

SERFF Tracking Number: SFBL-127061170 State: Arkansas  
Filing Company: Southern Farm Bureau Life Insurance company State Tracking Number: 48140  
Company Tracking Number:  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: Supplemental Application  
Project Name/Number: /

## Filing at a Glance

Company: Southern Farm Bureau Life Insurance company

Product Name: Supplemental Application SERFF Tr Num: SFBL-127061170 State: Arkansas  
TOI: L08 Life - Other SERFF Status: Closed-Approved- State Tr Num: 48140  
Closed

Sub-TOI: L08.000 Life - Other Co Tr Num: State Status: Approved-Closed  
Filing Type: Form Reviewer(s): Linda Bird  
Author: Hart Sullivan Disposition Date: 04/20/2011  
Date Submitted: 03/02/2011 Disposition Status: Approved-Closed  
Implementation Date Requested: On Approval Implementation Date:

State Filing Description:

## General Information

Project Name: Status of Filing in Domicile: Authorized  
Project Number: Date Approved in Domicile: 02/21/2011  
Requested Filing Mode: Domicile Status Comments: Was filed via  
Interstate Compact and approval received 2-21-  
2011 in domicile state.  
Explanation for Combination/Other: Market Type: Individual  
Submission Type: New Submission Individual Market Type:  
Overall Rate Impact: Filing Status Changed: 04/20/2011  
State Status Changed: 03/09/2011  
Deemer Date: Created By: Hart Sullivan  
Submitted By: Hart Sullivan Corresponding Filing Tracking Number:  
Filing Description:  
RE: Form 01333-AR (3/10) – Supplemental Application  
Form L475-AR – Simplified Supplemental Application  
NAIC# 68896

Attached for your consideration are following applications:

Form 01333-AR (3/10) – Supplemental Application – this application will be used for policy changes and reinstatements.

Form L475-AR – Simplified Supplemental Application – this is a new application and will also be used for changes and reinstatements. It's simply a condensed version of the Supplemental Application (01333-AR (3/10) without the health

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questions and used for changes that don't require any underwriting.

## Company and Contact

### Filing Contact Information

Hart Sullivan, hsullivan@sfbli.com  
 1401 Livingston Lane 601-981-7422 [Phone] 1522 [Ext]  
 Jackson, MS 39213 601-713-3071 [FAX]

### Filing Company Information

Southern Farm Bureau Life Insurance company CoCode: 68896 State of Domicile: Mississippi  
 1401 Livingston Lane Group Code: Company Type:  
 Jackson, MS 39213 Group Name: State ID Number:  
 (601) 981-7422 ext. [Phone] FEIN Number: 64-0283583  
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## Filing Fees

Fee Required? Yes  
 Fee Amount: \$50.00  
 Retaliatory? No  
 Fee Explanation: Application Filing fees if filed separate from policy/contract.  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Southern Farm Bureau Life Insurance company	\$50.00	03/02/2011	45193330
Southern Farm Bureau Life Insurance company	\$50.00	03/07/2011	45327541

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	04/20/2011	04/20/2011
Approved-Closed	Linda Bird	03/09/2011	03/09/2011

### Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Supplemental Application	Hart Sullivan	04/19/2011	04/19/2011
Form	Supplemental Application	Hart Sullivan	03/07/2011	03/07/2011

### Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Form 01333-AR (3/11) - Replacement Question...	Note To Filer	Linda Bird	04/19/2011	04/19/2011
Form 01333-AR (3/11) - Replacement Question...	Note To Reviewer	Hart Sullivan	04/18/2011	04/18/2011
Form 01333-AR (3/10)	Note To Reviewer	Hart Sullivan	03/02/2011	03/02/2011

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## Disposition

Disposition Date: 04/20/2011

Implementation Date:

Status: Approved-Closed

Comment: Company has made correction to the Replacement Question on page 3, Section 8 of Form 01333-AR (3/11).

Rate data does NOT apply to filing.

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 Product Name: Supplemental Application  
 Project Name/Number: /

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Application		No
Supporting Document	Flesch Certification		Yes
Form (revised)	Supplemental Application		Yes
Form	Supplemental Application	Replaced	Yes
Form	Supplemental Application	Replaced	Yes
Form	Simplified Supplemental Application		Yes

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## Disposition

Disposition Date: 03/09/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Form	Supplemental Application	Replaced	Yes
Form	Simplified Supplemental Application		Yes

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**Amendment Letter**

Submitted Date: 04/19/2011

**Comments:**

Ms. Bird, I have updated the Supplemental Application to include the correct Replacement Question in Form 01333-AR (3/11) -- see pg 3, Section 8. I was originally going to attach pg 3 only to the Form Schedule tab but realized if I added it, the incorrect pg 3 would still be included; therefore, I deleted the previous version and added the entire form back to the Form Schedule. Thank you, once again, for your assistance with this matter. I appreciate your help. Please let me know if you should have any questions.

**Changed Items:**

**Form Schedule Item Changes:**

**Form Schedule Item Changes:**

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
Form 01333-AR (3/11)	Application/Enrollment Form	ESupplemental Application	Initial				50.400	1333-AR.pdf

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Product Name: Supplemental Application  
Project Name/Number: /

**Note To Filer**

**Created By:**

Linda Bird on 04/19/2011 01:33 PM

**Last Edited By:**

Linda Bird

**Submitted On:**

04/19/2011 01:33 PM

**Subject:**

Form 01333-AR (3/11) - Replacement Question...

**Comments:**

Filing has been re-opened in order for correction to be made.

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*TOI:* L08 Life - Other *Sub-TOI:* L08.000 Life - Other  
*Product Name:* Supplemental Application  
*Project Name/Number:* /

**Note To Reviewer**

**Created By:**

Hart Sullivan on 04/18/2011 11:23 AM

**Last Edited By:**

Hart Sullivan

**Submitted On:**

04/18/2011 11:23 AM

**Subject:**

Form 01333-AR (3/11) - Replacement Question...

**Comments:**

Ms. Bird, Pursuant to our telephone conversation this morning, the incorrect replacement question was included in the form submission for Form 1333-AR (3/10). Please see Page 3, Section 8 - Replacement. I respectfully request re-opening this filing to make this change. Please let me know if you should have any questions. Thank you for your assistance with this matter.

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 Product Name: Supplemental Application  
 Project Name/Number: /

**Amendment Letter**

Submitted Date: 03/07/2011

**Comments:**

Ms. Bird, Pursuant to our telephone conversation of March 2, 2011 (and as noted in the Note to Reviewer), I inadvertently attached the incorrect Form 1333-AR (3/10) to this filing. The correct Form 01333-AR (3/11) is now attached for your review and the filing fees have been updated.

Thank you for your attention to this form submission. So sorry for the inconvenience. Please let me know if questions.

**Changed Items:**

**Form Schedule Item Changes:**

**Form Schedule Item Changes:**

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
Form 01333-AR (3/11)	Application/Enrollment Form	ESupplemental Application	Initial				50.400	1333-AR.pdf

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Product Name: Supplemental Application  
Project Name/Number: /

**Note To Reviewer**

**Created By:**

Hart Sullivan on 03/02/2011 02:40 PM

**Last Edited By:**

Linda Bird

**Submitted On:**

03/09/2011 08:36 AM

**Subject:**

Form 01333-AR (3/10)

**Comments:**

Wait - Wait - Wait! So sorry to do this to you! I discovered that I've attached the wrong Form 01333 to this filing. What should I do at this point? Withdraw this form filing? or continue, delete incorrect form and attach the correct form? It will have a different form number.

Again, I apologize!

Thank you for your assistance with this matter.

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## Form Schedule

### Lead Form Number: Form 01333-AR (3/10) and Form L475-AR

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	Form 01333-AR (3/11)	Application/ Enrollment Form	Supplemental Application	Initial		50.400	1333-AR.pdf
	Form L475-AR	Application/ Enrollment Form	Simplified Supplemental Application	Initial		51.200	L475-AR.pdf

**Southern Farm Bureau Life Insurance Company**  
**[P.O. Box 78, Jackson, MS 39205]**  
 Supplemental Application

Application No.

Policy Number(s):

**1 - Proposed Insured**

Name (Last, First Middle)		Birthdate	Age	Driver's License No.	DL State	Sex <input type="checkbox"/> M <input type="checkbox"/> F	
Social Security No./Tax ID		Place of Birth: State		Height	Weight	Marital Status	
Employer		Employer Address (City, State, Zip)				Yrs. Employed	
Occupation & Specific Duties including secondary or part-time							

**2 - Owner Contact Information**

Physical Address: Number & Street, City, State, and Zip		Is this address for this policy only <input type="checkbox"/> or all policies for this client? <input type="checkbox"/>	
Mailing Address: Number & Street, City, State, and Zip (only needed if different from Physical Address)		Is this address for this policy only <input type="checkbox"/> or all policies for this client? <input type="checkbox"/>	
Home Telephone Number ( )	Work Telephone Number ( )	Convenient Place and Time to Call During the Day	
Cell Telephone Number ( )	E-Mail Address		

**3 - Spouse To Be Insured (Complete for spouse term rider.)**

Name (Last, First Middle)			Sex <input type="checkbox"/> M <input type="checkbox"/> F		Birthdate	Age
Driver's License No.	DL State	Social Security No./Tax ID	Height	Weight	Place of Birth: State	
Home Telephone Number ( )	Work Telephone Number ( )	Convenient Place and Time to Call During the Day				
Employer	Employer Address (City, State, Zip)				Yrs. Employed	
Occupation & Specific Duties including secondary or part-time						

**4 - Children To Be Insured (If children's term rider is requested, complete for each child starting with the oldest child.)**

Name of Dependent Child (Last, First Middle)	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Birthdate	Age	Social Security No./Tax ID	Hgt	Wgt	Amt. Life Ins. Now In Force
	<input type="checkbox"/> M <input type="checkbox"/> F						
	<input type="checkbox"/> M <input type="checkbox"/> F						
	<input type="checkbox"/> M <input type="checkbox"/> F						
	<input type="checkbox"/> M <input type="checkbox"/> F						

**5 - Premium Payor To Be Insured (Complete for premium insurance.)**

Name (Last, First Middle)			Sex <input type="checkbox"/> M <input type="checkbox"/> F		Driver's License No.	DL State
Social Security No./Tax ID	Height	Weight	Marital Status	Relationship to Insured	Place of Birth: State	
Home Telephone Number ( )	Work Telephone Number ( )	Convenient Place and Time to Call During the Day				
Employer	Employer Address (City, State, Zip)				Yrs. Employed	
Occupation & Specific Duties including secondary or part-time						

**6 – Action To Be Taken**

**CONVERSION** Plan: \_\_\_\_\_ Amount: \_\_\_\_\_ Automatic Conversion Class: \_\_\_\_\_

- I want to:  Retain  Delete Remaining Term
- I want to:  Retain  Delete Waiver of Premium
- I want to:  Retain  Delete Child Term Rider
- I want to:  Retain  Delete Accidental Death Benefit
- I want to:  Retain  Delete Accelerated Benefit Rider

**Consider Underwriting Class:**  Standard Tobacco  Preferred Tobacco  Standard Non-tobacco  
 Preferred Non-tobacco  Super Preferred Non-tobacco (min. \$250,000)

**Dividend Option** (If no choice is made, Additional Paid-Up insurance will be used.)

- Pay by Check  Reduce Premiums  Accumulate  Additional Paid-Up Insurance  Other \_\_\_\_\_

**Automatic Premium Loan** (If available on product)  Yes  No

**CHANGES TO BENEFITS/RIDER**

**ADD**  **DELETE BENEFIT:**  Waiver of Premium  **ADD**  **DELETE:** Accelerated Benefit Rider

**ADD**  **DELETE BENEFIT:**  Guaranteed Insurability Option \_\_\_\_\_  **ADD**  **DELETE:** Other \_\_\_\_\_

**ADD**  **DELETE RIDER:**  Base Insured Rider (Plan, Amount & Underwriting Classification):

\_\_\_\_\_

Consider Underwriting Class:  Standard Tobacco  Preferred Tobacco  Standard Non-tobacco  
 Preferred Non-tobacco  Super Preferred Non-tobacco (min. \$250,000)

**ADD**  **DELETE RIDER:**  Spouse Term Rider (Plan, Amount & Underwriting Classification):

\_\_\_\_\_

Consider Underwriting Class:  Standard Tobacco  Preferred Tobacco  Standard Non-tobacco  
 Preferred Non-tobacco  Super Preferred Non-tobacco (min. \$250,000)

**ADD**  **DELETE RIDER:**  Child Term Rider

**UL/APLIFE -- Increase/Decrease Coverage** (specify changes below):

Increase coverage to \_\_\_\_\_

Decrease coverage to \_\_\_\_\_

**Death Benefit Option Change** (UL only):  Option 1  Option 2

**REINSTATE POLICY**

**CONSIDER UNDERWRITING CLASSIFICATION CHANGES:**

**Proposed Insured:**

Standard Tobacco  Preferred Tobacco  Standard Non-tobacco  Preferred Non-tobacco  Super Preferred Non-tobacco (min. \$250,000)

**Spouse:**

Standard Tobacco  Preferred Tobacco  Standard Non-tobacco  Preferred Non-tobacco  Super Preferred Non-tobacco (min. \$250,000)

**DIVIDEND OPTION** (If no choice is made, Additional Paid-Up insurance will be used.)

- Pay by Check  Reduce Premiums  Accumulate  Additional Paid-Up Insurance  Other \_\_\_\_\_

**7 - Special Requests**

\_\_\_\_\_  
\_\_\_\_\_

**8 - Replacement**

Does the proposed insured have any existing life insurance policies or annuity contracts?  Yes  No  
 If "yes", complete Notice of Replacement Form.  
 Is this intended to be a 1035 Exchange?  Yes  No

**9 - Life Insurance Now In Force** (include applied for, pending, or awaiting reinstatement on each person proposed for insurance.)

Proposed Insured	Name of Insurance Company	Policy Number	Year Issued	Type Plan	Face Amount	Accidental Death Amount

**10 - Premium**

Send Premium Notice to:  Proposed Insured  Owner  Other \_\_\_\_\_  
 Premium With Application \$ \_\_\_\_\_ Scheduled Premium Amount \$ \_\_\_\_\_  
 Premium Method:  Annual  Semiannual  Monthly EFT  Monthly Salary Savings  Monthly PRD  Single  
 If method is monthly EFT, attach a voided check.

**Authorization Agreement for Preauthorized Payments:** I have authorized \_\_\_\_\_ Bank to honor electronic debit entries or drafts on my account by you to cover premium insuring \_\_\_\_\_. Such debit entries or drafts are to be charged to my account with said bank in the same manner as if they were personally drawn by me.  
 It is understood that such debit entry or draft shall constitute notice of premium due. Should any debit entry or draft not be paid by said bank for any reason, then it is understood that this method of premium payment shall terminate and that premiums shall be payable annually directly to the Company. It is also understood that the Company assumes no responsibility for bank charges on these draws.

Bank Name \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_  
 Transit Number \_\_\_\_\_  
 Account Number \_\_\_\_\_  
 Account Type:  Checking  Savings  
 Preferred Withdrawal Date: \_\_\_\_\_

Signature of Depositor/Premium Payor  
 (If Corporate Payor, Signature of Appropriate Corporate Officer)  
 Is this bank account being used for existing policies?  Yes  No  
 If "yes", should drafts be combined with existing policies?  Yes  No  
 List policy numbers: \_\_\_\_\_

Do you want us to change your Physical  Mailing  address as shown on voided check?  Yes  No

**11 - Family Record** (Complete history for mother, father, brothers and sisters for each person proposed for insurance.)

Relative	If Living	Age	Year	If Dead	Relative	If Living	Age	Year	If Dead
	Age			Cause of Death		Age			Cause of Death

**Proposed Insured:**

Mother					Brothers				
Father					Sisters				

**Other Insured:**

Mother					Brothers				
Father					Sisters				

**Other Insured:**

Mother					Brothers				
Father					Sisters				

## 12 - Military

Are you a member of the service (Armed Forces, Reserves, or National Guard) or have entered into a written agreement to become a member at a future date? If "yes", complete the Military questionnaire for each person proposed for insurance.  Yes  No

## 13 - Aviation

Has any person proposed for insurance ever flown or intends within the next two years to fly, other than as a fare paying passenger on a scheduled airline? If "yes", complete the Aviation questionnaire for each person proposed for insurance.  Yes  No

## 14 - Tobacco Use (Please list details for each "Yes" answer in the space provided below for each person proposed for insurance.)

Have you smoked one or more cigarettes in the last [12] months?  Yes  No

Have you used any form of tobacco in the past [12] months?  Yes  No

Have you used any form of tobacco in the past [24] months?  Yes  No

Have you ever used any form of tobacco?  Yes  No

Do you use nicotine gum, nicotine patch or other form of nicotine?  Yes  No

Give complete details for every "Yes" answer noted on the above question.

Proposed Insured	Type	Average Daily Usage	Date Last Used

## 15 - Avocation

Has any person proposed for insurance ever engaged in or intends to participate (within the next 24 months) in any of the following activities:  Yes  No

Check all that apply and complete the necessary supplemental questionnaire.

- |   |  |                                       |                                       |
|---|--|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Vehicle Racing   | <input type="checkbox"/> Parasailing         | <input type="checkbox"/> Hang Gliding | <input type="checkbox"/> Rodeo        |
| <input type="checkbox"/> Other Racing     | <input type="checkbox"/> Diving              | <input type="checkbox"/> Ballooning   | <input type="checkbox"/> Water Sports |
| <input type="checkbox"/> Skydiving        | <input type="checkbox"/> Professional Sports | <input type="checkbox"/> Climbing     | <input type="checkbox"/> Skiing       |
| <input type="checkbox"/> Big Game Hunting | <input type="checkbox"/> Surfing             | <input type="checkbox"/> Spelunking   | <input type="checkbox"/> Rocketeering |

## 16 - Other/Driving History

Do you own or ride a motorcycle? If "yes", please complete the motorcycle questionnaire.  Yes  No

Within the last five years, has any person proposed for insurance been convicted of any moving violations? If "yes", please provide details as indicated below.  Yes  No

Has any person proposed for insurance ever been convicted of Driving While Intoxicated, Driving Under the Influence, or had a Driver's License suspended or revoked? If "yes", please provide details as indicated below.  Yes  No

Proposed Insured	Date	Violation Type	Details (Speed, Length of suspension / revocation, etc.)

The following questions must be completed in all cases with respect to all persons proposed for insurance:

	Yes	No
A. In the last 7 years, have you filed, or are you in the process of filing bankruptcy?	<input type="checkbox"/>	<input type="checkbox"/>
B. Have you ever plead guilty to or been convicted of a felony or misdemeanor, or have such a charge currently pending?	<input type="checkbox"/>	<input type="checkbox"/>

Give details for "yes" answers:

## 17 - Financial Information

Net Worth (assets minus liabilities) \_\_\_\_\_ Annual Earned Income \_\_\_\_\_

Spouse: Net Worth (assets minus liabilities) \_\_\_\_\_ Annual Earned Income \_\_\_\_\_

A FINANCIAL STATEMENT (FORM 1310) MUST ALSO BE COMPLETED IF THE FACE AMOUNT OF THE APPLICATION EXCEEDS \$1,000,000, OR WHERE THE TOTAL AMOUNT OF INSURANCE WITH ALL COMPANIES, INCLUDING THIS APPLICATION, IS \$5,000,000 OR MORE.



## 19 - Agreement

We, the undersigned, state that all statements and answers in this application are complete and true, to the best of our knowledge and belief. We also agree as follows:

1. This application will include: (a) Application Questions; (b) Statement to Medical Examiner, if required by the Company's rules; and (c) Any supplements. This application, with any policy issued or reinstated as a result of this application, will form a part of the contract of insurance.
2. Any insurance **issued** by the Company as a result of this application will not be effective until: (a) A policy is delivered while the persons proposed for insurance are alive and a risk insurable; and (b) the full first premium for that policy is paid. An earlier Effective Date will apply only as specified in the conditional receipt with the same number as this application.
3. Any insurance **reinstated** by this application will not be effective until: (a) The reinstatement application is approved by the Company; and (b) all premiums and charges required for reinstatement by the terms of the insurance contract are tendered to the Company while all persons proposed for reinstatement are alive and in the same state of health as is stated on the application. The Owner agrees that if insurance is reinstated as a result of this application, any policy loan or indebtedness which existed on the date of termination shall be repaid or reinstated with interest, and shall apply to the policy when reinstated.
4. No statement made to or by, and no knowledge on the part of: (a) any agent; (b) any medical examiner; or (c) any other person; as to facts about any persons proposed for insurance shall be construed as having been made to or brought to the attention of the Company, unless stated in this application.
5. Only an Officer of the Company may make, modify, or discharge any insurance contract on its behalf. NO AGENT OR MEDICAL EXAMINER HAS THE AUTHORITY TO: (A) ACCEPT RISKS; (B) DETERMINE INSURABILITY; (C) MAKE OR MODIFY ANY CONTRACTUAL PROVISION; OR (D) WAIVE ANY OF THE COMPANY'S RIGHTS OR REQUIREMENTS.
6. The Company may amend this application by endorsement. Such an endorsement will be used to: (a) correct apparent errors or omissions; and (b) conform the application to any policy that may be issued. Any amendments will be deemed to be approved by the undersigned if and when such a policy is accepted. Any change in the plan of insurance, amount, age at issue, gender, class or benefits shall require the written consent of the owner and the proposed insured.

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.

We attest all applicants have read, or had read to them, the completed application. We realize that any false statements or misrepresentations which would affect the acceptance of the risk or hazard assumed may result in loss of coverage, subject to the Incontestability Provision of the policy.

We state that all Proposed Insureds (parent or guardian if Proposed Insured is a minor) have received and read a copy of the "Notice to Proposed Insured" regarding: (a) investigative consumer reports; (b) information which may be obtained from and released to the Medical Information Bureau; and (c) conditional receipt.

The Owner of this policy hereby certifies the following: Under Federal law, I am required to supply, and Southern Farm Bureau Life Insurance Company is required to obtain, my social security or taxpayer identification number. Penalties for failure to supply such a number include withholding a portion of interest otherwise payable to me. I hereby certify or affirm (under penalty of perjury as provided under federal law) that the social security number or taxpayer identification number I am providing is correct and I am not currently subject to backup withholding.

Dated at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_, Year \_\_\_\_\_

Witnessed:

\_\_\_\_\_  
Printed Name of Agent

\_\_\_\_\_  
Signature of Proposed Insured (not required if a minor)

\_\_\_\_\_  
Agent

\_\_\_\_\_  
Signature of Other Person Proposed for Insurance (not required if a minor)

\_\_\_\_\_  
Agent Code

\_\_\_\_\_  
Signature of Parent or Guardian if Proposed Insured is a minor

\_\_\_\_\_  
Signature of Owner if other than Proposed Insured

I, the interested party, of one or more of the policies listed on Page 1, agree to the changes as shown on this application.

Witnessed:

\_\_\_\_\_  
Printed Name of Agent

\_\_\_\_\_  
Signature of Irrevocable Beneficiary (if applicable)

\_\_\_\_\_  
Agent

\_\_\_\_\_  
Signature of Trustee (if applicable) with Title

\_\_\_\_\_  
Agent Code

\_\_\_\_\_  
Signature of Assignee (if applicable) with Title

# Southern Farm Bureau Life Insurance Company

## [P.O. Box 78, Jackson, MS 39205]

Simplified Supplemental Application

Application No. \_\_\_\_\_

Policy Number(s):
-------------------

### 1 - Insured

Name (Last, First Middle)	Birthdate	Age	Social Security No.	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Mailing Address: Number & Street, City, State, and Zip				Yrs. Lived There
Home Telephone Number (    )	Work Telephone Number (    )	Cell Telephone Number (    )	E-Mail Address	

### 2 - Owner Contact Information

Physical Address: Number & Street, City, State, and Zip	Is this address for this policy only <input type="checkbox"/> or all policies for this client? <input type="checkbox"/>	
Mailing Address: Number & Street, City, State, and Zip (only needed if different from Physical Address)	Is this address for this policy only <input type="checkbox"/> or all policies for this client? <input type="checkbox"/>	
Home Telephone Number (    )	Work Telephone Number (    )	Convenient Place and Time to Call During the Day
Cell Telephone Number (    )	E-Mail Address	

### 3 - Action To Be Taken

**CONVERSION** Plan: \_\_\_\_\_ Amount: \_\_\_\_\_ Automatic Conversion Class: \_\_\_\_\_

- |            |                                 |                                 |                           |
|------------|---------------------------------|---------------------------------|---------------------------|
| I want to: | <input type="checkbox"/> Retain | <input type="checkbox"/> Delete | Remaining Term            |
| I want to: | <input type="checkbox"/> Retain | <input type="checkbox"/> Delete | Waiver of Premium         |
| I want to: | <input type="checkbox"/> Retain | <input type="checkbox"/> Delete | Child Term Rider          |
| I want to: | <input type="checkbox"/> Retain | <input type="checkbox"/> Delete | Accidental Death Benefit  |
| I want to: | <input type="checkbox"/> Retain | <input type="checkbox"/> Delete | Accelerated Benefit Rider |

**Dividend Option** (If no choice is made, Additional Paid-Up Insurance will be used.)

- Pay by Check   
  Reduce Premiums   
  Accumulate   
  Additional Paid-Up Insurance   
  Other \_\_\_\_\_

**AUTOMATIC PREMIUM LOAN (if available on product)**     Yes     No

**CHANGES TO BENEFITS / RIDERS:**

**DELETE BENEFIT:**     Waiver of Premium     Accidental Death Benefit     Guaranteed Insurability Option     Other \_\_\_\_\_

**DELETE RIDER:**     Base Insured Rider (Specify Plan and Amount):

\_\_\_\_\_

\_\_\_\_\_

Spouse Term Rider (Specify Plan and Amount):

\_\_\_\_\_

\_\_\_\_\_

Child Term Rider

**ADD RIDER:**     Child Term Rider (No living children proposed for insurance. If children are living, use Form ICC10-1333.)

Accelerated Benefit Rider

**ADD OR REMOVE CHILDREN** (For existing Child Term Rider):

<input type="checkbox"/> Add <input type="checkbox"/> Remove	Name of Dependent Child (Last, First Middle)	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Birthdate	Age	Social Security No./Tax ID
<input type="checkbox"/> Add <input type="checkbox"/> Remove		<input type="checkbox"/> M <input type="checkbox"/> F			
<input type="checkbox"/> Add <input type="checkbox"/> Remove		<input type="checkbox"/> M <input type="checkbox"/> F			
<input type="checkbox"/> Add <input type="checkbox"/> Remove		<input type="checkbox"/> M <input type="checkbox"/> F			

**DECREASE COVERAGE (UL / AP Life):** Decrease Coverage to: \_\_\_\_\_

**CHANGES UNDER FREE LOOK PROVISION:**

- Change Plan to \_\_\_\_\_
- Decrease Face Amount to (increase in coverage requires Form ICC10-1333) \_\_\_\_\_
- Other: \_\_\_\_\_

**4 - Special Requests**

**5 - Premium**

Send Premium Notice to:  Proposed Insured  Owner  Other \_\_\_\_\_  
 Premium With Application \$ \_\_\_\_\_ Scheduled Premium Amount \$ \_\_\_\_\_  
 Premium Method:  Annual  Semiannual  Monthly EFT  Monthly Salary Savings  Monthly PRD  Single  
 If method is monthly EFT, attach a voided check.

**Authorization Agreement for Preauthorized Payments:** I have authorized \_\_\_\_\_ Bank to honor electronic debit entries or drafts on my account by you to cover premium insuring \_\_\_\_\_. Such debit entries or drafts are to be charged to my account with said bank in the same manner as if they were personally drawn by me.

It is understood that such debit entry or draft shall constitute notice of premium due. Should any debit entry or draft not be paid by said bank for any reason, then it is understood that this method of premium payment shall terminate and that premiums shall be payable annually directly to the Company. It is also understood that the Company assumes no responsibility for bank charges on these draws.

Bank Name \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_  
 Transit Number \_\_\_\_\_  
 Account Number \_\_\_\_\_  
 Account Type:  Checking  Savings  
 Preferred Withdrawal Date: \_\_\_\_\_

Signature of Depositor/Premium Payor  
 (If Corporate Payor, Signature of Appropriate Corporate Officer)  
 Is this bank account being used for existing policies?  Yes  No  
 If yes, should drafts be combined with existing policies?  Yes  No  
 List policy numbers: \_\_\_\_\_

Do you want us to change your Physical  Mailing  address as shown on voided check?  Yes  No

## 6 - Agreement

We, the undersigned, state that all statements and answers in this application are complete and true, to the best of our knowledge and belief. We also agree as follows:

1. This application will include: (a) Application Questions; and (b) Any supplements. This application, with any policy issued as a result of this application, will form a part of the contract of insurance.
2. To the extent that this application requests conversion of any existing insurance and/or requests deletion of any existing insurance, these policy changes shall be effective as of the date of conversion.
3. No statement made to or by, and no knowledge on the part of: (a) any agent; (b) any medical examiner; or (c) any other person; as to facts about any persons proposed for insurance shall be construed as having been made to or brought to the attention of the Company, unless stated in this application.
4. Only an Officer of the Company may make, modify, or discharge any insurance contract on its behalf. NO AGENT HAS THE AUTHORITY TO: (A) ACCEPT RISKS; (B) DETERMINE INSURABILITY; (C) MAKE OR MODIFY ANY CONTRACTUAL PROVISION; OR (D) WAIVE ANY OF THE COMPANY'S RIGHTS OR REQUIREMENTS.
5. The Company may amend this application by endorsement. Such an endorsement will be used to: (a) correct apparent errors or omissions; and (b) conform the application to any policy that may be issued. Any amendments will be deemed to be approved by the undersigned if and when such a policy is accepted. Any change in the plan of insurance, amount, age at issue, gender, class or benefits shall require the written consent of the owner and the proposed insured.

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.

We attest all applicants have read, or had read to them, the completed application. We realize that any false statements or misrepresentations which would affect the acceptance of the risk or hazard assumed may result in loss of coverage, subject to the Incontestability Provision of the policy.

The Owner of this policy hereby certifies the following: Under Federal law, I am required to supply, and Southern Farm Bureau Life Insurance Company is required to obtain, my social security or taxpayer identification number. Penalties for failure to supply such a number include withholding a portion of interest otherwise payable to me. I hereby certify or affirm (under penalty of perjury as provided under federal law) that the social security number or taxpayer identification number I am providing is correct and I am not currently subject to backup withholding.

Dated at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_, Year \_\_\_\_\_

Witnessed:

\_\_\_\_\_  
Printed Name of Agent

\_\_\_\_\_  
Signature of Proposed Insured (not required if a minor)

\_\_\_\_\_  
Agent

\_\_\_\_\_  
Signature of Other Person Proposed for Insurance (not required if a minor)

\_\_\_\_\_  
Agent Code

\_\_\_\_\_  
Signature of Parent or Guardian if Proposed Insured is a minor

\_\_\_\_\_  
Signature of Owner if other than Proposed Insured

I, the interested party, of one or more of the policies listed on Page 1, agree to the changes as shown on this application.

Witnessed:

\_\_\_\_\_  
Printed Name of Agent

\_\_\_\_\_  
Signature of Irrevocable Beneficiary (if applicable)

\_\_\_\_\_  
Agent

\_\_\_\_\_  
Signature of Trustee (if applicable) with Title

\_\_\_\_\_  
Agent Code

\_\_\_\_\_  
Signature of Assignee (if applicable) with Title

SERFF Tracking Number: SFBL-127061170 State: Arkansas  
Filing Company: Southern Farm Bureau Life Insurance company State Tracking Number: 48140  
Company Tracking Number:  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: Supplemental Application  
Project Name/Number: /

## Supporting Document Schedules

**Item Status:**

**Status**

**Date:**

**Satisfied - Item:** Flesch Certification

**Comments:**

Rule and Regulation 19 is not applicable as it is an application being submitted for review.

Rule and Regulation 49 is not applicable as it is an application being submitted for review.

Attached is a flesch certification for these applications.

Bulletin 11-88 is not applicable as it is an application being submitted.



**Southern Farm Bureau Life Insurance Company**  
**[P.O. Box 78, Jackson, MS 39205]**  
 Supplemental Application

Application No.

Policy Number(s):

**1 - Proposed Insured**

Name (Last, First Middle)		Birthdate	Age	Driver's License No.	DL State	Sex <input type="checkbox"/> M <input type="checkbox"/> F	
Social Security No./Tax ID		Place of Birth: State		Height	Weight	Marital Status	
Employer		Employer Address (City, State, Zip)				Yrs. Employed	
Occupation & Specific Duties including secondary or part-time							

**2 - Owner Contact Information**

Physical Address: Number & Street, City, State, and Zip		Is this address for this policy only <input type="checkbox"/> or all policies for this client? <input type="checkbox"/>	
Mailing Address: Number & Street, City, State, and Zip (only needed if different from Physical Address)		Is this address for this policy only <input type="checkbox"/> or all policies for this client? <input type="checkbox"/>	
Home Telephone Number ( )	Work Telephone Number ( )	Convenient Place and Time to Call During the Day	
Cell Telephone Number ( )	E-Mail Address		

**3 - Spouse To Be Insured (Complete for spouse term rider.)**

Name (Last, First Middle)			Sex <input type="checkbox"/> M <input type="checkbox"/> F		Birthdate	Age
Driver's License No.	DL State	Social Security No./Tax ID	Height	Weight	Place of Birth: State	
Home Telephone Number ( )	Work Telephone Number ( )	Convenient Place and Time to Call During the Day				
Employer	Employer Address (City, State, Zip)				Yrs. Employed	
Occupation & Specific Duties including secondary or part-time						

**4 - Children To Be Insured (If children's term rider is requested, complete for each child starting with the oldest child.)**

Name of Dependent Child (Last, First Middle)	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Birthdate	Age	Social Security No./Tax ID	Hgt	Wgt	Amt. Life Ins. Now In Force
	<input type="checkbox"/> M <input type="checkbox"/> F						
	<input type="checkbox"/> M <input type="checkbox"/> F						
	<input type="checkbox"/> M <input type="checkbox"/> F						
	<input type="checkbox"/> M <input type="checkbox"/> F						

**5 - Premium Payor To Be Insured (Complete for premium insurance.)**

Name (Last, First Middle)			Sex <input type="checkbox"/> M <input type="checkbox"/> F		Driver's License No.	DL State
Social Security No./Tax ID	Height	Weight	Marital Status	Relationship to Insured	Place of Birth: State	
Home Telephone Number ( )	Work Telephone Number ( )	Convenient Place and Time to Call During the Day				
Employer	Employer Address (City, State, Zip)				Yrs. Employed	
Occupation & Specific Duties including secondary or part-time						

**6 – Action To Be Taken**

**CONVERSION** Plan: \_\_\_\_\_ Amount: \_\_\_\_\_ Automatic Conversion Class: \_\_\_\_\_

- I want to:  Retain  Delete Remaining Term
- I want to:  Retain  Delete Waiver of Premium
- I want to:  Retain  Delete Child Term Rider
- I want to:  Retain  Delete Accidental Death Benefit
- I want to:  Retain  Delete Accelerated Benefit Rider

**Consider Underwriting Class:**  Standard Tobacco  Preferred Tobacco  Standard Non-tobacco  
 Preferred Non-tobacco  Super Preferred Non-tobacco (min. \$250,000)

**Dividend Option** (If no choice is made, Additional Paid-Up insurance will be used.)

Pay by Check  Reduce Premiums  Accumulate  Additional Paid-Up Insurance  Other \_\_\_\_\_

**Automatic Premium Loan** (If available on product)  Yes  No

**CHANGES TO BENEFITS/RIDER**

**ADD**  **DELETE BENEFIT:**  Waiver of Premium  **ADD**  **DELETE:** Accelerated Benefit Rider

**ADD**  **DELETE BENEFIT:**  Guaranteed Insurability Option \_\_\_\_\_  **ADD**  **DELETE:** Other \_\_\_\_\_

**ADD**  **DELETE RIDER:**  Base Insured Rider (Plan, Amount & Underwriting Classification):  
\_\_\_\_\_  
\_\_\_\_\_

Consider Underwriting Class:  Standard Tobacco  Preferred Tobacco  Standard Non-tobacco  
 Preferred Non-tobacco  Super Preferred Non-tobacco (min. \$250,000)

**ADD**  **DELETE RIDER:**  Spouse Term Rider (Plan, Amount & Underwriting Classification):  
\_\_\_\_\_  
\_\_\_\_\_

Consider Underwriting Class:  Standard Tobacco  Preferred Tobacco  Standard Non-tobacco  
 Preferred Non-tobacco  Super Preferred Non-tobacco (min. \$250,000)

**ADD**  **DELETE RIDER:**  Child Term Rider

**UL/APLIFE -- Increase/Decrease Coverage** (specify changes below):

Increase coverage to \_\_\_\_\_

Decrease coverage to \_\_\_\_\_

**Death Benefit Option Change** (UL only):  Option 1  Option 2

**REINSTATE POLICY**

**CONSIDER UNDERWRITING CLASSIFICATION CHANGES:**

**Proposed Insured:**

Standard Tobacco  Preferred Tobacco  Standard Non-tobacco  Preferred Non-tobacco  Super Preferred Non-tobacco (min. \$250,000)

**Spouse:**

Standard Tobacco  Preferred Tobacco  Standard Non-tobacco  Preferred Non-tobacco  Super Preferred Non-tobacco (min. \$250,000)

**DIVIDEND OPTION** (If no choice is made, Additional Paid-Up insurance will be used.)

Pay by Check  Reduce Premiums  Accumulate  Additional Paid-Up Insurance  Other \_\_\_\_\_

**7 - Special Requests**

\_\_\_\_\_  
\_\_\_\_\_

**8 - Replacement**

1. Based on the answers to the following questions, complete the Notice of Replacement Form as required by state regulation.
- 1a. Does proposed insured(s) have existing life insurance or annuity contracts?  Yes  No
- 1b. Is the insurance applied for intended to replace or change any life insurance or annuity contract in force?  Yes  No
2. Is this intended to be a 1035 Exchange?  Yes  No

**9 - Life Insurance Now In Force** (include applied for, pending, or awaiting reinstatement on each person proposed for insurance.)

Proposed Insured	Name of Insurance Company	Policy Number	Year Issued	Type Plan	Face Amount	Accidental Death Amount

**10 - Premium**

Send Premium Notice to:  Proposed Insured  Owner  Other \_\_\_\_\_

Premium With Application \$ \_\_\_\_\_ Scheduled Premium Amount \$ \_\_\_\_\_

Premium Method:  Annual  Semiannual  Monthly EFT  Monthly Salary Savings  Monthly PRD  Single

If method is monthly EFT, attach a voided check.

**Authorization Agreement for Preauthorized Payments:** I have authorized \_\_\_\_\_ Bank to honor electronic debit entries or drafts on my account by you to cover premium insuring \_\_\_\_\_. Such debit entries or drafts are to be charged to my account with said bank in the same manner as if they were personally drawn by me.

It is understood that such debit entry or draft shall constitute notice of premium due. Should any debit entry or draft not be paid by said bank for any reason, then it is understood that this method of premium payment shall terminate and that premiums shall be payable annually directly to the Company. It is also understood that the Company assumes no responsibility for bank charges on these draws.

Bank Name \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Transit Number \_\_\_\_\_

Account Number \_\_\_\_\_

Account Type:  Checking  Savings

Preferred Withdrawal Date: \_\_\_\_\_

Signature of Depositor/Premium Payor  
(If Corporate Payor, Signature of Appropriate Corporate Officer)

Is this bank account being used for existing policies?  Yes  No

If "yes", should drafts be combined with existing policies?  Yes  No

Do you want us to change your Physical  Mailing  address as shown on voided check?  Yes  No

**11 - Family Record** (Complete history for mother, father, brothers and sisters for each person proposed for insurance.)

Relative	If Living	Age	Age	Year	If Dead	Relative	If Living	Age	Age	Year	If Dead
					Cause of Death						Cause of Death
<b>Proposed Insured:</b>											
Mother						Brothers					
Father						Sisters					
<b>Other Insured:</b>											
Mother						Brothers					
Father						Sisters					
<b>Other Insured:</b>											
Mother						Brothers					
Father						Sisters					

**12 - Military**

Are you a member of the service (Armed Forces, Reserves, or National Guard) or have entered into a written agreement to become a member at a future date? If "yes", complete the Military questionnaire for each person proposed for insurance.  Yes  No

**13 - Aviation**

Has any person proposed for insurance ever flown or intends within the next two years to fly, other than as a fare paying passenger on a scheduled airline? If "yes", complete the Aviation questionnaire for each person proposed for insurance.  Yes  No

**14 - Tobacco Use** (Please list details for each "Yes" answer in the space provided below for each person proposed for insurance.)

- Have you smoked one or more cigarettes in the last [12] months?  Yes  No
- Have you used any form of tobacco in the past [12] months?  Yes  No
- Have you used any form of tobacco in the past [24] months?  Yes  No
- Have you ever used any form of tobacco?  Yes  No
- Do you use nicotine gum, nicotine patch or other form of nicotine?  Yes  No

Give complete details for every "Yes" answer noted on the above question.

Proposed Insured	Type	Average Daily Usage	Date Last Used

**15 - Avocation**

Has any person proposed for insurance ever engaged in or intends to participate (within the next 24 months) in any of the following activities:  Yes  No

Check all that apply and complete the necessary supplemental questionnaire.

- Vehicle Racing  Parasailing  Hang Gliding  Rodeo
- Other Racing  Diving  Ballooning  Water Sports
- Skydiving  Professional Sports  Climbing  Skiing
- Big Game Hunting  Surfing  Spelunking  Rocketeering

**16 - Other/Driving History**

Do you own or ride a motorcycle? If "yes", please complete the motorcycle questionnaire.  Yes  No

Within the last five years, has any person proposed for insurance been convicted of any moving violations? If "yes", please provide details as indicated below.  Yes  No

Has any person proposed for insurance ever been convicted of Driving While Intoxicated, Driving Under the Influence, or had a Driver's License suspended or revoked? If "yes", please provide details as indicated below.  Yes  No

Proposed Insured	Date	Violation Type	Details (Speed, Length of suspension / revocation, etc.)

The following questions must be completed in all cases with respect to all persons proposed for insurance:	Yes	No
A. In the last 7 years, have you filed, or are you in the process of filing bankruptcy?	<input type="checkbox"/>	<input type="checkbox"/>
B. Have you ever plead guilty to or been convicted of a felony or misdemeanor, or have such a charge currently pending?	<input type="checkbox"/>	<input type="checkbox"/>

Give details for "yes" answers:

**17 - Financial Information**

Net Worth (assets minus liabilities) \_\_\_\_\_ Annual Earned Income \_\_\_\_\_

Spouse: Net Worth (assets minus liabilities) \_\_\_\_\_ Annual Earned Income \_\_\_\_\_

A FINANCIAL STATEMENT (FORM 1310) MUST ALSO BE COMPLETED IF THE FACE AMOUNT OF THE APPLICATION EXCEEDS \$1,000,000, OR WHERE THE TOTAL AMOUNT OF INSURANCE WITH ALL COMPANIES, INCLUDING THIS APPLICATION, IS \$5,000,000 OR MORE.



**19 - Agreement**

We, the undersigned, state that all statements and answers in this application are complete and true, to the best of our knowledge and belief. We also agree as follows:

1. This application will include: (a) Application Questions; (b) Statement to Medical Examiner, if required by the Company's rules; and (c) Any supplements. This application, with any policy issued or reinstated as a result of this application, will form a part of the contract of insurance.
2. Any insurance **issued** by the Company as a result of this application will not be effective until: (a) A policy is delivered while the persons proposed for insurance are alive and a risk insurable; and (b) the full first premium for that policy is paid. An earlier Effective Date will apply only as specified in the conditional receipt with the same number as this application.
3. Any insurance **reinstated** by this application will not be effective until: (a) The reinstatement application is approved by the Company; and (b) all premiums and charges required for reinstatement by the terms of the insurance contract are tendered to the Company while all persons proposed for reinstatement are alive and in the same state of health as is stated on the application. The Owner agrees that if insurance is reinstated as a result of this application, any policy loan or indebtedness which existed on the date of termination shall be repaid or reinstated with interest, and shall apply to the policy when reinstated.
4. No statement made to or by, and no knowledge on the part of: (a) any agent; (b) any medical examiner; or (c) any other person; as to facts about any persons proposed for insurance shall be construed as having been made to or brought to the attention of the Company, unless stated in this application.
5. Only an Officer of the Company may make, modify, or discharge any insurance contract on its behalf. NO AGENT OR MEDICAL EXAMINER HAS THE AUTHORITY TO: (A) ACCEPT RISKS; (B) DETERMINE INSURABILITY; (C) MAKE OR MODIFY ANY CONTRACTUAL PROVISION; OR (D) WAIVE ANY OF THE COMPANY'S RIGHTS OR REQUIREMENTS.
6. The Company may amend this application by endorsement. Such an endorsement will be used to: (a) correct apparent errors or omissions; and (b) conform the application to any policy that may be issued. Any amendments will be deemed to be approved by the undersigned if and when such a policy is accepted. Any change in the plan of insurance, amount, age at issue, gender, class or benefits shall require the written consent of the owner and the proposed insured.

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.

We attest all applicants have read, or had read to them, the completed application. We realize that any false statements or misrepresentations which would affect the acceptance of the risk or hazard assumed may result in loss of coverage, subject to the Incontestability Provision of the policy.

We state that all Proposed Insureds (parent or guardian if Proposed Insured is a minor) have received and read a copy of the "Notice to Proposed Insured" regarding: (a) investigative consumer reports; (b) information which may be obtained from and released to the Medical Information Bureau; and (c) conditional receipt.

The Owner of this policy hereby certifies the following: Under Federal law, I am required to supply, and Southern Farm Bureau Life Insurance Company is required to obtain, my social security or taxpayer identification number. Penalties for failure to supply such a number include withholding a portion of interest otherwise payable to me. I hereby certify or affirm (under penalty of perjury as provided under federal law) that the social security number or taxpayer identification number I am providing is correct and I am not currently subject to backup withholding.

Dated at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_, Year \_\_\_\_\_

Witnessed:

\_\_\_\_\_  
Printed Name of Agent

\_\_\_\_\_  
Signature of Proposed Insured (not required if a minor)

\_\_\_\_\_  
Agent

\_\_\_\_\_  
Signature of Other Person Proposed for Insurance (not required if a minor)

\_\_\_\_\_  
Agent Code

\_\_\_\_\_  
Signature of Parent or Guardian if Proposed Insured is a minor

\_\_\_\_\_  
Signature of Owner if other than Proposed Insured

I, the interested party, of one or more of the policies listed on Page 1, agree to the changes as shown on this application.

Witnessed:

\_\_\_\_\_  
Printed Name of Agent

\_\_\_\_\_  
Signature of Irrevocable Beneficiary (if applicable)

\_\_\_\_\_  
Agent

\_\_\_\_\_  
Signature of Trustee (if applicable) with Title

\_\_\_\_\_  
Agent Code

\_\_\_\_\_  
Signature of Assignee (if applicable) with Title

# Supplemental Application

Application No. \_\_\_\_\_

Policy Number(s): \_\_\_\_\_

## 1 - Proposed Insured

Name (Last, First Middle)				Birthdate	Age	Driver's License No.	DL State	Sex <input type="checkbox"/> M <input type="checkbox"/> F	
Social Security No./Tax ID		Place of Birth: State		Height	Weight	Marital Status			
Mailing Address: Number & Street, City, State, and Zip								Yrs. Lived There	
Home Telephone Number ( )		Work Telephone Number ( )		Convenient Place and Time to Call During the Day					
Cell Telephone Number ( )		E-Mail Address							
Employer			Employer Address (City, State, Zip)					Yrs. Employed	
Occupation & Specific Duties including secondary or part-time									

## 2 - Spouse To Be Insured (Complete for spouse term rider.)

Name (Last, First Middle)				Sex <input type="checkbox"/> M <input type="checkbox"/> F		Birthdate	Age
Driver's License No.	DL State	Social Security No./Tax ID	Height	Weight	Place of Birth: State		
Home Telephone Number ( )		Work Telephone Number ( )		Convenient Place and Time to Call During the Day			
Employer			Employer Address (City, State, Zip)				Yrs. Employed
Occupation & Specific Duties including secondary or part-time							

## 3 - Children To Be Insured (If children's term rider is requested, complete for each child starting with the oldest child.)

Name of Dependent Child (Last, First Middle)	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Birthdate	Age	Social Security No./Tax ID	Hgt	Wgt	Amt. Life Ins. Now In Force
	<input type="checkbox"/> M <input type="checkbox"/> F						
	<input type="checkbox"/> M <input type="checkbox"/> F						
	<input type="checkbox"/> M <input type="checkbox"/> F						
	<input type="checkbox"/> M <input type="checkbox"/> F						

## 4 - Premium Payor To Be Insured (Complete for premium insurance.)

Name (Last, First Middle)				Sex <input type="checkbox"/> M <input type="checkbox"/> F		Driver's License No.	DL State
Social Security No./Tax ID		Height	Weight	Marital Status	Relationship to Insured	Place of Birth: State	
Home Telephone Number ( )		Work Telephone Number ( )		Convenient Place and Time to Call During the Day			
Employer			Employer Address (City, State, Zip)				Yrs. Employed
Occupation & Specific Duties including secondary or part-time							

**5 – Action To Be Taken**

**CONVERSION** Plan: \_\_\_\_\_ Amount: \_\_\_\_\_ Automatic Conversion Class: \_\_\_\_\_

- I want to:  Retain  Delete Remaining Term
- I want to:  Retain  Delete Waiver of Premium
- I want to:  Retain  Delete Child Term Rider
- I want to:  Retain  Delete Accidental Death Benefit
- I want to:  Retain  Delete Accelerated Benefit Rider

**Consider Underwriting Class:**  Standard Tobacco  Preferred Tobacco  Standard Non-tobacco  
 Preferred Non-tobacco  Super Preferred Non-tobacco (min. \$250,000)

**Dividend Option** (If no choice is made, option 4 will be used.)

Pay by Check (1)  Reduce Premiums (2)  Accumulate (3)  Additional Paid-Up Insurance (4)  Other \_\_\_\_\_

**CHANGES TO BENEFITS/RIDER**

- ADD**  **DELETE BENEFIT:**  Waiver of Premium  **ADD**  **DELETE:** Accelerated Benefit Rider
- ADD**  **DELETE BENEFIT:**  Guaranteed Insurability Option \_\_\_\_\_  **ADD**  **DELETE:** Other \_\_\_\_\_
- ADD**  **DELETE RIDER:**  Base Insured Rider (Plan, Amount & Underwriting Classification):  
\_\_\_\_\_

Consider Underwriting Class:  Standard Tobacco  Preferred Tobacco  Standard Non-tobacco  
 Preferred Non-tobacco  Super Preferred Non-tobacco (min. \$250,000)

- ADD**  **DELETE RIDER:**  Spouse Term Rider (Plan, Amount & Underwriting Classification):  
\_\_\_\_\_

Consider Underwriting Class:  Standard Tobacco  Preferred Tobacco  Standard Non-tobacco  
 Preferred Non-tobacco  Super Preferred Non-tobacco (min. \$250,000)

- ADD**  **DELETE RIDER:**  Child Term Rider

**UL/APLIFE -- Increase/Decrease Coverage** (specify changes below):

- Increase coverage to \_\_\_\_\_
- Decrease coverage to \_\_\_\_\_

**Death Benefit Option Change** (UL only):  Option 1  Option 2

**REINSTATE POLICY**

**CONSIDER UNDERWRITING CLASSIFICATION CHANGES:**

**Proposed Insured:**

Standard Tobacco  Preferred Tobacco  Standard Non-tobacco  Preferred Non-tobacco  Super Preferred Non-tobacco (min. \$250,000)

**Spouse:**

Standard Tobacco  Preferred Tobacco  Standard Non-tobacco  Preferred Non-tobacco  Super Preferred Non-tobacco (min. \$250,000)

**DIVIDEND OPTION** (If no choice is made, option 4 will be used.)

Pay by Check (1)  Reduce Premiums (2)  Accumulate (3)  Additional Paid-Up Insurance (4)  Other \_\_\_\_\_

Automatic Premium Loan (If available on product)  Yes  No

**6 - Special Requests**

\_\_\_\_\_  
\_\_\_\_\_

**7 - Replacement**

Does the proposed insured have any existing life insurance policies or annuity contracts?  Yes  No  
 If "yes", complete Notice of Replacement Form.  
 Is this intended to be a 1035 Exchange?  Yes  No

**8 - Life Insurance Now In Force** (include applied for, pending, or awaiting reinstatement on each proposed insured.)

Proposed Insured	Name of Insurance Company	Policy Number	Year Issued	Type Plan	Face Amount	Accidental Death Amount

**9 - Premium**

Send Premium Notice to:  Proposed Insured  Owner  Other \_\_\_\_\_

Premium With Application \$ \_\_\_\_\_

Premium Method:  Annual  Semiannual  Monthly EFT  Monthly Salary Savings  Monthly PRD  Single  
 If method is monthly EFT, attach a voided check.

**Authorization Agreement for Preauthorized Payments:** I have authorized \_\_\_\_\_ Bank to honor electronic debit entries or drafts on my account by you to cover premium insuring \_\_\_\_\_. Such debit entries or drafts are to be charged to my account with said bank in the same manner as if they were personally drawn by me.

It is understood that such debit entry or draft shall constitute notice of premium due. Should any debit entry or draft not be paid by said bank for any reason, then it is understood that this method of premium payment shall terminate and that premiums shall be payable annually directly to the Company. It is also understood that the Company assumes no responsibility for bank charges on these draws.

Bank Name \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Transit Number \_\_\_\_\_

Account Number \_\_\_\_\_

Account Type:  Checking  Savings

Preferred Withdrawal Date: \_\_\_\_\_

Signature of Depositor/Premium Payor  
 (If Corporate Payor, Signature of Appropriate Corporate Officer)

Is this bank account being used for existing policies?  Yes  No

If yes, should drafts be combined with existing policies?  Yes  No

List policy numbers: \_\_\_\_\_

Do you want us to change your address as shown on voided check?  Yes  No

**10 - Family Record** (Complete history for each proposed insured's mother, father, brothers and sisters.)

Relative	If Living		Age	Year	If Dead Cause of Death	Relative	If Living		Age	Year	If Dead Cause of Death
	Age	Health					Age	Health			

**Proposed Insured:**

Mother						Brothers					
Father						Sisters					

**Other Insured:**

Mother						Brothers					
Father						Sisters					

**Other Insured:**

Mother						Brothers					
Father						Sisters					

**11 - Military**

Do you have any present membership, or have you contemplated membership, in the Armed Forces, Reserves, or National Guard? If yes, complete the Military questionnaire.  Yes  No

**12 - Aviation**

Has any proposed insured ever flown or does any proposed insured plan to fly in the next 24 months as a pilot, crew member, student, or in any capacity other than as a fare paying passenger? If yes, complete the Aviation questionnaire.  Yes  No

**13 - Tobacco Use** (Please list details for each "Yes" answer in the space provided below for each proposed insured.)

- Have you smoked one or more cigarettes in the last 12 months?  Yes  No
- Have you used any form of tobacco in the past 12 months?  Yes  No
- Have you used any form of tobacco in the past 24 months?  Yes  No
- Have you ever used any form of tobacco?  Yes  No
- Do you use nicotine gum, nicotine patch or other form of nicotine?  Yes  No

Give complete details for every Yes answer noted on the above question.

Proposed Insured	Type	Average Daily Usage	Date Last Used

**14 - Avocation**

Has any proposed insured ever participated in or have plans to participate in (within the next 12 months) any of the following or similar activities:  Yes  No

Check all that apply and complete the necessary supplemental questionnaire.

- Vehicle Racing       Parasailing       Hang Gliding       Rodeo
- Skydiving       Scuba Diving       Ballooning       Other \_\_\_\_\_

**15 - Other/Driving History**

Do you own or ride a motorcycle? If yes, please complete the motorcycle questionnaire.  Yes  No

Within the last three years, has any Proposed Insured been convicted of two or more moving violations? If yes, please provide details as indicated below.  Yes  No

Within the last ten years, has any Proposed Insured been convicted of Driving While Intoxicated, Driving Under the Influence, or reckless driving, or had a Driver's License suspended or revoked? If yes, please provide details as indicated below.  Yes  No

Proposed Insured	Date	Violation Type	Details (Speed, Length of suspension / revocation, etc.)

The following questions must be completed in all cases with respect to all persons proposed for insurance: Yes No

- A. In the last 7 years, have you filed or are you currently contemplating filing bankruptcy?  Yes  No
- B. Have you ever been convicted of or arrested for a felony?  Yes  No

Give details for yes answers:

**16 - Financial Information**

Net Worth (assets minus liabilities) \_\_\_\_\_ Annual Earned Income \_\_\_\_\_

Spouse: Net Worth (assets minus liabilities) \_\_\_\_\_ Annual Earned Income \_\_\_\_\_

A FINANCIAL STATEMENT (FORM 1310) MUST ALSO BE COMPLETED IF THE FACE AMOUNT OF THE APPLICATION EXCEEDS \$1,000,000, OR WHERE THE TOTAL AMOUNT OF INSURANCE WITH ALL COMPANIES, INCLUDING THIS APPLICATION, IS \$5,000,000 OR MORE.



**18 - Agreement**

We, the undersigned, state that all statements and answers in this application are complete and true, to the best of our knowledge and belief. We also agree as follows:

1. This application will include: (a) Application Questions; (b) Statement to Medical Examiner, if required by the Company's rules; and (c) Any supplements. This application, with any policy issued or reinstated as a result of this application, will form a part of the contract of insurance.
2. Any insurance **issued** by the Company as a result of this application will not be effective until: (a) A policy is delivered while the persons proposed for insurance are alive and a risk insurable; and (b) the full first premium for that policy is paid. An earlier Effective Date will apply only as specified in the conditional receipt with the same number as this application.
3. Any insurance **reinstated** by this application will not be effective until: (a) The reinstatement application is approved by the Company; and (b) all premiums and charges required for reinstatement by the terms of the insurance contract are tendered to the Company while all persons proposed for reinstatement are alive and in the same state of health as is stated on the application. The Owner agrees that if insurance is reinstated as a result of this application, any policy loan or indebtedness which existed on the date of termination shall be repaid or reinstated with interest, and shall apply to the policy when reinstated.
4. No statement made to or by, and no knowledge on the part of: (a) any agent; (b) any medical examiner; or (c) any other person; as to facts about any persons proposed for insurance shall be construed as having been made to or brought to the attention of the Company, unless stated in this application.
5. Only an Officer of the Company may make, modify, or discharge any insurance contract on its behalf. NO AGENT OR MEDICAL EXAMINER HAS THE AUTHORITY TO: (A) ACCEPT RISKS; (B) DETERMINE INSURABILITY; (C) MAKE OR MODIFY ANY CONTRACTUAL PROVISION; OR (D) WAIVE ANY OF THE COMPANY'S RIGHTS OR REQUIREMENTS.
6. The Company may amend this application by endorsement. Such an endorsement will be used to: (a) correct apparent errors or omissions; and (b) conform the application to any policy that may be issued. Any amendments will be deemed to be approved by the undersigned if and when such a policy is accepted. Where required by law or insurance department regulation, changes in the following will need the written consent of the Proposed Insured: (a) the plan or amount of insurance; (b) the premium; (c) the risk class; or (d) the benefits.

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.

We attest all applicants have read, or had read to them, the completed application. We realize that any false statements or misrepresentations which would affect the acceptance of the risk or hazard assumed may result in loss of coverage, subject to the Incontestability Provision of the policy.

We state that all Proposed Insureds (parent or guardian if Proposed Insured is a minor) have received and read a copy of the "Notice to Proposed Insured" regarding: (a) investigative consumer reports; (b) information which may be obtained from and released to the Medical Information Bureau; and (c) conditional receipt.

The Owner of this policy hereby certifies the following: Under Federal law, I am required to supply, and Southern Farm Bureau Life Insurance Company is required to obtain, my social security or taxpayer identification number. Penalties for failure to supply such a number include withholding a portion of interest otherwise payable to me. I hereby certify or affirm (under penalty of perjury as provided under federal law) that the social security number or taxpayer identification number I am providing is correct and I am not currently subject to backup withholding.

Dated at \_\_\_\_\_ this \_\_\_\_ day of \_\_\_\_\_, Year \_\_\_\_\_

Witnessed:

\_\_\_\_\_  
Signature of Proposed Insured (not required if a minor)

\_\_\_\_\_  
Agent

\_\_\_\_\_  
Signature of Other Person Proposed for Insurance (not required if a minor)

\_\_\_\_\_  
Signature of Owner if other than Proposed Insured

\_\_\_\_\_  
Signature of Parent or Guardian if Proposed Insured is a minor

I, the interested party, of one or more of the policies listed on Page 1, agree to the changes as shown on this application.

\_\_\_\_\_  
Agent

\_\_\_\_\_  
Signature of Irrevocable Beneficiary (if applicable)

\_\_\_\_\_  
Signature of Assignee (if applicable) with Title

\_\_\_\_\_  
Signature of Trustee (if applicable) with Title