applications.

Company and Contact

Filing Contact Information

SERFF Tracking Number: SHLI-126809060 State: Arkansas
 Filing Company: Shelter Life Insurance Company State Tracking Number: 46757
 Company Tracking Number: 03LI0610
 TOI: L04I Individual Life - Term Sub-TOI: L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life

Product Name: Questionnaires
 Project Name/Number: Questionnaires/L11110

Berretta 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: \$100.00
 Retaliatory? No
 Fee Explanation: 2 forms @ \$50.00 each
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Shelter Life Insurance Company	\$100.00	09/10/2010	39419375

SERFF Tracking Number: SHLI-126809060 State: Arkansas
Filing Company: Shelter Life Insurance Company State Tracking Number: 46757
Company Tracking Number: 03LI0610
TOI: L04I Individual Life - Term Sub-TOI: L04I.213 Specified Age or Duration -
Fixed/Indeterminate Premium - Single Life
Product Name: Questionnaires
Project Name/Number: Questionnaires/L11110

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	09/14/2010	09/14/2010

SERFF Tracking Number: *SHLI-126809060* *State:* *Arkansas*
Filing Company: *Shelter Life Insurance Company* *State Tracking Number:* *46757*
Company Tracking Number: *03LI0610*
TOI: *L04I Individual Life - Term* *Sub-TOI:* *L04I.213 Specified Age or Duration -*
Product Name: *Questionnaires* *Fixed/Indeterminate Premium - Single Life*
Project Name/Number: *Questionnaires/L11110*

Disposition

Disposition Date: 09/14/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: SHLI-126809060 State: Arkansas
 Filing Company: Shelter Life Insurance Company State Tracking Number: 46757
 Company Tracking Number: 03L10610
 TOI: L041 Individual Life - Term Sub-TOI: L041.213 Specified Age or Duration -
 Fixed/Indeterminate Premium - Single Life
 Product Name: Questionnaires
 Project Name/Number: Questionnaires/L11110

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Yes	Yes
Supporting Document	Application	Yes	Yes
Supporting Document	Life & Annuity - Acturial Memo	No	No
Form	Hazardous Activities Questionnaire	Yes	Yes
Form	Aviation Questionnaire	Yes	Yes

SERFF Tracking Number: SHLI-126809060 State: Arkansas
 Filing Company: Shelter Life Insurance Company State Tracking Number: 46757
 Company Tracking Number: 03LI0610
 TOI: L04I Individual Life - Term Sub-TOI: L04I.213 Specified Age or Duration -
 Fixed/Indeterminate Premium - Single Life
 Product Name: Questionnaires
 Project Name/Number: Questionnaires/L11110

Form Schedule

Lead Form Number: L-18.3

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	L-18.3	Application/Hazardous Activities Enrollment Questionnaire Form	Initial		65.100	L-18.3.pdf
	L-18.4	Application/Aviation Enrollment Questionnaire Form	Initial		65.100	L-18.4.pdf



HAZARDOUS ACTIVITIES QUESTIONNAIRE

Supplement to Application for

Dated

To: SHELTER LIFE INSURANCE COMPANY, Columbia, Missouri 65218-0001

PLEASE GIVE FULL DETAILS - TYPES OF ACTIVITY, FREQUENCY, EXTENT, NAMES OF ORGANIZATIONS, ETC.

1. Have you ever engaged in or do you anticipate engaging in within the next 2 years: Rodeo riding, underwater diving, sky diving or parachute jumping, racing of any motor powered vehicle, or rock and mountain climbing? If yes, please complete the appropriate section below. Yes [] No []

2. Rodeo competition? Yes [] No []
a. Type of activity:
b. How often:
c. Date of last:

3. Underwater diving? Yes [] No []
a. How long have you been diving:
b. Max time under water:
c. How often:
d. Average Depth:
e. Date of last:
f. Greatest depth:
g. Have you ever done underwater recovery or salvage work? Yes [] No []
When: What type:

4. Sky diving or parachute jumping? Yes [] No []
a. How long have you been sky diving:
b. How often:
c. Total number of jumps made:
d. Do you belong to any sky divers' association or club? Yes [] No []
Name:
e. Are all jumps made under auspices of your association or club? Yes [] No []
If no, details:

5. Rock and mountain climbing? Yes [] No []
a. Greatest technical class:
b. Do you climb outside North America? Yes [] No []

6. Racing, performance testing, or stunt driving - automobile, motorcycle, motorboat, etc.? Yes [] No []
a. How long have you been participating:
b. Date of last event:
c. Location of last event:
d. Have you ever attended any type of drivers' or operators' school? Yes [] No []
Name:
e. Do you hold a competition drivers' license from any organization? Yes [] No []
Name:
f. Have you ever, or do you expect to within the next two years, engage in
i. other than sanctioned events? Yes [] No []
ii. stunt driving? Yes [] No []
iii. racing professionally or for cash prizes? Yes [] No []
g. Types and number of events and mileage in past 12 months, past 24 months, and estimated total for next 12 months (include midget, sports car, stock car, modified, championship, drag, go-cart, motorcycle, motorboat, hydroplane, etc.)

Table with 4 columns: Types of Events, Past 12 Months (Number, Miles), Past 24 Months (Number, Miles), Est. Next 12 Months (Number, Miles)

I hereby declare that all the statements and answers to the above questions are true, and I agree that they shall form a part of my application for insurance.

Applicant's Signature Witness Date

AVIATION QUESTIONNAIRE

Supplement to Application of _____ Dated _____
To: SHELTER LIFE INSURANCE COMPANY, Columbia, Missouri 65218-0001 **Aviation Questionnaire**

PLEASE GIVE FULL DETAILS ON ALL QUESTIONS—TYPES OF PLANES, ACTIVITIES, NAMES OF ORGANIZATIONS, ETC.

	YES	NO	
1. Have you a current valid pilot's license?	<input type="checkbox"/>	<input type="checkbox"/>	
Grade of class? _____ Date issued? _____			
Date last renewed? _____ Date of expiration? _____			
a. If not, do you intend to renew it?	<input type="checkbox"/>	<input type="checkbox"/>	
b. Was it issued subject to physical waiver? (Why?)	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has flying activity ended?	<input type="checkbox"/>	<input type="checkbox"/>	
a. When?			
b. Why?			
3. Have you ever been grounded or had your license revoked?	<input type="checkbox"/>	<input type="checkbox"/>	
a. When?			
b. Why?			
4. Do you serve as crew member only?	<input type="checkbox"/>	<input type="checkbox"/>	
a. What are your duties aboard aircraft?			
5. Are you, or have you been, a pilot or crew member of any military service <input type="checkbox"/>			
or National Guard <input type="checkbox"/> — active <input type="checkbox"/> , reserve <input type="checkbox"/> , or student <input type="checkbox"/> ?	<input type="checkbox"/>	<input type="checkbox"/>	
a. What branch? In what capacity?			
b. Date of last flight in military aircraft? _____			
6. Do you belong to any pilot's association, aviation club, school or other organization? (Name?)	<input type="checkbox"/>	<input type="checkbox"/>	
7. Do you own your own plane?	<input type="checkbox"/>	<input type="checkbox"/>	
a. Who maintains the plane you fly?			
8. Do you do any crop treatment work?	<input type="checkbox"/>	<input type="checkbox"/>	
Type of Plane? _____ Usual height above ground? _____			
Type of work? _____			
Type of spray, dust or other material used? _____			
a. Who maintains plane?			

9. How many total hours have you flown as pilot?

10. Type of flying, total hours flown in past 12 months, past 24 months, and estimated for next 12 months?

Type of Flying	Hours Past 12 Months	Hours Past 24 Months	Hours Est. Next 12 Months	Type of Flying	Hours Past 12 Months	Hours Past 24 Months	Hours Est. Next 12 Months
Private flying, pleasure and/or business				Inspection—pipe, power, telephone lines			
Scheduled airline				Experimental			
Nonscheduled airline				Testing			
Company-owned plane				Racing			
Instructing				Stunting			
Student				Jet			
Photography				Glider or sailplane			
Crop treatment				Helicopter			
Charter, sight-seeing, air taxi				Other (describe fully)			
Forestry, traffic control, fish and game							

I hereby declare that all the statements and answers to the above questions are complete and true, and I agree that they shall form a part of my application for insurance.

Applicant's Signature

Witness

Date

SERFF Tracking Number: SHLI-126809060

State: Arkansas

Filing Company: Shelter Life Insurance Company

State Tracking Number: 46757

Company Tracking Number: 03LI0610

TOI: L04I Individual Life - Term

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

Product Name: Questionnaires

Project Name/Number: Questionnaires/L11110

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:

Attachments:

L-953.pdf

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-18.3	Hazardous Activities Questionnaire	65.1
L-18.4	Aviation Questionnaire	65.1

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



1817 West Broadway
Columbia, Missouri 65218-0001

**INDIVIDUAL LIFE
INSURANCE APPLICATION**

Agent Name:
Agent #:
Agent Phone #:
Family #:

Personal Information

- | | | | |
|-----------------------------|----------------------------|---------|-----------------------|
| 1. Name: | Gender: | SSN: | Marital Status: |
| 2. Birth Date: | Age: | Height: | Place of Birth: |
| 3. Physical Address: | | Weight: | County: |
| 3a. Mailing Address: | | | County: |
| 4. Home Phone: | Cell Phone: | | Best Time to Contact: |
| 5. Driver's License Number: | State: | | |
| 6. Country of Citizenship: | Length of Residency in US: | | Expiration Date: |
| Visa Type: | Category: | | Date Employed: |
| 7. Occupation: | Name of Employer: | | |
| 8. Annual Earned Income: | Income All Sources: | | |

Coverage Information

- | | | |
|------------------------|-------------------|---------------------------------------|
| 9. Plan: | Face Amount: \$ | Rate Class: |
| 10. Waiver of Premium: | Accidental Death: | Amount: \$ |
| 11. Mode Premium: \$ | Mode of Premium: | Premium included with application: \$ |
| 11a. Remarks: | | |

Information for Other Involved Parties

12. Primary Beneficiary:
- Contingent Beneficiary:
- Payor:
- Owner:
- Successor Owner:

Existing Insurance Information

13. Total individual life insurance and accidental death coverage in force or pending (excluding this application):

	(Life)	(Accidental Death)
With Shelter Life:	\$	\$
With Other Companies:	\$	\$

- | | | | | |
|-----------------------------------|-------------|-------------|-------------|-------------|
| 13a. Amount of life insurance on: | Father: | Mother: | Sibling #1: | Sibling #2: |
| Sibling #3: | Sibling #4: | Sibling #5: | Sibling #6: | Sibling #7: |

- 14a. Do you have existing life insurance policies or contracts? Yes No
If yes, please send Replacement Form L-243.29 with this application.

- 14b. Will this application replace an existing policy or contract? Yes No
If yes, please send Replacement Form L-243.33 with this application.

Underwriting Information

15. Have you ever seen a doctor? Yes No

Please provide the following information for your most recent doctor consultation(s):

Hospital or clinic:	Date of last consultation:
Physician's name:	Reason for last consultation:
Street address:	Diagnosis:
City, State, Zip:	Treatment:
Phone Number:	Medication(s) prescribed:
Fax Number:	

16. Do you have a parent or sibling who has a history of diabetes, heart or kidney disease, or hypertension? Yes No
 Relationship to Insured: Explanation:

17. Do you have a parent or sibling who died before age 60? Yes No
 Relationship to Insured: Age at death:
 Explanation:

18. Have you engaged in or do you anticipate engaging in:
 a) Aviation activities, including ultralight flying, hang gliding or parachute jumping? Yes No
 b) Rodeo riding, underwater diving, racing of any motor powered vehicle or any other hazardous sport or hobby? Yes No

19. 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
 Violation Date: Description:

20. Are you planning travel, residence, or employment outside the United States? Yes No
 Travel Dates: Description:

21. Do you now use or have you ever used any form of tobacco or nicotine substitutes? Yes No
 Date last used: Details:

22. Are you in the National Guard or Reserves? Yes No
 Details:

23. Have you been charged with any misdemeanor or felony? Yes No
 Date of crime: Type of offense:
 Were you convicted? Description:

Medical Information

Questions in the Medical Information section (questions 24-41) may be left unanswered if a medical exam is required.

24. To the best of your knowledge and belief, have you ever been diagnosed or treated by a medical professional for hypertension, coronary artery disease, stroke, heart attack, chest pain, irregular heartbeat, or any other disease or disorder of the heart or blood vessels? Yes No
 Date of onset: Duration:
 Description of illness or injury, medical attention received, remaining effects, and any other details:
 Treating hospital(s) and/or physician(s):

25. To the best of your knowledge and belief, have you ever been diagnosed or treated by a medical professional for cancer, tumor or other growth or malignancy of any kind? Yes No
 Date of onset: Duration:
 Description of illness or injury, medical attention received, remaining effects, and any other details:
 Treating hospital(s) and/or physician(s):

Medical Information Continued

26. To the best of your knowledge and belief, have you ever been diagnosed or treated by a medical professional for bronchitis, emphysema, shortness of breath or any other disease or disorder of the lungs or respiratory system? Yes No
- Date of onset: _____ Duration: _____
 Description of illness or injury, medical attention received, remaining effects, and any other details:

 Treating hospital(s) and/or physician(s): _____
27. To the best of your knowledge and belief, have you ever been diagnosed or treated by a medical professional for depression, anxiety or any other behavioral, mental or nervous disorder? Yes No
- Date of onset: _____ Duration: _____
 Description of illness or injury, medical attention received, remaining effects, and any other details:

 Treating hospital(s) and/or physician(s): _____
28. To the best of your knowledge and belief, have you ever been diagnosed or treated by a medical professional for epilepsy, seizures, sleep apnea or any other disease or disorder of the brain or nervous system? Yes No
- Date of onset: _____ Duration: _____
 Description of illness or injury, medical attention received, remaining effects, and any other details:

 Treating hospital(s) and/or physician(s): _____
29. To the best of your knowledge and belief, have you ever been diagnosed or treated by a medical professional for diabetes, hepatitis, anemia or any other disease or disorder of the blood or glands? Yes No
- Date of onset: _____ Duration: _____
 Description of illness or injury, medical attention received, remaining effects, and any other details:

 Treating hospital(s) and/or physician(s): _____
30. To the best of your knowledge and belief, have you ever been diagnosed or treated by a medical professional for arthritis, gout, or any other disease or disorder of the bones, muscles, joints, eyes or skin? Yes No
- Date of onset: _____ Duration: _____
 Description of illness or injury, medical attention received, remaining effects, and any other details:

 Treating hospital(s) and/or physician(s): _____
31. To the best of your knowledge and belief, have you ever been diagnosed or treated by a medical professional for any disease or disorder of the stomach, intestines, colon, rectum, liver, pancreas or digestive system? Yes No
- Date of onset: _____ Duration: _____
 Description of illness or injury, medical attention received, remaining effects, and any other details:

 Treating hospital(s) and/or physician(s): _____
32. To the best of your knowledge and belief, have you ever been diagnosed or treated by a medical professional for any disease or disorder of the kidney, bladder, prostate, urinary system or genital organs including complication of pregnancy? Yes No
- Date of onset: _____ Duration: _____
 Description of illness or injury, medical attention received, remaining effects, and any other details:

 Treating hospital(s) and/or physician(s): _____
33. To the best of your knowledge and belief, have you ever been diagnosed or treated by a medical professional for Acquired Immune Deficiency Syndrome (AIDS), positive HIV test, or other immunological disorder? Yes No
- Date of onset: _____ Duration: _____
 Description of illness or injury, medical attention received, remaining effects, and any other details:

 Treating hospital(s) and/or physician(s): _____

Medical Information Continued

34. Are you now pregnant? Yes No
 Approximate Delivery Date:
 Description of pregnancy and any medical attention received:

 Treating hospital(s) and/or physician(s):
35. Are you currently receiving treatment, taking medication, or scheduled to have surgery? Yes No
 Date of onset: Duration:
 Description of illness or injury, medical attention received, remaining effects, and any other details:

 Treating hospital(s) and/or physician(s):
36. Have you had weight loss of more than 10 lbs. in the past year? Yes No
 Date: Number of pounds lost:
 Reason for and details of weight loss:

 Treating hospital(s) and/or physician(s):
37. Have you used or do you now use cocaine, methamphetamines, marijuana or any other drugs? Yes No
 Date last used: Length of drug use:
 Amount: Frequency:
 Drug type(s):
 Details including any remaining effects:

 Treating hospital(s) and/or physician(s):
38. Have you used or do you now use alcoholic beverages? Yes No
 Date of last drink: Frequency:
 Amount: Alcohol type(s):
 Details including any remaining effects:

 Treating hospital(s) and/or physician(s):
39. Have you sought or received treatment or counseling for alcohol or drug use? Yes No
 Date of treatment: Duration:
 Description of illness or injury, medical attention received, remaining effects, and any other details:

 Treating hospital(s) and/or physician(s):
40. Have you received or do you now receive disability benefits or do you currently have a disability of any kind? Yes No
 Date of onset: Duration:
 Description of illness or injury, medical attention received, remaining effects, and any other details:

 Treating hospital(s) and/or physician(s):
41. In the past 5 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
 Date of onset: Duration:
 Description of illness or injury, medical attention received, remaining effects, and any other details:

 Treating hospital(s) and/or physician(s):
-

Special Requests

42.

Signatures/Declaration

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.

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 _____
Month Year Time A.M. P.M. in the city of _____ State of _____

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.

Print Name of Writing Agent

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, tests 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

**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 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.

PAYMENT BY CREDIT OR DEBIT CARD - Payment will be charged to your card on the date and time of the application. 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 by company check.

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 the best of your 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

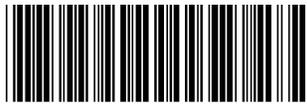
Information regarding your insurability will be treated as confidential. Shelter Life Insurance Company or its reinsurer(s) may, however, make a brief report thereon to **the MIB, Inc., formerly known as Medical Information Bureau**, a not-for-profit membership organization of insurance companies, which 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.



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.

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 question 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 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?.....

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?.....

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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give policy numbers
2. Has a Medical Examination and/or other testing been arranged? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No
4. Do you know or have any reason to believe that replacement of existing Life insurance is involved? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No (UL, PUA Only) If Yes, send appropriate form. <input type="checkbox"/> External <input type="checkbox"/> 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)? <input type="checkbox"/> YES.
7. Did you solicit this business? <input type="checkbox"/> Yes <input type="checkbox"/> No. If No, explain
8. Is any person applying for coverage related to you? <input type="checkbox"/> Yes <input type="checkbox"/> 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.

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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.

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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.