Family1
PLAN AHEAD FOR THOSE YOU LOVE

TEXAS SERVICE LIFE INSURANCE COMPANY
(A Stipulated Premium Company)P.O. Box 341899, Austin, TX 78734
LIMITED PAY NON-PRENEED INSURANCE APPLICATION

Proposed Insured Name: Last, First, Middle	Sex	DOB	Age	Height	Weight	Social Security No.

Address	City	State	Zip	Home Phone

Primary Beneficiary/Relationship to Insured	Contingent Beneficiary/Relationship to Insured	Cell Phone
/	/	

HEALTH QUESTIONS (IMPORTANT: MISREPRESENTATION CAN VOID COVERAGE)

1. Has the **Proposed Insured EVER** been treated for, or diagnosed as having, by a medical professional any of the following conditions?

a. AIDS, HIV+ or ARC disorders
b. Recurring or Spreading Cancer
c. Stroke with Paralysis
d. Amyotrophic Lateral Sclerosis (ALS)
e. Lung Disorder requiring Oxygen
f. Liver Failure and/or Cirrhosis of Liver
g. Alzheimer's
h. Heart or Kidney Failure
i. ANY TERMINAL CONDITION

Is the Proposed Insured now (a) bedridden, (b) homeless in the last 365 days, (c) residing in, (d) currently admitted to or (e) been advised to enter: a Hospital, Penal Institution, Hospice or any Extended Care Facility?

2. **At any time** in the **past 5 YEARS** has the **Proposed Insured** been diagnosed for, received advice, care or treatment for, or experienced any of the following Health Conditions?

a. Cancer
b. Degenerative Disease or Disorder
c. Blood Disorder
d. Brain Disorder or Nervous Disorder
e. Kidney Disorder
f. Diabetes Requiring Insulin
g. Heart Disorder
h. Circulatory System Disorder
i. Liver Disorder
j. Lung Disorder
k. Neurological Disorder
l. Stroke
m. Anemia
n. Down's Syndrome
o. Dementia
p. Drug Abuse, Alcohol Abuse, Opioid Abuse or any non-prescribed use of a prescription medication
q. Unexplained or unintended weight loss of greater than 10% of body weight within a 12 month period

☐ **NO TO ALL CONDITIONS IN QUESTION 1 & 2**

☐ **YES TO ANY CONDITION IN QUESTION 1or 2 (If yes, Graded Benefit or MIB only)**

☐ **Proposed Insured's Initials indicating COMPLETE AGREEMENT** with the answers to Health Questions 1 and 2 above.

COVERAGE

FULL BENEFIT:
☐ **SERIES 1**
☐ **SERIES 2**
☐ **SERIES 3**
☐ **SERIES FH**

☐ **GRADED BENEFIT**
☐ **MIB**

PAYMENT TERMS

METHOD
☐ Bank Draft
☐ Direct Bill
☐ Credit Card

PAYMENT PLAN
☐ Single-Pay (n/a graded benefit)
☐ 3 Years
☐ 5 Years
☐ 7 Years
☐10 Years

PREMIUM MODE
☐ Monthly
☐ Quarterly
☐ Semi-Annual
☐ Annual

POLICY TYPE AND RIDERS

	SINGLE-PAY	MULTI-PAY
Face Amount:		
Premium: $	_____	**$** _____
OPTIONAL RIDERS: List Rider Premiums Below		
Deferred Payment $	**N/A**	**$** _____
Accidental Death $	_____	**$** _____
(Coverage Included with S3)		
Total Mode Premium:$	_____	**$** _____

Initial Amount Collected with Application: $_____ (*1st payment is due one period from the application date)

☐ **CHILD RIDER APPLICATION ATTACHED (Maximum 8 Children)**

SAMPLE

AGREEMENT – AUTHORIZATION
TEXAS SERVICE LIFE INSURANCE COMPANY

I, the Primary Proposed Insured (and any Owner or other Authorized Applicant signing), by my signature set forth on page 3 **AGREE to the following:**

(a) All Statements and answers in this application are complete and true to the best of my knowledge and belief.

(b) Contestability period: If the Primary Proposed Insured should die within the first two years of the policy issue date then the COMPANY reserves the right to contest payment of a claim. The policy is incontestable after it has been in-force for two years following the policy issue date.

(c) No insurance will take effect until the policy has been approved and issued by TEXAS SERVICE LIFE INSURANCE COMPANY and the first full premium is paid and a policy is delivered while the health of any proposed insured continues, without material change, to be as represented in this application.

(d) No agent has authority to waive any answer or otherwise modify this application or to bind Texas Service Life Insurance Company, hereinafter called "Company", in any way by making any promise or representation which is not set out in writing in this Application.

I HEREBY AUTHORIZE any licensed physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance or Reinsuring company, MIB, Inc. ("MIB"), consumer reporting agency, Pharmacy Benefits Manager or any other organization, Institution or person to give to the Company (Texas Service Life Insurance Company) or its reinsurer(s) all information it holds that pertains to medical consultations, Treatments, surgeries, and hospital confinements which relate to the physical and mental condition of myself or my minor children. This authorization also includes information about drugs or alcoholism or any other non-health (non-medical) history information. I understand that such information will be used to determine eligibility for insurance, or for benefits under existing insurance. I further authorize the Company to release any information obtained only to reinsuring companies, MIB, or other persons or Organizations performing business or legal services in connection with my application or claim, or as may be otherwise lawfully Required or as I may further authorize. As to this Authorization, I agree that a photographic copy will be as valid as the original and that it will be valid for 30 months from the date shown on page 3 of this application. I know that I or my representative may request a copy of this authorization.

I understand that I may revoke this Authorization, except to the extent that any healthcare provider or Texas Service Life Insurance Company has acted in reliance upon this Authorization. My revocation of this Authorization must be submitted in writing to the address below. I also understand that my revocation of this authorization will not result in the deletion of codes in the MIB database if such codes are reported by the Company (or the Company becomes obligated to report such codes to MIB) while this authorization is in force.

Texas Service Life Insurance Company
P O Box 341899
Austin, TX 78734

The information disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected by the federal privacy regulations.

Notice about Electronic Check Conversion: When you provide a check as payment, you authorize us either to use information from your check to make a one-time electronic fund transfer from your account or to process the payment as a check transaction. When we use information from your check to make an electronic fund transfer, funds may be withdrawn from your account as soon as the same day you make your payment, and you will not receive your check back from your financial institution.

SAMPLE

Family1
PLAN AHEAD FOR THOSE YOU LOVE

TEXAS SERVICE LIFE INSURANCE COMPANY
(A Stipulated Premium Company)P.O. Box 341899, Austin, TX 78734
LIMITED PAY NON-PRENEED INSURANCE APPLICATION

IMPORTANT NOTICES AND REQUIRED SIGNATURES

1. **IMPORTANT:** This application serves as the RECEIPT for the payment(s) received with the application. There is no insurance or coverage for the Proposed Insured until the Policy has been approved, issued and delivered by TEXAS SERVICE LIFE INSURANCE COMPANY ("Company") during the lifetime of the applicant while the health of the applicant remains as is indicated on this application and the first full premium is paid.

2. **IMPORTANT: I**f the Proposed Insured is not found to be acceptable to the Company, then no insurance coverage shall become effective and the Company shall have no liability hereunder except for the return of any premium received.

3. **IMPORTANT:** BY SIGNING BELOW, Proposed Insured and/or Owner agree completely to the AGREEMENT-AUTHORIZATION-ACKNOWLEDGEMENT on page 2 and 4 of this application.

***Date Application Signed** | **Proposed Insured Signature (or Legal Guardian)**

Owner's Name Printed | **Owner's Signature (if not insured)**

Owner's Address City ST Zip | **Owner's Relationship to insured**

Owner's Phone | **Owner's Email Address**

Payor's Name Printed | **Payor's Signature (if not insured or owner)**

AGENT'S STATEMENT AND REQUIRED SIGNATURE

By my signature I hereby certify that, to the best of my knowledge, all information on this form is correct, was recorded accurately, and was completed by me.

1. **I HAVE PERSONALLY MET THE INSURED IN THE PROCESS OF TAKING THE APPLICATION.** ☐ **YES** ☐ **NO**
2. **THE PROPOSED OWNER/INSURED IS AN AGENT OR RELATIVE OF MINE.** ☐ **YES** ☐ **NO**

Agent's Name Printed | **Agent's Signature**

Agent's Number | **Agent Email Address**

SAMPLE

ACKNOWLEDGEMENT
TEXAS SERVICE LIFE INSURANCE COMPANY

ACKNOWLEDGE receipt of the following notice, when applicable:

(a) MIB Pre-Notice

Information regarding your insurability will be treated as confidential. Texas Service Life Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., 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. 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.

Texas Service 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.

SAMPLE