

1. Applicant/Employee (First, Middle, Last)			2. Street Address			
3. Phone Number (home) (work)		4. City		5. State	6. Zip	7. Social Security No.
8. Proposed Insured (if other than Applicant) (First, Middle, Last)			9. Height	10. Weight	11. Sex	12. Date of Birth
13. Age Last Birthday	14. State of Birth	15. Occupation	16 Relationship to Applicant		17. Beneficiary	
18. Spouse (If Proposed for Insurance) (First, Middle, Last)			19. Height	20. Weight	21. Sex	22. Date of Birth
23. Age Last Birthday	24. State of Birth	25. Spouse Occupation	26. Spouse Beneficiary and Relationship			

Corrections & Notations (for Home Office Use Only)

27. Mode:  Annual  Semi-Annual  Quarterly  Payroll Deduction  PAC, Payment with Application \$ \_\_\_\_\_

28. Application for: Living Term Life Face Amount \$ \_\_\_\_\_

29. Does any person proposed for insurance by this application:

A Have any other accidental death benefit insurance in force?  Yes  No If yes, amount \$ \_\_\_\_\_

B Within the past two years engaged in scuba diving below 50 feet, sky diving, boxing, martial arts, rock or mountain climbing, cave exploring, hang-gliding, organized motor vehicle, motorcycle, bicycle, motorboat or horse racing; rodeo activities; or are such activities contemplated:  Yes  No

C Flown other than as a fare-paying passenger within the last two years, or contemplated such flying?  Yes  No

30. Has any person proposed for insurance by this application:

A Used tobacco in any form within the past 12 months?  Yes  No If yes, who and in what form? \_\_\_\_\_

B Within the past 5 years, been evaluated or treated for alcoholism/chemical dependency or used alcoholic beverage to excess, used marijuana, cocaine, sedatives, hallucinogenic or narcotic drugs, except prescribed by a physician, or received treatment for a drug habit, been arrested or convicted for possession, sale or use of drugs?  Yes  No If yes, list details including chemicals used, amount frequency, and date of last use.

PLEASE COMPLETE AND SIGN REVERSE SIDE OF THIS APPLICATION

MBA503 (07/02)

### NOTICE TO APPLICANT NOTICE OF THE FAIR CREDIT REPORTING ACT

In compliance with Federal Laws known as the Fair Credit Reporting Act, this notice is to inform you that as part of our procedure for processing your insurance application:

- An investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends, or other with whom you are acquainted. This inquiry will include information as to character, general reputation, personal characteristics, and mode of living, with respect to you, members of your family, and others having an interest in or closely connected with the insurance transaction; and
- upon your written request, made within a reasonable time after you receive this notice, additional information as to the nature and scope of the investigation, if one is made, will be provided. Request for additional information should be addressed to: Security Life Insurance Company of America, 10901 Red Circle Dr., Minnetonka, MN 55343-9137.

### PRE-NOTICE REGARDING THE MEDICAL INFORMATION BUREAU (MIB)

Information provided regarding your insurability will be treated as confidential. Security Life Insurance Company of America or its reinsurer(s) may, however, make a brief report thereon to the Medical Information Bureau (MIB), a non-profit membership organization of life insurance companies, which operates an information exchange in behalf of its members. Upon request by another member insurance company to which you have applied for life or health insurance coverage, or to which a claim is submitted, the MIB will supply such company with the information it may have in its files. Upon receipt of a request from you, the Bureau will arrange disclosures of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedure set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is 50 Braintree Hill Ste 400, Braintree, MA 02184-8734. Telephone #: (617) 426-3660.

Security Life Insurance company of America or our reinsurer(s) may also release information in our files to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

**HEALTH INFORMATION**

The applicant does not have to disclose information about any test performed to determine the presence of blood borne pathogens causing hepatitis B virus (HBV), hepatitis C virus (HCV), or human immunodeficiency virus (HIV) when such tests were performed on: (1) an offender or performed on a crime victim who was exposed to or had contact with an offender's bodily fluids during commission of a crime that was reported to law enforcement officials; (2) a patient who received the services of emergency medical services personnel at a hospital or medical care facility; or (3) emergency medical services personnel who were tested as a result of performing emergency medical services. **Review, understand, and sign the "Minnesota Disclosure Notice" before answering the health questions below.**

31. Answer ALL questions fully with respect to Applicant and Spouse.

- A. Do you or any person proposed for coverage, have or been told you had or been treated for, cancer, muscular dystrophy, multiple sclerosis, seizures, epilepsy, brain or nervous system disorder, depression, anxiety, or any other mental or emotional disorder?  Yes  No
- B. Have you or any person proposed for coverage ever had or been told you had or been treated for heart trouble, high blood pressure, rheumatic fever, goiter, ulcers, tuberculosis, asthma, diabetes, gout, back or joint disorder, arthritis, stroke or paralysis, or any liver, kidney, bowel, respiratory, circulatory, or stomach disease, problem or disorder?  Yes  No
- C. Have you or any person proposed for coverage ever been told you had immune deficiency disorder including AIDS or AIDS-Related Complex, (ARC), or AIDS-Related conditions; or had a blood test showing evidence of antibodies to the AIDS (HIV) virus? Yes  No
- D. Have you or any person proposed for coverage been treated for or ever had any known indications of any sexually transmitted disease including Syphilis, Gonorrhea or Herpes?  Yes  No
- E. In the past 10 years have you or any person proposed for coverage had chronic cough, significant weight loss, chronic fatigue, chronic diarrhea, enlargement of lymph nodes (glands), unusual skin lesions, or unexplained infections?  Yes  No

- F. Are you or any person proposed for coverage on medication? If yes, give name of drug and daily dosage.?  Yes  No  
\_\_\_\_\_
- G. Have you or any person proposed for coverage:
  - a) Ever had or been advised to have a surgical operation?  Yes  No
  - b) Ever been rated, declined, or postponed for life or health insurance?  Yes  No
  - c) Within the past 5 years had medical or surgical advice or treatment or any departure from good health? (If so, state when, what illness, duration, and give names and addresses of attending physicians.)  Yes  No
- H. Do you or any person proposed for coverage have other life insurance in force? If yes, what amount \$ \_\_\_\_\_  Yes  No
- I. Has a medical exam been arranged for?  Yes  No
- J. Will this insurance applied for replace any existing insurance? If yes, give name and address of company?  Yes  No  
\_\_\_\_\_  
\_\_\_\_\_

Give full details if any questions A through G is answered "Yes"

Name	Illness or Injury	Date	Duration	Name and Address of Doctor/Hospital

I understand that this Plan will not pay any benefits for losses which commence prior to the effective date of coverage or for any losses resulting from injury or sickness for which I or my spouse received or were advised to receive medical care or treatment or which in any way first manifests itself prior to the effective date of coverage.

I hereby represent that to the best of my knowledge and belief; all answers made on this application are complete and true and agree that this application shall be the basis for any part of any certificate issued. I further agree that no coverage shall be in force until the certificate is issued and the premium paid; and if issued and the premium paid, that coverage will be in force, subject to the group policy provisions, as of the effective date shown on the issued certificate.

I hereby apply for coverage as an employee of a qualified Employer, (Employer Name and Number) \_\_\_\_\_

**AUTHORIZATION AND ACKNOWLEDGEMENT**

I authorize any: licensed physician, medical practitioner, hospital, clinic, medical facility, insurance company, the Medical Information Bureau, Inc., or other organization, institution or person having information available about me or my health relevant to my insurability, to give Security Life Insurance Company of America, or its reinsures, any and all such information. **This authorization excludes, however, the release of information about any tests performed to determine the presence of blood borne pathogens causing hepatitis B virus (HBV), hepatitis C virus (HCV), or human immunodeficiency virus (AIDS virus or HIV) when such tests were performed under the circumstances spelled out in the separate "Minnesota Disclosure Notice" referenced above.**

I understand the information obtained by this Authorization will be used by Security Life Insurance Company of America to determine eligibility for insurance. A photocopy of this Authorization may be used in place of the original Authorization.

I have read and received the Medical Information Bureau (MIB, Inc.) Pre-Notice. I understand that this Authorization shall be valid for 26 months from the date signed.

Signatures: \_\_\_\_\_  
(APPLICANT) (PROPOSED INSURED IF OTHER THAN APPLICANT) (SPOUSE)

Signed at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_ 20 \_\_\_\_\_  
(CITY) (STATE) (AGENT SIGNATURE)

Agent Name (please print) \_\_\_\_\_ Agent No. \_\_\_\_\_

**RECEIPT FOR APPLICATION FOR INSURANCE WITH  
The Association Group Insurance Policy No. 100MBA**

Insured and Administered by  
**Security Life Insurance Company of America**  
 10901 Red Circle Drive  
 Minnetonka, Minnesota 55343-9137

The insurance for which application is made shall be effective on the date of issue according to the group policy and coverage applied for if the Proposed Insured(s) is (are) insurable and acceptable for insurance under the Company's rules and practices on the plan of insurance for which application is made. If the Company declines to issue a certificate or issues a certificate other than the coverage for which application is made, the Company shall incur no liability hereunder unless the certificate with coverage other than applied for is accepted by you in writing. Your coverage will be effective on the first of the month following approval by Security Life Insurance Company of America or its appointed administrator unless a later date is requested.

# MINNESOTA DISCLOSURE NOTICE

Minnesota Statutes, as amended August 1, 2000, require that all affected applicants for insurance be informed that no insurer may:

1. obtain or use the performance of or the results of a test to determine the presence of the human immune deficiency virus (HIV) antibody performed on an offender or performed on a crime victim who was exposed to or had contact with an offender's bodily fluids during commission of a crime that was reported to law enforcement officials, in order to make an underwriting decision, cancel, fail to renew, or take any other action with respect to a policy, plan, certificate, or contract; or
2. obtain or use the performance of or the results of such a test to determine the presence of a bloodborne pathogen performed on an individual in order to make an underwriting decision, cancel, fail to renew, or take any other action with respect to a policy, plan, certificate, or contract; or
3. ask an applicant for coverage or a person already covered whether the person has: (i) had a test performed for the reason set forth in clause (1) or (2); or (ii) been the victim of an assault or any other crime which involves bodily contact with the offender.

The following terms have the meanings given to them:

1. "**Bloodborne pathogens**" means pathogenic microorganisms that are present in human blood and can cause disease in humans. These pathogens include, but are not limited to, hepatitis B virus (HBV), hepatitis C virus (HCV), and human immunodeficiency virus (HIV).
2. "**Emergency Medical Services Person**" means: (i) an individual employed or receiving compensation to provide out-of-hospital emergency medical services such as a firefighter, paramedic, emergency medical technician, licensed nurse, rescue squad person, or other individual who serves as an employee or volunteer of an ambulance service or a member of an organized first responder squad that is formally recognized by a political subdivision in the state, who provides out-of-hospital emergency medical services during the performance of the individual's duties; (ii) an individual employed as a licensed peace officer; (iii) an individual employed as a crime laboratory worker while working outside the laboratory and involved in a criminal investigation; (iv) any individual who renders emergency care or assistance at the scene of an emergency or while an injured person is being transported to receive medical care and who is acting as a good samaritan; and (v) any individual who, in the process of executing a citizen's arrest, may have experienced a significant exposure to a source individual.
3. "**Source individual**" means an individual, living or dead, whose blood, tissue, or potentially infectious body fluids may be a source of bloodborne pathogen exposure to an emergency medical services person. Examples include, but are not limited to, a victim of an accident, injury, or illness or a deceased person.
4. "**Significant exposure**" means contact likely to transmit a bloodborne pathogen, in a manner supported by the most current guidelines and recommendations of the United States Public Health Service at the time an evaluation takes place, that includes: (i) percutaneous injury, contact of mucous membrane or nonintact skin, or prolonged contact of intact skin; and (ii) contact, in a manner that may transmit a bloodborne pathogen, with blood, tissue, or potentially infectious body fluids.

\_\_\_\_\_  
Signature of Agent  
(Not Applicable for Group Plans)

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

Original - Security Life

Yellow - Applicant

Pink - Agent/Provider

# Payroll Deduction Authorization

I here by authorize the State of Minnesota or the named Political Subdivision or School District to deduct from my wages or salary the amount indicated to pay the contribution, including a processing fee, for my Minnesota Benefit Association Program. I further authorize payment of such amount to the Minnesota Benefit Association. I understand that changes in the amount of deduction may be made without further authorization from me. I hereby release and agree to hold the State of Minnesota or the named Political Subdivision or School District harmless from any claim as a result of any error in paying such amounts. This authorization is to remain in effect until I provide written notice that it is to be cancelled.

Employer \_\_\_\_\_

Name of Employee \_\_\_\_\_

Employee I.D. # \_\_\_\_\_

Social Security # \_\_\_\_\_

Home Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_

Employee Signature \_\_\_\_\_

Date \_\_\_\_\_

**\*\*\* FOR OFFICE USE ONLY\*\*\***

Group # \_\_\_\_\_

Statement Due Date \_\_\_\_\_

New Deduction Amount \$ \_\_\_\_\_

PRD auth form