APPLICATION FOR INSURANCE AS
PROVIDED BY THE ASSOCIATON
GROUP INSURANCE POLICY
GROUP NO. 100MBA

SECURITYLIFE
INSURANCE COMPANY OF AMERICA
10901 Red Circle Drive, Minnetonka, MN 55343-9137

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:

1. 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
2. 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.

AMENDED PRE-NOTICE REGARDING MIB, Inc.

Information regarding your insurability will be treated as confidential. Security Life Insurance Company of America or its reinsurers may, however, make a brief report thereon to 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 company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901. If you question the accuracy of 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, Suite 400, Braintree, Massachusetts 02184-8734.

Security Life Insurance Company of America, or its reinsurers, may also release information in 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.

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 Com-plex,(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 Syphillis, 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) _____

AUTHORIZATON AND ACKNOWLEDGEMENT

I authorize any: licensed physician, medical practitioner, hospital, clinic, medical facility, insurance company, MIB, 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. I also authorize Security Life Insurance Company of America, or its reinsurers, to make a brief report to of my personal health information to MIB, Inc. **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 MIB, Inc. Pre-Notice and hereby authorize Security Life Insurance Company of America, or its reinsurers, to make a brief report of my personal health to MIB. I understand that this Authorization shall be valid for 26 months from the date signed.

Signatures: _____ (APPLICANT) _____ (PROPOSED INSURED IF OTHER THAN APPLIANT) _____ (SPOUSE)

Signed at _____ (CITY) (STATE) this _____ day of _____ 20 _____ _____ (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.

_____ 20_____ _____Agent

SECURITYLIFE
INSURANCE COMPANY OF AMERICA

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

Minnesota Benefit Association
Since 1929

6701 Upper Afton Road
Woodbury, MN 55125-2154
651.735.9874 Fax 651.739.3265
www.minnesotabenefitassociation.org
Toll-free 800-360.6117

APPLICATION INSTRUCTIONS FOR SECURITY LIFE 5 YR TERM INSURANCE, OFFERED EXCLUSIVLY THROUGH MINNESOTA BENEFIT ASSOCIATION

Please complete your application in blue or black ink. All applications must be signed in Minnesota. **A separate application must be completed for each proposed insured.**

This is a fully underwritten plan where medical records might be requested from your doctor and/or clinic. You might be required to complete an exam, urinalysis/blood profile depending on your age and face amount requested.

When filling out the application please note that the 'Applicant' denotes the MBA member (public employee). A separate application is required for each individual applying for coverage.

- ✓ Questions 1 – 7 pertain to the applicant (member) and are required on each individual application being submitted.
- ✓ Questions 8 – 17 pertain to the proposed insured (example: child or grandchild of member). *If the proposed insured is the spouse of the member, questions 8–17 should be left blank.*
- ✓ Questions 18 – 26 - are only used for spouse application.
- ✓ Question 27 - desired method of payment. For those wishing to use payroll deduction or PAC (automatic deduction from your bank account). A separate authorization form will be sent for your signature and two months premium will be requested at that time. This form along with a check or money order for the specified amount must be returned to our office before any deduction of premiums can begin.
- ✓ Question 28 - the death benefit amount you are applying for.
- ✓ Question 29 B and C – an Avocation and/or Aviation form will be mailed to you if necessary.

When completing page two of your application please answer all remaining health questions with respect to the proposed insured as well as the applicant *(due to the waiver of premium on the policy).* Indicate name of person and include details in the space provided or on a separate sheet. Also include the nature of the illness or injury, the date of the illness or injury, duration and the name and address of the doctor and/or hospital where the diagnosis or treatment was received.

Sign and date the application. You may email (info@MinnesotaBenefitAssociation.org), fax or mail (see fax number and address above) the completed application and disclosure form to Minnesota Benefit Association.

Minnesota Benefit Association
Since 1929

6701 Upper Afton Road
Woodbury, MN 55125-2154
651.735.9874 Fax 651.739.3265
www.minnesotabenefitassociation.org
Toll-free 800-360.6117

Payroll Deduction Authorization for Minnesota Benefit Association

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 _____

Home Address _____

City _____ **State** _____ **Zip** _____

Employee I.D. # _____

Social Security # _____

Home Phone # _____ **Work Phone #** _____

Email Address _____

Employee Signature _____

Date _____

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

Group #_____

Billing Due Date _____

New Deduction Amount $_____

PRD auth form 5-2014