Security National
Life Insurance Company

SECURITY NATIONAL LIFE
CONTRACT BROCHURE

The Statement of Funeral Goods and Services (Utah)

1. The Agreement Section (BLUE) must include the contract number, the funeral license number, and the preneed license number. The date and name of buyer and provider must also be completed.

2. All the selected goods and services must have a numerical amount written in the space provided in (ORANGE). Also, the values cannot contain the words "estimate," "approximately," or "towards" because these have the potential to be challenged or misconstrued when the contract becomes at-need. Then, all dollar amounts must then be totaled and the exact cost displayed in each of the spaces provided in (RED). The absolute total funeral price must be listed in the space labeled "Total Funeral Price." (RED)

3. Items that have been changed, scratched through or marked out MUST have the policy owner's initials beside them.

4. All goods and services selected that include a space for a description must be described explicitly and accurately. (e.g. "How many days will there a visitation and at what price per day" OR "What type of casket is being purchased.") Any boxes provided must be checked to accurately reflect the choices of the insured: for example the check-boxes for disposition and the casket (PURPLE).

Pre-need Funeral Agreement and Assignment
STATEMENT OF FUNERAL GOODS AND SERVICES

Funeral Service Arrangements For: ______
Name of Funeral Home: ______

Contract # ______
Funeral License # ______
Pre-Need License# ______

This Agreement ("Agreement") is entered into this ____ day of ______, 20____, between ______, hereinafter called "Buyer" and ______, hereinafter called "Provider," a pre-need funeral arrangement provider licensed in the State of Utah.

1. STATEMENT OF GOODS AND SERVICES

Arrangement and Professional Staff Services $ ______
Embalming $ ______
If you have selected a funeral that may require embalming, such as a funeral with viewing, you may have to pay for embalming. You do not have to pay for embalming that you did not approve, if you selected arrangements such as direct cremation or immediate burial. If we charge for embalming, we will explain why below: ______

Dressing, Cosmeizing, Caskeketing $ ______
Use of Facilities/Staff/Equipment for:
Visitation ____ Days @ $ ____ /day $ ______
Funeral/Memorial Service $ ______
Graveside Service $ ______
Transfer of Deceased (____ mi.) $ ______
Family Car(s) # ____ @ $ ____ each $ ______
Coach Vehicle $ ______
Utility Vehicle $ ______
Forwarding/Receiving Remains $ ______
Other Services/Facilities/Equipment $ ______
(Specify) ______ $ ______

Total Cost of Guaranteed Services $ ______

Casket $ ______
Manufacturer ______
Model # and Name ______
Exterior Material & Color ______
Interior Material & Color ______

Outer Burial Container $ ______
Manufacturer ______
Model # and Name ______
Material ______

Other Merchandise (specify) ______ $ ______

Required Purchases
Charges are only for those items that you selected or that are required. If we are required by law or by a cemetery or crematory to use any items, we will explain the reasons in writing below. Any legal, cemetery or crematory requirement that we represented to you as compelling the purchase of any goods and services called for by this Agreement is identified and described below:

Total Guaranteed Cost of Items Selected $ ______

Additional Benefit: For the Recipient's benefit, Provider has given the Buyer the option of adding coverage to the face amount of the insurance policy/annuity contract. If an additional benefit is included, the total death benefit payable will be prorated to the goods and services selected and to the additional benefit. The additional benefit amount will be paid to the contingent beneficiary named in the insurance policy/annuity contract for use however he or she deems necessary. ______ (Initial Here) $ ______

Disposition ☐ **Burial** ☐ **Cremation** ☐ **Other** **TOTAL FUNERAL PRICE** $ ______

2. **IRREVOCABLE ASSIGNMENT**. By initialing here (______), you agree to irrevocably assign beneficial interest of the life insurance policy funding this Agreement to Funeral Provider, as their interest may appear and subject to the terms set forth in paragraph 5 of this Agreement.

This Agreement, including the terms contained on the reverse side, constitutes the entire pre-need funeral agreement.

AGREEMENT AND ASSIGNMENT BY:
X ______
(Signature of Buyer) (Date)
______
(Address) (Phone)
______
(City / State) (Zip)
X ______
(Signature of Agent)

AGREEMENT AND ACCEPTANCE BY:
X ______
(Funeral Provider's Authorized Representative) (Date)
______
(Funeral Provider's Address) (Phone)
______
(City / State) (Zip)

S FGS (08/06) -UT **ORIG: INSURANCE COMPANY** **COPY 1: SELLER** **COPY 2: BUYER**

5. Additional Benefit Section (GREEN):
If the purchaser chooses to add coverage to the face amount of the policy/annuity contract they must initial in the space provided (GREEN). Then the total additional amount of coverage must be listed in the space provided (RED).

6. **Irrevocable Assignment** (GREEN) – This waves the owner's right to cancel the policy and receive cash value. This is the preferred option as it prevents the policy backing the preneed contract from being viewed as an asset by any firms evaluating the owner's holdings.

7. **Agreement and Assignment By** (YELLOW) – The signature of the purchaser and date must be filled out (dates on the contract and application must be the same), mailing address and the name and address of the contract insured (if other than the purchaser).

8. **Agreement and Acceptance By** (PINK) – The signature of the funeral provider's authorized representative and date must be filled out, and the funeral home's mailing address and agent's signature.

1. "In consideration that" (YELLOW) is where the name of the person for whom the prearranged funeral is for and that same person is identified by the Statement of Goods and Services on the pre-paid funeral contract.
2. Listed as #2 on the Supplement Form and in (GREEN), the name of the funeral home that is providing the prearranged funeral must be listed here. It will also be the same funeral home that is identified on the Statement of Funeral Goods and Services of the pre-paid funeral contract.

   Listed as #3 on the Supplement Form and in (ORANGE) is where the applicant should initial that he/she understands the specific death benefit of the Child-Grandchild-Great Grandchild Supplement. Also in (ORANGE) at the bottom of the page is where the applicant will sign to participate in the Supplement.
3. Identified in (PINK) is where the funeral home representative or funeral director or funeral home owner will counter-sign the Supplement.
4. The selling agent will sign in the space marked in (PURPLE).

Family and Pet Protection Supplemental Benefit

Rev 7/8/10

(This is NOT an INSURANCE POLICY and is Expensed in Payment Provision)

____________________ is applying for a Pre-Arranged Funeral Services and/or Funeral Merchandise contract, identified and itemized by Statement of Funeral Goods and Services, subject to those terms and conditions, the following is provided at ***No Additional Cost.***

The Child-Grandchild–Great Grandchild (Step or Legally Adopted) Supplemental Benefit:

In the event of the death of any child, legally adopted child or stepchild, or grandchild, or great grandchild of the Purchaser, Providing that the child **has** attained his/her first year birthday, and providing the child **has not** attained his/her 18th birthday, **and** has never married prior to the time of death, will be provided funeral expenses as similar as is possible to those being purchased in the original funeral contract referred to above, provided that the purchaser is still living. The casket provided shall be appropriate for the age of the deceased.

The Child- Grandchild- Great Grandchild (Step or Legally Adopted) Supplemental benefit is further conditional upon the following (see back for additional conditions):

1. These funds are made available only when the pre-arranged funeral services and/or funeral merchandise as outlined above are provided by ________________ Funeral Home.
2. The **purchaser may not be in default** of any payment on the funeral contract for any period exceeding 30 days AND the maximum value of funeral services and/or merchandise provided shall be equal to the lesser of (1) the amount paid in on the prepaid funeral agreement at the time of death, and (2) the price of the funeral services and/or merchandise selected in the prepaid funeral agreement, **but in no event shall the maximum value exceed $5,000. Initial here to confirm You have read and understand this________________.**

Additional children born after this contract is executed can be covered with this benefit upon receipt of the original contract and certified copy of the child's birth certificate. The funding amount per child claim is limited to a **maximum amount of $5,000**, regardless of the number of participating parents, grandparents, etc.

The Pet Disposition Supplemental Benefit:

In the event of the death of any pet (limited to canine or feline) of the purchaser, provided the disposition is handled by a licensed veterinarian or professional animal disposition service, purchaser will be reimbursed up to $150 per pet (limit of three throughout the life of the purchaser's policy) for disposition services rendered, provided that the purchaser is still living.

Pet Disposition Supplemental Benefit is conditional upon the following:

1. At the time of the signing of this agreement, each pet as defined above may NOT be under the care of a licensed veterinarian for any chronic or critical ailment.
2. The purchaser may not be in default of any payment on the funeral contract for any period exceeding 30 days AND the maximum value of Pet Disposition Services provided shall be equal to the lesser of (1) the amount paid in on the prepaid funeral agreement at the time of death, and (2) in no event shall the maximum value of the benefit exceed $150 (per pet).
3. State taxes and/or any other outside costs, including cash advances from a third party provider are not included in the agreement, and must be paid separate and apart from this benefit description at the time of need.
4. The benefit for each pet herein is limited to services and/or merchandise provided by a licensed veterinarian or certified animal disposition service.
5. This shall not apply if the death is a result of a natural disaster, declared or undeclared.
6. In the event that the above referenced Funeral Pre-arrangement Contract, and/or subsequent coverage, is cancelled for any reason whatsoever, including the death of the purchaser, this benefit will become null and void.

By signing below, I acknowledge and understand that all children or pets to be covered by this benefit must comply with the stipulations listed above and on the reverse side of this form.

Signed this ________________ day of ____________, year 20______.

Applicant________________ Funeral Home Representative________________

Selling Agent________________________________

THIS CERTIFICATE OF BENEFIT HAS NO CASH EXCHANGE VALUE AND IS NOT TRANSFERABLE.
WE RESERVE THE RIGHT TO CHANGE OR DISCONTINUE THIS PROGRAM AT ANY TIME.

CGCSB-(08-06) Original/White: Seller/Agency Copy 1/Yellow: Funeral Home Copy 2/Pink: Purchaser

The Application Page

1. **Proposed Insured/Owner** (ORANGE) should include name, date of birth, age, sex, social security number and mailing address of the proposed insured. Section 1 (ORANGE) should also provide the name of the owner or payor (if different than proposed insured), relationship to insured, email address and mailing address. The premium notice will be sent to the owner/payor address if other than the proposed insured.

2. **Beneficiary** (ORANGE) should include the name of the beneficiary and the relationship to the insured.

Application for:
☐ Individual Life Insurance
☐ Individual Annuity Insurance

SECURITY NATIONAL LIFE INSURANCE COMPANY
5300 South 360 West, Suite 250, Salt Lake City, UT 84123 • Telephone: (801) 264-1060 or Toll Free: 1 (800) 574-7117

LEAD SOURCE: ☐ Mailer ☐ Referral ☐ Family Service ☐ Bookmark ☐ iRegister ☐ Telemarket ☐ Other

Name of Proposed Insured/Annuitant (Print) Birthdate (mm/dd/yy):___/___/___ Age:___ Gender:___
First:___ Middle Initial:___ Last:___
Address:___ City:___ State:___ Zip:___
Telephone Number: Social Security Number/TIN:

Owner (if other than Proposed Insured/Annuitant):___
Address:___ City:___ State:___ Zip:___
Telephone Number: Relationship:

Payor (if other than Proposed Insured/Annuitant):___
Address:___ City:___ State:___ Zip:___
Telephone Number: Relationship:

Primary Beneficiary: Relationship:

Answer all Medical Questions for the Proposed Insured to determine Plan eligibility. (see Plans below) Yes No

1. Are you now receiving hospice care, a patient in a hospital of any kind, been advised by a licensed member of the medical profession to be hospitalized or confined to a bed? Have you been medically diagnosed, tested or treated by a licensed member of the medical profession with having a terminal illness resulting in death within the next 12 months? ☐ ☐
2. Have you been diagnosed by a licensed member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive for HIV? Have you been diagnosed, treated or prescribed medication by a licensed member of the medical profession for Alzheimer's or dementia? ☐ ☐
3. **In the past 5 years** have you been diagnosed, tested positive for, treated or prescribed medication by a licensed member of the medical profession for any of the following: ☐ ☐

☐ seizure disorders ☐ lung disorder ☐ alcohol or drug abuse ☐ brain or neurological disorder, stoke or tumor
☐ kidney disorder or dialysis ☐ organ transplant ☐ treated in a nursing facility ☐ diabetes in combination with high blood pressure
☐ heart disease or condition ☐ circulatory disorder ☐ liver disorder, including hepatitis ☐ mental disorder, down syndrome or depression
☐ amputation due to disease ☐ Parkinson's disease ☐ cancer, except basal cell skin disorder

Dollar for Dollar Plan:
Answer medical question #1 only. Answer must be "No".
☐ 1 Pay ☐ 3 Pay ☐ 5 Pay ☐ 10 Pay

Full Benefit	Answers to all medical questions must be "No".	☐ 3 Pay ☐ 5 Pay ☐ 8 Pay ☐ 10 Pay
Limited Benefit	Answers to medical questions 1 & 2 must be "No".	☐ 3 Pay ☐ 5 Pay ☐ 8 Pay ☐ 10 Pay
Annuity	No medical questions required.	☐ Single Pay ☐ Flexible

Funeral Price $___ **Face Amount $**___
Initial Payment $ **Periodic Payment Amount $**

Billing Mode: ☐ EFT* ☐ Direct Bill ☐ Credit/Debit Card*
*Complete the EFT/CC Information/Authorization below.

Draft Upon Approval: ☐ Yes ☐ No
Payment Mode: ☐ Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annual
Bill Date: month/day (1st – 28th): ___/___

Electronic Funds Transfer (EFT) Information/Authorization – Checks must be made payable to Security National Life Insurance Company.
Name of Bank:___ Account Number:___ Routing Number:___ ☐ Checking ☐ Savings
Credit Card Number:___ Expiration Date:___ CVV:___ ☐ VISA ☐ MasterCard ☐ Discover ☐ AMEX
I authorize SNL to initiate debit entries to my checking or savings account, or credit/debit card account indicated above. I authorize the financial institution (bank) named above to debit my account for payment of my SNL account(s). I understand this authorization is subject to the terms and conditions of the EFT agreement.
Account Holders Name: Account Holders Signature:

Replacement: Do you have an existing life insurance policy or annuity contract? ☐ **Yes** ☐ **No**
If "Yes", please fill out and submit the notice regarding the replacement of life insurance or annuities.

Agreement/Authorization – I have read the questions and reviewed the answers shown above. They are complete and true to the best of my knowledge. I understand that the agent does not have the authority to waive any answers I have given. No Insurance shall take effect until the premium has been paid and a policy has been issued while the insured is living. If the medical questions were answered, I then authorize my doctor, hospital or related facility, pharmacy benefit manager, insurance company, person or organization, having records of me or my family to give to Security National Life Insurance Company and its representatives any such information. Such records or information will be used by Company personnel to determine eligibility for insurance and/or benefits. There may be certain circumstances under which the information received may be disclosed to third parties who are not subject to the regulations under federal health privacy law. A reproduction of this authorization shall be valid as the original. This authorization shall be valid for 2 years from the date signed, as permitted by applicable law in the state where the policy is issued for delivery. This authorization may be revoked upon submission of a written notice to the Home Office.
Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Signed at: City___ State:___ Signed Date (mm/dd/yy):___/___/___
Proposed Insured's/Annuitant Signature: Owners Signature (if different):

Agent's Statement – Is the applicant replacing an existing life insurance policy or annuity contract? ☐ Yes ☐ No
I certify to the best of my knowledge that all medical questions asked in this application are true and complete. The signature of the Proposed Insured/Annuitant is what they are represented to be and were signed in my presence.
Agent's Signature:___ Agent's Printed Name:___ Date (mm/dd/yy):___/___/___
Agent #: Funeral Home Name:

HOME OFFICE ADDITIONS OR CORRECTIONS:

ICC17- COMBO1 APP (06/2016) WHITE – Company YELLOW – Funeral Home PINK – Family

3. **Plan Selection:**
Question 1 (PINK) This section is to be answered if the proposed insured is applying for a Single Pay, Dollar-for-Dollar or Multi-pay product. If the proposed insured answers Question 1 "YES", then an Annuity product will be issued. If the propsed insured answers Question 1 "NO" and wants to apply for an insured product, then they can proceed in answering questions 2 & 3 to determine qualifying product.

   - Security National does not consider a nursing home to be a "Hospital" unless the proposed insured is there specifically for: hospital care, receiving hospice care, is bedridden, is not able to perform activities of daily living (ADL) or diagnosed with a terminal illness.
   - Proposed insureds who are under age 50 or over age 90 are not eligible for the Dollar-for-Dollar singe pay product - an Annuity product will be issued.
   - If the proposed insured is applying for a Dollar-for-Dollar plan, then the number of payment years needs to be selected (1, 3, 5, 10).

Questions 2 and 3 (PURPLE) These questions are to be answered (in addition to Question 1) for proposed insureds applying for an Insured Multi-Pay Product. If all questions (1, 2 and 3) are answered "NO" they will be eligible for a Fully Insured Product ("Full Benefit" should be CHECKED). If Questions 1 and 2 are "NO," but Question 3 is "YES" then the proposed insured will be eligible for a Limited Benefit Product ("Limited Benefit" should be CHECKED). If there are questions with health issues, illness or medications, they need to contact underwriting for direction.

- A selection should be made for either "Full Benefit" or "Limited Benefit". The number of payment years need to be selected. (3, 5, 8 or 10).
- Make sure to CHECK the correct plan.
- If Limited Plan is selected, please mark the appropriate ailment.

4. **Annuity** (RED) This plan selection is for proposed insured/annuitants that answered Question 1 of this "YES". A selection should be made as either Single Pay or Flexible Pay.

5. **Coverage Amount** (GRAY) should include:
   - The Funeral Contract Amount should reflect the "Total Funeral Price" from the Goods and Services portion of the pre-paid funeral contract.
   - The Initial Face Amount of the policy is the funeral contract plus any applied BUMP from the Premium Rate Sheet or product offering.
   - The Initial Premium Collected reflects a "down payment" towards the funeral contract and insurance policy that backs the pre-paid funeral.
   - The Periodic Payment Amount is the Mode Premium the payor has agreed to pay.

6. **Initial Payment & Billing Information** (GREEN) should include the following:
   - Billing Mode – How the payor would like to pay their premiums: "EFT" (Bank Draft – Electronic Funds Transfer [EFT] Information) or Direct Bill. ***A $3 fee will be added to the premium on applicable insured products if paid with a credit card or directly billed.** A selection should be made as either "EFT", Direct Bill or Credit Card.
   - Payment Mode – A selection should be made at what frequency the payor would like to pay their premiums: annual, semi-annual, quarterly or monthly.
   - Bill Date – A selection should be made on what date the payor wants Security National Life to withdraw funds from the bank account for the pre-paid funeral.
   - Draft Upon Approval – A selection should be made either "Yes" or "No".
   - Initial payments made with check or money order need to be made payable to Security National Life (SNL).

7. **Electronic Funds Transfer (EFT) Information** (GREEN) should be completed when the payor elects EFT as their preferred method of billing.
   - If Credit Card is selected as the preferred method of payment, the Expiration Date and CVV for the card are required.

8. **Replacement** (BLUE) should be answered Yes or No to indicate whether or not the insurance/annuity being applied for will replace any existing policy to fund their funeral. This is also asked again in Section 8 (BLUE). If the insured is replacing an existing policy, the agent must fill out replacement papers and submit it with the application. The policy cannot be issued until we have replacement papers.

9. **Agreement** (YELLOW)
   - City and state where the application was signed and dated.
   - Signature of proposed insured/annuitant.
   - Proposed insured must sign. If owner is different from insured, the owner must also sign.

10. **Agent's Statement** (YELLOW) – In addition to the information listed below, this section also includes another replacement question (BLUE).
    - Agent's signature, printed name and date of application.
    - Agent number and funeral home name.

11. **Lead Source** (DARK GREEN) – Indicate how the person found out about Security National Life. Make sure to check at least one box. Select Other if not listed.