

SERFF Tracking Number: SHLI-127929386 State: Arkansas
 Filing Company: Shelter Life Insurance Company State Tracking Number: 50568
 Company Tracking Number: 03L10711
 TOI: L04I Individual Life - Term Sub-TOI: L04I.203 Specified Age or Duration - Single Premium - Single Life
 Product Name: Junior Special Conversion Application
 Project Name/Number: JS Conv App/L10410

Filing at a Glance

Company: Shelter Life Insurance Company
 Product Name: Junior Special Conversion Application SERFF Tr Num: SHLI-127929386 State: Arkansas
 TOI: L04I Individual Life - Term SERFF Status: Closed-Approved-Closed State Tr Num: 50568
 Sub-TOI: L04I.203 Specified Age or Duration - Single Premium - Single Life Co Tr Num: 03L10711 State Status: Approved-Closed
 Filing Type: Form Reviewer(s): Linda Bird
 Authors: Dina Krofta, Berdetta Moore Disposition Date: 01/04/2012
 Date Submitted: 12/27/2011 Disposition Status: Approved-Closed
 Implementation Date Requested: On Approval Implementation Date:
 State Filing Description:

General Information

Project Name: JS Conv App Status of Filing in Domicile: Pending
 Project Number: L10410 Date Approved in Domicile:
 Requested Filing Mode: Review & Approval Domicile Status Comments:
 Explanation for Combination/Other: Market Type: Individual
 Submission Type: New Submission Individual Market Type:
 Overall Rate Impact: Filing Status Changed: 01/04/2012
 State Status Changed: 01/04/2012
 Deemer Date: Created By: Berdetta Moore
 Submitted By: Berdetta Moore Corresponding Filing Tracking Number:
 03L10711

Filing Description:

Life insurance application used only to apply for conversions on Term to Age 26 policies. This form will only be used by our sales agents for applications submitted electronically to our Home Office. Before the application is submitted, agents will give applicants a printed copy of the application for their review. Once the application data is verified, agents will obtain a wet signature from the applicant and send the signature page to our Home Office. A full, signed copy of the application will be included with the policy.

SERFF Tracking Number: SHLI-127929386 State: Arkansas
 Filing Company: Shelter Life Insurance Company State Tracking Number: 50568
 Company Tracking Number: 03LI0711
 TOI: L04I Individual Life - Term Sub-TOI: L04I.203 Specified Age or Duration - Single Premium - Single Life
 Product Name: Junior Special Conversion Application
 Project Name/Number: JS Conv App/LI0410

Company and Contact

Filing Contact Information

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

Filing Company Information

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

Filing Fees

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Shelter Life Insurance Company	\$50.00	12/27/2011	54837991

SERFF Tracking Number: SHLI-127929386 State: Arkansas
Filing Company: Shelter Life Insurance Company State Tracking Number: 50568
Company Tracking Number: 03LI0711
TOI: L04I Individual Life - Term Sub-TOI: L04I.203 Specified Age or Duration - Single Premium - Single Life
Product Name: Junior Special Conversion Application
Project Name/Number: JS Conv App/LI0410

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	01/04/2012	01/04/2012

SERFF Tracking Number: SHLI-127929386 State: Arkansas
 Filing Company: Shelter Life Insurance Company State Tracking Number: 50568
 Company Tracking Number: 03L10711
 TOI: L041 Individual Life - Term Sub-TOI: L041.203 Specified Age or Duration - Single Premium - Single Life
 Product Name: Junior Special Conversion Application
 Project Name/Number: JS Conv App/L10410

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Life & Annuity - Acturial Memo		No
Supporting Document	Drop Down Answers		Yes
Form	Junior Special Conversion Application		Yes

SERFF Tracking Number: SHLI-127929386 State: Arkansas
 Filing Company: Shelter Life Insurance Company State Tracking Number: 50568
 Company Tracking Number: 03LI0711
 TOI: L04I Individual Life - Term Sub-TOI: L04I.203 Specified Age or Duration - Single Premium - Single Life
 Product Name: Junior Special Conversion Application
 Project Name/Number: JS Conv App/LI0410

Form Schedule

Lead Form Number: L-103

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	L-103	Application/ Junior Special Enrollment Conversion Form Application	Initial		50.900	AR Jr Spec Conv App (full).pdf.pdf



SHELTER LIFE INSURANCE COMPANY

1817 WEST BROADWAY, COLUMBIA, MISSOURI 65218-0001

**Junior Special
Individual Life Conversion Application**

Agent Name:
Agent Number:
Applicant's Family Number:

Personal Information

- 1a. Name: Gender: SSN:
- b. Birth Date: Age: Phone Number:
- c. Physical Address: County:
- d. Mailing Address: County:
- e. Have you used any form of tobacco or nicotine substitutes in the last 12 months? Yes No
- f. Marital Status: Height: Weight: Place of Birth:
- g. Drivers' License Number: State:
- h. Alternate Phone Number: Best Time to Contact:
- i. Country of Citizenship: Length of Residency in US:
- Visa Type: Category: Expiration Date:
- j. Occupation: Name of Employer: Date Employed:
- k. Annual Earned Income: Income All Sources:

Coverage Information

- 2a. Policy Number being converted: Face Amount of original policy:
- b. Plan: Specified Amount:
- c. Accidental Death*: AD Amount: Waiver of Monthly Deduction:
- d. Guaranteed Insurability Rider: Amount:
- e. Option: New Policy Increase to UL Policy #
- f. Target Premium: Planned Premium: Planned premium after increase:

* If the Insured wants the Accidental Death benefit, a regular application must be completed to provide evidence of insurability.

- g. Payment Mode: Premium with application:
- h. Details:

Coverage Information

- 2a. Policy Number being converted: Face Amount of original policy or rider:
- b. Plan: Face Amount:
- c. Waiver of Premium: Accidental Death*: AD Amount:
- d. Guaranteed Insurability Rider: Amount:
- e. Automatic Premium Loan: Dividend Option: Mode Premium:
- f. Paid-Up Additional Insurance Rider Amount**:

* If the Insured wants the Accidental Death benefit, a regular application must be completed to provide evidence of insurability.

** Based on the amount of the Paid-Up Additional Insurance Rider, the Home Office will determine if an application is needed to provide evidence of insurability.

- g. Payment Mode: Premium with application: PUA Rider Prem. Collected:
- h. Details:

Policy Information

- 3a. Primary Beneficiary:
- b. Contingent Beneficiary:
- c. Payor:
- d. Owner:
- e. Successor Owner:
- f. Total individual life insurance and accidental death coverage in force or pending (excluding this application):
(Life) (Accidental Death)

With Shelter Life: \$ \$
With Other Companies: \$ \$

- g. Do you have existing life insurance policies or contracts? Yes No
If yes, please send Replacement Form L-243.29 with this application.
- h. Will this application replace an existing policy or contract? Yes No
If yes, please send Replacement Form L-243.33 with this application.
- i. 1035 Exchange? Yes No Company:
-

Underwriting Information

4. Have you seen a doctor within the past 5 years? 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:	

5. Do you have a parent or sibling who has been diagnosed with or treated for diabetes, heart or kidney disease, or hypertension? Yes No

Relationship to Insured: Explanation:

6. Do you have a parent or sibling who died before age 60? Yes No

Relationship to Insured: Age at death:
Explanation:

7. Have you ever engaged in or do you anticipate engaging in within the next 2 years:
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 rock and mountain climbing? Yes No

8. In the past five years: Yes No

a) Has your driver's license been suspended or revoked?

b) Have you plead guilty to a moving violation or been involved in any accident where you were found to be at fault?

c) Have you plead guilty or been convicted of driving while impaired, intoxicated, or under the influence of any drug?

Violation Date: Description:

9. Are you planning travel, residence, or employment outside the United States within the next two years? Yes No

Travel Dates: Description:

10. Are you in the National Guard or Reserves? Yes No

Details:

11. Have you ever plead guilty to or been convicted of a felony or misdemeanor or have such a charge currently pending against you? Yes No

Date of occurrence: Nature of plea, charge, or conviction:
Was prison time served? Are you currently on probation or parole?

Medical Information

12. 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 diagnosis:

Description of illness or injury, medical attention received, remaining effects, and any other details:

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

13. 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 diagnosis:

Description of illness or injury, medical attention received, remaining effects, and any other details:

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

Proposed Insured Name:

Application Number:

Medical Information Continued

14. 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 diagnosis:

Description of illness or injury, medical attention received, remaining effects, and any other details:

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

15. 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 diagnosis:

Description of illness or injury, medical attention received, remaining effects, and any other details:

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

16. 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 diagnosis:

Description of illness or injury, medical attention received, remaining effects, and any other details:

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

17. 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 diagnosis:

Description of illness or injury, medical attention received, remaining effects, and any other details:

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

18. 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 diagnosis:

Description of illness or injury, medical attention received, remaining effects, and any other details:

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

19. 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 diagnosis:

Description of illness or injury, medical attention received, remaining effects, and any other details:

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

20. 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 diagnosis:

Description of illness or injury, medical attention received, remaining effects, and any other details:

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

Proposed Insured Name:

Application Number:

Medical Information Continued

21. 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 diagnosis:
Description of illness or injury, medical attention received, remaining effects, and any other details:

Treating hospital(s) and/or physician(s):
22. Are you now pregnant? Yes No
Approximate Delivery Date:
Treating hospital(s) and/or physician(s):
23. Are you currently receiving treatment, taking medication, or scheduled to have surgery? Yes No
Date of diagnosis:
Description of illness or injury, medical attention received, remaining effects, and any other details:

Treating hospital(s) and/or physician(s):
24. 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):
25. 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):
26. 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):
27. 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):
28. In the past five years, have you made a claim for or received benefits, compensation, or pension for any injury, sickness, disability, or impaired condition? Yes No
Dates: _____
Description of illness or injury, medical attention received, remaining effects, and any other details:

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

Proposed Insured Name:

Application Number:

Medical Information Continued

29. 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 diagnosis:

Description of illness or injury, medical attention received, remaining effects, and any other details:

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

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. 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 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.

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 when application is written.

MIB PRE-NOTICE

Information regarding your insurability will be treated as confidential. Shelter Life Insurance Company or its reinsurer(s) may, however, make a brief report thereon to **the MIB, Inc., formerly known as Medical Information Bureau**, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is **50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734**.

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

NOTICE OF CONSUMER REPORT

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

SERFF Tracking Number: SHLI-127929386 State: Arkansas
 Filing Company: Shelter Life Insurance Company State Tracking Number: 50568
 Company Tracking Number: 03LI0711
 TOI: L04I Individual Life - Term Sub-TOI: L04I.203 Specified Age or Duration - Single Premium - Single Life
 Product Name: Junior Special Conversion Application
 Project Name/Number: JS Conv App/LI0410

Supporting Document Schedules

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

	Item Status:	Status Date:
Satisfied - Item: Application		
Comments:		
Attachment: AR Jr Spec Conv App (full)pdf.pdf		

	Item Status:	Status Date:
Bypassed - Item: Life & Annuity - Acturial Memo		
Bypass Reason: Not applicable. This is an application.		
Comments:		

	Item Status:	Status Date:
Satisfied - Item: Drop Down Answers		
Comments:		
Attachment: Arkansas Conversion Applications.pdf		



**SHELTER
INSURANCE
COMPANIES**

SHELTER MUTUAL
SHELTER GENERAL
SHELTER LIFE

CERTIFICATION

I, Dina C. Krofta, FSA, MAAA, herby certify that we have reviewed our processes regarding Ark. Code Ann. 23-79-138, Bulletin 6-87 and Bulletin 11-88 and found them to be in compliance. We have also reviewed our procedures and are in compliance with Regulation 49 and Regulation 19§10B.

<u>Form No.</u>	<u>Name</u>	<u>Score</u>
L-104	Junior Special Conversion Application	50.9

Dina C.
Krofta

Digitally signed by Dina C. Krofta
DN: cn=Dina C. Krofta, o=Shelter Life
Insurance Company, ou=Shelter Life
Insurance Company,
email=dkrofta@shelterinsurance.
com, c=US
Date: 2011.12.27 13:32:01 -06'00'

Signed

Dina C. Krofta, FSA, MAAA
Senior Life Actuary
Shelter Life Insurance Company



SHELTER LIFE INSURANCE COMPANY

1817 WEST BROADWAY, COLUMBIA, MISSOURI 65218-0001

**Junior Special
Individual Life Conversion Application**

Agent Name:
Agent Number:
Applicant's Family Number:

Personal Information

- 1a. Name: Gender: SSN:
- b. Birth Date: Age: Phone Number:
- c. Physical Address: County:
- d. Mailing Address: County:
- e. Have you used any form of tobacco or nicotine substitutes in the last 12 months? Yes No
- f. Marital Status: Height: Weight: Place of Birth:
- g. Drivers' License Number: State:
- h. Alternate Phone Number: Best Time to Contact:
- i. Country of Citizenship: Length of Residency in US:
- Visa Type: Category: Expiration Date:
- j. Occupation: Name of Employer: Date Employed:
- k. Annual Earned Income: Income All Sources:

Coverage Information

- 2a. Policy Number being converted: Face Amount of original policy:
- b. Plan: Specified Amount:
- c. Accidental Death*: AD Amount: Waiver of Monthly Deduction:
- d. Guaranteed Insurability Rider: Amount:
- e. Option: New Policy Increase to UL Policy #
- f. Target Premium: Planned Premium: Planned premium after increase:

* If the Insured wants the Accidental Death benefit, a regular application must be completed to provide evidence of insurability.

- g. Payment Mode: Premium with application:
- h. Details:

Coverage Information

- 2a. Policy Number being converted: Face Amount of original policy or rider:
- b. Plan: Face Amount:
- c. Waiver of Premium: Accidental Death*: AD Amount:
- d. Guaranteed Insurability Rider: Amount:
- e. Automatic Premium Loan: Dividend Option: Mode Premium:
- f. Paid-Up Additional Insurance Rider Amount**:

* If the Insured wants the Accidental Death benefit, a regular application must be completed to provide evidence of insurability.

** Based on the amount of the Paid-Up Additional Insurance Rider, the Home Office will determine if an application is needed to provide evidence of insurability.

- g. Payment Mode: Premium with application: PUA Rider Prem. Collected:
- h. Details:

Policy Information

- 3a. Primary Beneficiary:
- b. Contingent Beneficiary:
- c. Payor:
- d. Owner:
- e. Successor Owner:
- f. Total individual life insurance and accidental death coverage in force or pending (excluding this application):
(Life) (Accidental Death)

With Shelter Life: \$ \$
With Other Companies: \$ \$

- g. Do you have existing life insurance policies or contracts? Yes No
If yes, please send Replacement Form L-243.29 with this application.
- h. Will this application replace an existing policy or contract? Yes No
If yes, please send Replacement Form L-243.33 with this application.
- i. 1035 Exchange? Yes No Company:
-

Underwriting Information

4. Have you seen a doctor within the past 5 years? 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:	

5. Do you have a parent or sibling who has been diagnosed with or treated for diabetes, heart or kidney disease, or hypertension? Yes No

Relationship to Insured: Explanation:

6. Do you have a parent or sibling who died before age 60? Yes No

Relationship to Insured: Age at death:
Explanation:

7. Have you ever engaged in or do you anticipate engaging in within the next 2 years:
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 rock and mountain climbing? Yes No

8. In the past five years: Yes No

- a) Has your driver's license been suspended or revoked?
b) Have you plead guilty to a moving violation or been involved in any accident where you were found to be at fault?
c) Have you plead guilty or been convicted of driving while impaired, intoxicated, or under the influence of any drug?

Violation Date: Description:

9. Are you planning travel, residence, or employment outside the United States within the next two years? Yes No

Travel Dates: Description:

10. Are you in the National Guard or Reserves? Yes No

Details:

11. Have you ever plead guilty to or been convicted of a felony or misdemeanor or have such a charge currently pending against you? Yes No

Date of occurrence: Nature of plea, charge, or conviction:
Was prison time served? Are you currently on probation or parole?

Medical Information

12. 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 diagnosis:
Description of illness or injury, medical attention received, remaining effects, and any other details:

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

13. 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 diagnosis:
Description of illness or injury, medical attention received, remaining effects, and any other details:

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

Proposed Insured Name:

Application Number:

Medical Information Continued

14. 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 diagnosis:

Description of illness or injury, medical attention received, remaining effects, and any other details:

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

15. 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 diagnosis:

Description of illness or injury, medical attention received, remaining effects, and any other details:

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

16. 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 diagnosis:

Description of illness or injury, medical attention received, remaining effects, and any other details:

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

17. 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 diagnosis:

Description of illness or injury, medical attention received, remaining effects, and any other details:

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

18. 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 diagnosis:

Description of illness or injury, medical attention received, remaining effects, and any other details:

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

19. 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 diagnosis:

Description of illness or injury, medical attention received, remaining effects, and any other details:

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

20. 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 diagnosis:

Description of illness or injury, medical attention received, remaining effects, and any other details:

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

Proposed Insured Name:

Application Number:

Medical Information Continued

21. 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 diagnosis:
Description of illness or injury, medical attention received, remaining effects, and any other details:

Treating hospital(s) and/or physician(s):
22. Are you now pregnant? Yes No
Approximate Delivery Date:
Treating hospital(s) and/or physician(s):
23. Are you currently receiving treatment, taking medication, or scheduled to have surgery? Yes No
Date of diagnosis:
Description of illness or injury, medical attention received, remaining effects, and any other details:

Treating hospital(s) and/or physician(s):
24. 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):
25. 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):
26. 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):
27. 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):
28. In the past five years, have you made a claim for or received benefits, compensation, or pension for any injury, sickness, disability, or impaired condition? Yes No
Dates: _____
Description of illness or injury, medical attention received, remaining effects, and any other details:

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

Proposed Insured Name:

Application Number:

Medical Information Continued

29. 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 diagnosis:

Description of illness or injury, medical attention received, remaining effects, and any other details:

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

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. 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 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.

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 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.

Arkansas Conversion Applications

L-103: Questions 1f-1k, 3f-3i, and 4-29 will only display if the applicant wants to increase the face amount, add a benefit or rider, or convert while disabled.

L-104: Questions 1e-1j, 3f-3i, and 4-29 will only display if the applicant wants to increase the face amount, add a benefit or rider, or convert while disabled.

Both Applications: Only one Coverage Information section will display; this is based on the plan they select.