The HEALTH GUARD Ltd. Plus

- **No Lifetime Maximums**
- **No Deductibles - Pays In and Out of the Hospital**
- **Additional Admission Benefits Paid - on 1st Day Hospital Confinement**
- **Inflation Fighter - Increasing Benefits the First Three Years**
- **Premiums do not Automatically Increase - as you grow older**
- **Freedom to choose your own Doctors and Hospitals without Penalty**

Providing Quality Health Insurance Coverage to Fellow Texans for 57 years.

Southwest Service Life Insurance Company
P.O. Box 982005
Fort Worth, TX 76182

Policy Form HI-2019 Plan A

Southwest Service Life Insurance Company HI- 2019 Plan A

NO LIFETIME MAXIMUMS

Aggregate Amount Per Sickness	$200,000 Per Person
Aggregate Amount Per Injury	$200,000 Per Person

No Deductible Policy

Increasing First Day Admission Benefits and Daily Hospital Benefits Plus ICU-Benefits In-Hospital Physicians' Benefits

(Outpatient Surgery paid same as In-Hospital Surgery)

1st Day Admission Benefit with Hospital Confinement			2nd Day & beyond of Hospital Confinement		
1st Policy Year	2nd Policy Year	3rd Policy Year +	1st Policy Year	2nd Policy Year	3rd Policy Year +
$3,000/day	$3,750/day	$4,500/day	$2,000/day	$2,500/day	$3,000/day
1st Day of ICU Confinement			**2nd Day & beyond of ICU Confinement**		
1st Policy Year	2nd Policy Year	3rd Policy Year +	1st Policy Year	2nd Policy Year	3rd Policy Year +
$3,750/day	$4,500/day	$5,250/day	$2,750/day	$3,250/day	$3,750/day

• Doctor's Visit	• $75 per day of confinement; limit one visit per day.
• Maximum Benefit	• $1,200 per Policy Year per Insured Person
• Surgical Benefits**	• 150% based on Medicare Fee Schedule*
• Assistant Surgeon Benefit	• 20% of Surgical Benefit
• Anesthetist Benefit	• 25% of Surgical Benefit
• Pathologist Benefit	• $350 per day of surgery
• Radiologist Benefit	• $350 per day of surgery

No Deductible Outpatient Services Benefits $2,000 Per Person Per Policy Year

• Doctor's Office Outpatient Visit Benefit	• $90 per day of visit
• MRI Scan Benefit	• $865 per day of visit
• PET Scan Benefit	• $575 per day of visit
• CT Scan Benefit	• $290 per day of visit
• X-Ray or Radiological Exam Benefit	• $115 per day of visit
• Emergency Room or Urgent Care	• $145 per day of visit (Limit one per Policy year)
• Other Covered Out-Patient Not Itemized	• $115 per day of event (Limit four per Policy year)
• Ambulance Service Benefit	• $200/day ambulance is used (Limit four per Policy year)
• Home Recuperation Benefit Maximum Home Recuperation	$200 per day equivalent Hospital Confinement $15,000 Per sickness or accident
• Radiation & Chemotherapy for Cancer	• $500 per day of therapy. Benefit Lifetime limit $12,500

Outpatient Preventive Care Benefits

• Well Care Visit Benefit	• $50 (Limit three per policy year)
• Immunizations	• $60 on the day or other period of time of immunization (Limit three per policy year).
• Mammography Benefit (Female 35 and over) or PSA Benefit (Male 40 and over)	• $115 per day of test (Limit one per policy year)
• Conventional Pap smear (Females 18 and over)	• $175 per day of screening (Limit one per Policy year)
• Spine or Back Manipulation	• $60 per Policy year.

Benefits are payable for each Insured Person on a fixed dollar amount per Day (or per other period) for Hospital Confinement, Outpatient Events, and Surgical Events, that occur while this Policy is in force and regardless of the amount of expenses incurred. Payment of benefits is subject to all terms, limitations, exclusions, waiting periods and aggregates in the Policy. *Surgery Benefits are based on 150% of the federal government's 2019 Resource-Based Relative Value System (RBRVS) as applied to the Medicare Physician's Free Schedule for Surgeries. **The policy will pay for the greater of either inpatient Doctor's Visits or Surgery Benefits on account same injury or sickness. **Please read your Policy carefully.**

The HEALTH GUARD Ltd. Plus

POLICY FORM HI-2019 Plan A

The Protection You Need at a Price You Can Afford

Providing Quality Affordable Health Insurance Coverage to Fellow Texans for over 57 years.

- Policy Guarantee Renewable to age 65.
- No Lifetime Maximums
- No Deductibles in or out of the Hospital
- Inflation Fighter - Increasing Daily Indemnity Benefits for the first three years on each Hospital confinement for Sickness and Accidents, per person per policy year
- Inflation Fighter - Additional First Day Hospital Admissions Benefits paid on each confinement for Sickness and Accidents, per person per policy year
- Policy pays an additional Indemnity Benefit for ICU Confinement
- Outpatient Surgery paid the same as In-Hospital Surgery
- Radiation and Chemotherapy for Cancer is included
- Well Care Visits and Immunizations benefits for all insured family members
- Mammography Benefits (females 35 and over) Conventional Pap Smear (Females 18 and over). PSA Benefit (Male and 40 and over)
- You're free to choose your own Doctor and Hospital
- Southwest Service Life also provides a Pre-Script Discount Prescription Drug Card at No additional cost to you.

These are just a few of the benefits that make the Health Guard Ltd. *Plus* the Best in Class.

Benefits are payable for each Insured Person on a fixed dollar amount per Day (or per other period) for Hospital Confinement, Outpatient Events, and Surgical Events, that occur while this Policy is in force and regardless of the amount of expenses incurred. Payment of benefits is subject to all terms, limitations, exclusions, waiting periods and aggregates in the Policy. **Please read your Policy carefully.**

This policy is not comprehensive health insurance, minimum essential coverage under the Patient Protection and Affordable Care Act of 2010, or workers' compensation insurance. You should consult your employer to determine whether your employer is a subscriber to the workers' compensation system.

Southwest Service Life Insurance Company
(A Stipulated Premium Company)
Administrative Office: P.O. Box 982005
Fort Worth, Texas 76182
Customer Service: 1-800-966-7491

INDIVIDUAL HOSPITAL INDEMNITY POLICY FOR INPATIENT AND OUTPATIENT MEDICAL CARE

REQUIRED OUTLINE OF COVERAGE
Policy Form HI-2019
PLAN A

This Outline of Coverage is not the policy

Part 1 READ YOUR POLICY CAREFULLY. This outline of coverage provides a very brief description of some of the important features of Your Policy. This is not the insurance contract and only the actual Policy provisions will control. The Policy itself sets forth, in detail, the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

Part 2. Hospital confinement indemnity coverage is designed to provide you with a fixed daily benefit during periods of hospital confinement resulting from a covered injury or sickness. The policy also provides fixed daily indemnification for surgical events. Coverage is provided for the benefits outlined in PART THREE. The benefits described in PART THREE may be limited by PART FOUR.

Part 3. Principal benefits and coverage of Plan A: After we have approved your application and issued your policy, we will pay a fixed dollar amount per day (or other period) for Covered Events that include Hospital Confinement, Surgery, and limited outpatient medical care, regardless of any other health plan that covers you or how much your provider charges. A "Covered Event" is an observable and distinct occurrence of Hospitalization, Medical Services, Medical Care, and/or Surgery due to injuries occurring on or after the policy issue date; sicknesses, which are not otherwise excluded or limited, first manifesting more than thirty (30) days after the policy issue date; after two (2) years, for sicknesses, which are not otherwise excluded, first manifesting within 30 days from the policy issue date; and for limited outpatient preventative care after the policy issue date. Outpatient Surgery Benefits will be paid the same as one day of Inpatient Surgery Benefits.

NO LIFETIME AGGREGATE MAXIMUM AGGREGATE AMOUNT

$200,000 per person for each sickness.
$200,000 per person for each accident.

NO POLICY YEAR DEDUCTIBLE

DAILY HOSPITAL CONFINEMENT BENEFITS

	1st Policy Year	2nd Policy Year	3rd Policy Year
1. Hospital Confinement for Sickness and Accidents	$2,000 per day	$2,500 per day	$3,000 per day
2. Additional First-Day Admission Benefit for Sickness and Accidents	1st Policy Year	2nd Policy Year	3rd Policy Year
	$1,000 per 1st day	$1,250 per 1st day	$1,500 per 1st day
3. Intensive Care Unit Confinement	Additional $750 per Day of ICU confinement.		

4. Surgical Benefit In-Hospital	If it shall be necessary for an Insured Person to have a surgical procedure while confined in a Hospital, performed by a duly licensed Physician, We will pay 150% based on *Medicare Fee Surgical Schedule for a covered surgical procedure regardless of what Your provider charges you. If one surgical procedure is performed, the allowance for that procedure will be paid. If two or more procedures are performed during one operative session, only one allowance (the greater) will be paid. $12,500.00 on maximum surgery benefit per person for each sickness and accident.
5. Additional Surgery Benefit	If, as a result of such injury or sickness, an Insured Person receives surgical care in an Ambulatory Surgical Center, Hospital Day Surgery Center or Hospital Outpatient Department, We will pay the amounts, herein provided, in the same manner as if the Insured Person had been Hospital confined for one day for a covered surgery. No benefits are payable for surgical care in a Hospital emergency room, trauma center, Physician's office or clinic or center for termination of pregnancy.
6. Assisting Surgeon Benefit	If a Physician is required to assist the Surgeon during the procedure, We will pay 20% of the payable Surgical Benefit for the Primary Assisting Surgeon.
7. Anesthetist Benefit	We will pay 25% of the payable Surgical Benefit for administration of anesthetic by a duly qualified anesthetist during a surgical procedure. Exception: we will not pay benefits for the administration of anesthetic by the operating surgeon or an assistant surgeon.
8. Pathologist Benefit	If the service of a licensed Pathologist is required while confined as a resident bed patient in a Hospital and in connection with a surgical procedure, We will pay $350.00 for services rendered by such licensed Pathologist for the day of a covered surgery.
9. Radiologist Benefit	If the service of a licensed Radiologist is required while confined as a resident bed patient in a Hospital and in connection with a surgical procedure, We will pay $350.00 for services rendered by such licensed Radiologist for the day of a covered surgery.
10. Doctor's Visits	If an Insured, as a result of such injury or such sickness, shall be confined as a resident bed patient in a Hospital, We will pay a maximum daily benefit of $75 for each personal call by a physician at the Hospital, provided however We will not pay for both doctor's calls in-hospital and surgical benefits on account of the same injury or sickness, but only which provides the greater benefit. Limit one call benefit per day up to the $ 1,200 per Year Benefit.
11. Mastectomy or Lymph Node Dissection	(Minimum Inpatient Stay): The policy will provide coverage for inpatient care for a minimum of 48 hours following a mastectomy, and 24 hours following a lymph node dissection.

NO DEDUCTIBLE OUTPATIENT SERVICES BENEFITS $2000 PER PERSON PER POLICY YEAR

12. Indemnity for Outpatient Events

If, as a result of "such injury" or "such sickness" an Insured Person requires any of the following itemized medical treatments or services or other services required by law, either in a Physician's office, clinic, or outpatient department of a hospital or other places prescribed by such law, We will pay the amounts shown on the daily Policy Benefit Schedule for each Insured Person for the following:

Doctor's Office Outpatient Visit Benefit	$90 per day of visit	Other Covered Out-Patient Not itemized	$115 per day of visit (Limit four per Policy year)
MRI Scan Benefit	$865 per day of visit	Ambulance Service Benefit	$200/day ambulance is used (Limit four per Policy year)
PET Scan Benefit	$575 per day of visit	Home Recuperation Benefit Maximum Home Recuperation	$200 per day equivalent Hospital Confinement $15,000 Per sickness or accident.
CT Scan Benefit	$290 per day of visit		
X-Ray or Radiological Exam Benefit	$115 per day of visit		
Emergency Room or Urgent Care	$145 per day of visit (Limit one per Policy year)	Radiation & Chemotherapy for Cancer	$500 per day of Therapy. Benefit Lifetime limit $12,500

OUTPATIENT PREVENTATIVE CARE BENEFITS

13. Indemnity for Outpatient Preventative Care

Well Care Visit Benefit	$50.00 (Limit three per policy year)	Mammography Benefits (Females: 35 and over) Or PSA Benefit (Males 40 and over)	$115.00 per day of test, (Limit one per policy year)
Immunizations	$60.00 on the day or other period of time of immunization, (Limit three per policy year).	Conventional Pap smear (Females 18 and over)	$175.00 per day of screening, (Limit one per Policy year)
		Spine or Back Manipulation	$60.00 per Policy year.

* Surgery Benefits are based on 150% of the federal government's 2019 Resource-Based Relative Value System (RBRVS) as applied to the Medicare Physician's Fee Schedule for Surgeries.

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

28 TAC §3.3608(1)

THIS IS NOT MEDICARE SUPPLEMENT INSURANCE This insurance pays a fixed amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits because Medicare generally pays for most of the expenses for the diagnosis and treatment of the specific conditions or diagnoses named in the policy.

This insurance duplicates Medicare benefits when:

- Any expenses or services covered by the policy are also covered by Medicare

  Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Hospice
- Other approved items and services

BEFORE YOU BUY THIS INSURANCE

✓ Check the coverage in **all** health insurance policies you already have.

✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

SOUTHWEST SERVICE LIFE INSURANCE CO.

A Stipulated Premium Company • Administrative Office: Fort Worth, Texas

INSTRUCTIONS TO AGENT: This form is provided for the purpose of compliance with regulations regarding the replacement of accident and sickness insurance.

When the replacement questions on the application is answered YES, this form must be dated, signed by applicant, and submitted with the application, AND a copy of this form must be left with the applicant.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

According to your application, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by Southwest Service Life Insurance Co.

For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have, pre-existing conditions, may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.
3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may prove a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.

The above ''Notice to applicant" was delivered to me on: (DATE) _____

Applicant's Signature _____

REPL-3(2-98)

SOUTHWEST SERVICE LIFE INSURANCE CO.

A Stipulated Premium Company • Administrative Office: Fort Worth, Texas

APPLICANT'S ACKNOWLEDGMENT OF UNDERSTANDING and DESCRIPTION OF AGENT'S AUTHORITY

Insurance agent,_____, talked with me about applying for insurance with Southwest Service Life Insurance Company and gave me an outline of coverage for the policy that I am applying for. The agent showed me on the outline of coverage the description of the policy benefits, the waiting periods and the limitations and exclusions, which I read and understand. I also understand that the policy I am applying for contains limited benefits, and any benefits payable will always be paid in accordance with policy provisions.

I have personally answered each question on the application, including the health history questions, and I read the application before signing it to make sure all the questions were answered correctly. No one told me to leave out any information asked for in the application.

I understand the agent taking this application does not have any authority to leave out any information that is asked for in the application. All the information I told the agent about my health history, and the health history of any other applicant, is written on the application. The agent explained that the company will rely on my answers in the application in deciding whether or not to issue a policy to me.

I understand that no insurance will become effective until a policy is actually issued by the company and that making this application and paying the initial premium does not guarantee that a policy will be issued. I understand the agent taking my application has no authority to guarantee me that a policy will be issued.

I HAVE READ AND UNDERSTOOD THE ABOVE STATEMENTS BEFORE SIGNING THIS DOCUMENT.

Signed:

Agent _____ Applicant _____

Co-Applicant _____

Date _____ Date _____

SOUTHWEST SERVICE LIFE INSURANCE COMPANY

IMPORTANT NOTICE

This Medical Records Authorization Form must be completed, signed and submitted with the initial application.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) COMPLIANT MEDICAL RECORDS AUTHORIZATION FORM

Patient/Primary Proposed Insured .....

Address: .....City: .....Zip: .....Date of Birth:..... / ..... / .....

This is an authorization under the Privacy Rules of the Health Insurance Portability and Accountability Act of 1996; 45 CFR §164.508. It authorizes Southwest Service Life Insurance Company to use my complete medical records, and those of my family members whose names appear in my application for health insurance, for the purposes of insurance underwriting, risk review, claims adjudication and other health plan insurance operations.

The person/people/entities authorized to make this disclosure to Southwest Service Life Insurance Company is/are my physicians, medical practitioners, hospitals, clinics, medical facilities, the Pharmacy Benefit Manager, or other health care providers having records or knowledge of my health, and those of my family members whose names appear in my application for health insurance. Treatment, payment, enrollment, or eligibility of benefits is not conditioned on obtaining my authorization.

The confidentiality of my health care information is waived by this authorization, which permits disclosure of any and all requested parts of my medical records. I understand that re-disclosure may not be protected by the federal privacy regulations. I also understand this may include drug, alcohol, mental health, HIV or AIDS information.

This authorization is valid for two years following the date written below and will then expire. Under the Privacy Rules, I have the right to revoke this authorization at any time, and Southwest Service Life Insurance Company must cease using this authorization. However, Southwest Service Life Insurance Company may complete any actions it initiated prior to my revocation and which rely on my complete medical records for completion. I must revoke this authorization in writing and send the revocation to Southwest Service Life Insurance Company, P.O. Box 982005, Fort Worth, Texas 76182-8005.

Notice to my health care provider(s): An electronic signature on this HIPAA Compliant Medical Records Authorization Form has the same legal authority as a hand-written signature under both state and federal law. Please accept my e-signature as if it were my original hand-written signature.

Signature of Patient/
Primary Proposed Insured

..... Date ..... / ..... / ..... Date of Birth:..... / ..... / .....

Signature of Patient/Spouse
(if proposed to be insured)

..... Date ..... / ..... / ..... Date of Birth:..... / ..... / .....

Signatures of other
Patients/Dependents 18 or over
(if proposed to be insured)

..... Date ..... / ..... / ..... Date of Birth:..... / ..... / .....

..... Date ..... / ..... / ..... Date of Birth:..... / ..... / .....

..... Date ..... / ..... / ..... Date of Birth:..... / ..... / .....

Please Complete if Applicable:

Print name(s) of covered children

..... Date of Birth: ..... / ..... / .....

..... Date of Birth: ..... / ..... / .....

..... Date of Birth: ..... / ..... / .....

HI-2019 Plan ❑ A

SWLT-10 & CCLB-Rider ..... ❑ YES
Non-Tobacco User ..... ❑ YES
Tobacco User ..... ❑ YES
Accident Plan - AO ..... ❑ YES
DEDUCTIBLE 0

Cancer Plan AC - 502
Standard Plan ... ❑ YES
Preferred Plan ... ❑ YES
H&S-1 Coverage .. ❑ YES

Southwest Service Life Insurance Company

(A Stipulated Premium Company) FORT WORTH, TEXAS

POLICY NUMBER	SPECIAL REQUEST

BILLING MODE ❑ MONTHLY ❑ MONTHLY BANK DRAFT	MAIL POLICY TO:	REP#

PRINT	Names of Applicant and of each Member of Family Group.	Relationship to Applicant	Age	Sex	Date of Birth Mo.	Day	Yr.	Ht.	Wt.	Amount of Life Insurance	Social Security Number
1.		Applicant								$	
2.											
3.											
4.											
5.											
6.											

2. MAILING ADDRESS

Street, Number, RFD City State Zip Code

3. Name of Applicant's Employer or Business Applicant's Occupation

Name of Spouse's Employer or Business Spouse's Occupation

4. Beneficiary (for Life Insurance) Relationship

5. List other coverage or any pending applications applicant may have.

NAME OF COMPANY	IS POLICY TO BE REPLACED? Yes	No	When

6. Applicant's Home Telephone

Work Telephone

Have you or any member listed ever been declined, restricted, rated up or postponed for any kind of personal insurance? ❑ YES ❑ NO

If "YES", Name of Company. Why?

7. Are any applicants covered by Medicare or Medicaid? ❑ YES ❑ NO

If "YES," which applicant?

APPLICANT OR SPOUSE MUST ANSWER ALL QUESTIONS IN FULL - YOUR REPRESENTATIVE DOES NOT HAVE AUTHORITY TO WAIVE OR OMIT ANY INFORMATION FROM YOUR APPLICATION

8. Are you and all the other members listed above now in good health and without physical or mental defect or deformity? ..... ❑ YES ❑ NO

9. **HAVE ANY OF YOU EVER HAD ANY OF THE FOLLOWING?**

(a) High Blood Pressure, Disease of the Heart, Circulatory System, Veins and Arteries or Stroke? ..... ❑ YES ❑ NO
(b) Chest Pain? ..... ❑ YES ❑ NO
(c) Hypercholestrolemia or Hypertriglyceridemia? ..... ❑ YES ❑ NO
(d) Tuberculosis, Emphysema, COPD, Bronchitis or any other Lung Disease? ..... ❑ YES ❑ NO
(e) Asthma? ..... ❑ YES ❑ NO
(f) Allergy, Hayfever, Sinusitis or Deviated Nasal Septum? ..... ❑ YES ❑ NO
(g) Hernia? ..... ❑ YES ❑ NO
(h) Hemorrhoids, Anal Fistula or Disease of the Rectum or Colon? ..... ❑ YES ❑ NO
(i) Disease of the Esophagus, Stomach, Pylorus or Duodenum? ..... ❑ YES ❑ NO
(j) Disease of the Intestines, Gall Bladder or Liver? ..... ❑ YES ❑ NO
(k) Diabetes, Hyperglycemia or Disease of the Pancreas? ..... ❑ YES ❑ NO
(l) Disease of the Kidneys, Ureters, Bladder or Urethra? ..... ❑ YES ❑ NO
(m) Any Venereal Disease? ..... ❑ YES ❑ NO
(n) Any Disease of the Thyroid or Parathyroid? ..... ❑ YES ❑ NO
(o) Any Neck, Back, Spine, or Hip Disease or Disorder? ..... ❑ YES ❑ NO
(p) Arthritis, Rheumatism, Gout or Joint Disorder? ..... ❑ YES ❑ NO
(q) Cancer ..... ❑ YES ❑ NO
(r) Glaucoma, Cataracts or any other Disorder of the Eyes? ..... ❑ YES ❑ NO
(s) Depression, Anxiety, Phobia, Alzheimer's Disease or any other Mental or Nervous Disease or Disorder? ..... ❑ YES ❑ NO
(t) Alcohol, Drug or any Chemical Abuse? ..... ❑ YES ❑ NO
(u) Any Disease or Disorder of either or both feet? ..... ❑ YES ❑ NO
(v) Any Injury to, or Disease or Disorder of, the knee(s)? ..... ❑ YES ❑ NO
(w) Any jaw disproportions or malocclusions? ..... ❑ YES ❑ NO
(x) Any other Disease or Disorder not specifically listed in (a) through (w) above? ..... ❑ YES ❑ NO

10. (a) Has any male Family Member ever had any Disease or Disorder of the Prostate or any other reproductive organ? ..... ❑ YES ❑ NO

Has any female Family Member ever had any of the following?

(b) Any Disease or Disorder of either or both breasts? ..... ❑ YES ❑ NO
(c) Any Breast Implant or Prosthesis? ..... ❑ YES ❑ NO
(d) Any hormone imbalance? ..... ❑ YES ❑ NO
(e) Caesarean section? ..... ❑ YES ❑ NO
(f) Any complication of a pregnancy? ..... ❑ YES ❑ NO
(g) Is any Family Member currently pregnant? ..... ❑ YES ❑ NO

11. Have you or any member listed above ever been told or advised to have a surgical operation which has not been performed? (If "YES," give full details below) ..... ❑ YES ❑ NO

12. Has any proposed insured been diagnosed HIV positive by a member of the medical profession or diagnosed as having AIDS or ARC? ..... ❑ YES ❑ NO

13. Do you or any dependent listed above own or operate a motorcycle or trail bike; engage in weight lifting; underwater diving; auto or vehicle racing, rodeo activities or any other hazardous work or sport activity?
❑ YES ❑ NO If YES, which applicant(s) _____

What sport or activity? _____

14. Name of Applicant's Doctor _____ Address _____

Name of Spouse's Doctor _____ Address _____

Name of Children's Doctor _____ Address _____

(OVER, QUESTION #15 CONTINUES ON BACK)

APP HI-2019

X _____
APPLICANT'S SIGNATURE

ADDITIONAL MEDICAL INFORMATION (CONTINUED)

15.If Question No. 8 was answered "NO," or any part of 9, 10, 11, or 12 was answered "YES," give full details below, and details of any other ailments about which any Doctor was consulted **IN THE LAST 10 YEARS** by you or any dependent listed above. If none, state "NONE." **LIST ALL HOSPITAL CONFINEMENTS OR OUTPATIENT SURGERIES IN LAST 10 YEARS (ROUTINE CONFINEMENTS, WITHOUT COMPLICATIONS, FOR CHILDBIRTH NEED NOT BE LISTED).**

Name of Person	Nature of Illness or Injury	Dates(s)	Names and Addresses of Doctor(s) and Hospitals	Recovery Complete?

16. List all prescriptions currently being taken by the:

Applicant

Spouse

Children

This is a supplement to your health insurance and is not a substitute for major medical coverage. Lack of major medical coverage (or other minimum essential coverage) may result in an additional payment with your taxes.

17."I hereby apply to Southwest Service LIfe Insurance Company for a policy to be issued solely and entirely in reliance on the written answers to the questions in this application. I understand and agree that (1) the insurance shall not take effect unless the application has been accepted and approved by the Company and until the Effective Date of the Policy and (2) the agent does not have the authority to waive a complete answer as to any question in the application, pass on insurability, make or alter any contract, or waive any of the Company's other rights or requirements. I understand and agree that the falsity of any answer or statement in this application may bar the right to recover thereunder if such answer materially affects the acceptance of the risk or hazard assumed by the Company. The Company may rely upon this application and all of the information contained herein. This is an authorization under the Privacy Rules of the Health Insurance Portability and Accountability Act of 1996, 45 CFR §164.508. It authorizes Southwest Service Life Insurance Co., to use my complete medical records, and those of my family members whose names appear in my application for health insurance, for the purposes of insurance underwriting, risk review, claims adjudication and other health plan insurance operations. The person/people/ entities authorized to make this disclosure to Southwest Service Life Insurance Co. are my physicians, medical practitioners, hospitals, clinics, medical facilities of other health care providers having records or knowledge of my health, and those of my family members whose names appear in my application for health insurance. The confidentiality of my health care information is waived by this authorization, which permits disclosure of any and all requested parts of my medical records. I understand this may include drug, alcohol, mental health, HIV and AIDS information. Southwest Service Life Insurance Co. will, within sixty days from the date written below, send me a copy of this authorization form as completed by me. This authorization is valid for two years following the date written below and will then expire. Under the Privacy Rules, I have a right to revoke this authorization at any time, and Southwest Service Life Insurance Co. must cease using this authorization. However, Southwest Service Life Insurance Co. may complete any actions it initiated prior to my revocation and which rely on my complete medical records for completion. I must revoke this authorization in writing and send the revocation to Southwest Service Life Insurance Co., PO. Box 982005, Fort Worth, Texas 76182-8005. A photocopy of this authorization is to be considered as valid as the original. **This application for insurance is medically underwritten. My policy may be issued as applied for or with either an exclusionary rider or a premium rating for a treated medical condition. I have received an outline of coverage for the policy applied for."**

I Certify I have accurately recorded herein the information supplied by the applicant and that an outline of coverage has been given the applicant.

Dated at _____ 20 ___ .
(City & State) (Month Day Year)

X _____
Representative's Signature

Address: _____

X _____
Applicant's Signature

X _____
Spouse's Signature

Amount paid for Policy form HI-2019 $ _____ for initial and First _____ Months Premium
Amount paid for Policy form SWLT-10 & CCLB-Rider $ _____ for initial and First _____ Months Premium
Amount paid for Policy form AO $ _____ for initial and First _____ Months Premium
Amount paid for Policy form AC-502 $ _____ for initial and First _____ Months Premium
Amount paid for Policy form H&S-1 $ _____ for initial and First _____ Months Premium

ADDITIONAL FAMILY MEMBERS

PRINT	Names of Additional Family Members to be Insured	Relationship to Applicant	Age	Sex	Date of Birth Mo.	Day	Yr.	Ht.	Wt.	Amount of Life Insurance	Social Security Number
7.										$	

AUTHORIZATION TO HONOR CHECKS DRAWN BY THE SOUTHWEST SERVICE LIFE INSURANCE COMPANY, FORT WORTH, TEXAS 76182

Bank Name: _____ ☐ Checking ☐ Savings

Bank Address: _____

Routing Number: _____

As a convenience to me, I hereby request and authorize you to pay and charge to my account checks drawn on my account by and payable to the order of the Southwest Service Life Insurance Company, Fort Worth, Texas. I agree that your rights in respect to each such check shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such check.
I further agree that if any such check be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

Date Account No. Signature EXACTLY as it appears on Bank Records

If Business Account, need
Name & Address of Business: _____

PART 4. EXCLUSIONS, LIMITATIONS, & REDUCTIONS

WAITING PERIODS & PRE-EXISTING CONDITIONS:

1. No waiting for coverage for Injuries occurring after the Effective Date of Coverage;

2. Coverage for Sickness:

a) The policy will cover Sickness which first manifests thirty (30) days after the Effective Date of Coverage;

b) During the first two (2) years, benefits would not be payable for Sickness which first manifests within the first thirty (30) days from the Effective Date of Coverage.

c) During the first year, benefits would not be payable for any pre-existing conditions disclosed during the application process. "Pre-Existing Condition" means the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment within a five-year period preceding the Effective Date of coverage or a condition for which medical advice or treatment was recommended by a Physician or received from a Physician within a five-year period preceding the Effective Date of coverage;

d) No benefits would be payable during the first six (6) months from the Effective Date of Coverage for Losses due to hernia, varicose veins, hemorrhoids, or diseases or disorders of the reproductive organs, appendix, tonsils, adenoids, and gallbladder. 3. Complications of Pregnancy are covered like a sickness if the policy has been in force at least thirty (30) days before the inception of the pregnancy.

EXCLUSIONS: Benefits otherwise provided by the policy will not be payable for Events, services, expenses or any Loss resulting from or in connection with:

a) Dental treatment except dental treatment for a covered Injury within 90 days thereof;

b) Accidental bodily Injury or Sickness caused by war or any act of war declared or undeclared; or service in the armed forces or units auxiliary thereto (Premium will be refunded on a pro-rata basis and coverage will be canceled for an Insured Person who enters military service.);

c) Any intentional self-inflicted Injury, suicide or attempted suicide;

d) Addiction to, overdose of, or Sickness or Injury resulting from use of alcohol, drugs, narcotics, hallucinogens, or other drugs, controlled or uncontrolled substances;

e) Termination of use or addiction to tobacco products;

f) Intoxicants and Narcotics. We are not liable for any loss sustained or contracted in consequence of an Insured Person being intoxicated or under the influence of any narcotic unless the narcotic is administered on the advice of a Physician. This exclusion applies whether or not the Insured Person is charged with any violation in connection with a loss; further, there is no need to prove a loss was caused, contributed to, or resulted from excessive blood alcohol concentration;

g) Cosmetic surgery, except operations necessary to repair disfigurement resulting from a covered Injury and performed (1) within two years of the date of the covered Injury, and (2) while this Policy is in force;

h) Any Injury or Sickness arising out of, or in the course of, employment for wage or profit, provided the Insured Person is covered under any Workers' Compensation Act, Occupational Disease Act, or similar act or law, unless the Insured Person is self-employed;

i) Voluntary sterilization; in vitro fertilization, fertility drugs or any other expenses or services relating to or in connection with assisted reproductive technology;

j) Normal pregnancy, except for Complications of Pregnancy as defined herein;

k) Elective abortion or any elective procedure or treatment;

l) Aviation of any type, except as a fare-paying passenger on a regularly scheduled flight on a commercial airline;

m) Services performed by an Insured Person on him- or herself.

n) Breast augmentation or reduction mammoplasty unless necessary in connection with breast reconstructive surgery following a mastectomy;

o) Gastric segmentation, stapling, or any other surgical procedure or medical treatment for weight control, weight reduction or dietary control or any expenses of any kind to treat obesity, weight control, weight reduction or dietary control;

p) Mental or nervous disorders without demonstrable organic disease;

q) Prostheses of any kind;

r) Occupational therapy;

s) Services which you are entitled to receive without incurring legal liability;

t) Medical treatment incurred outside the United States of America.

u) Charges for which there is no legal obligation to pay; charges which are compensated for or furnished by the United States government or any of its agencies; EXCEPT, coverage will not be excluded because of confinement in a Hospital operated by the federal government.

v) Expenses incurred which exceed the maximum benefits of this Policy;

w) Corrective vision or hearing supplies or for the examination for prescribing or fitting such supplies, or any treatment of refractive disorders;

x) Confinement or treatment in any sanitarium, or in facilities for the aged, criminals, educational care, drug addiction or alcoholism;

y) Treatment of temporomandibular joint dysfunction (TMJ);

z) Transplants;

aa) Rest cures, home hospice; **bb)** Treatment for foot conditions including, but not limited to: (i) flat foot conditions; (ii) foot supportive devices, including orthotics and corrective shoes; (iii) foot subluxation treatment; (iv) plantar fasciitis, corns, bunions, calluses, toenails, fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet; and (v) hygienic foot care that is routine; **cc)** Confinement or treatment in any convalescent home, rest or nursing facility, unless specifically provided herein; **dd)** The cost of blood plasma or blood derivatives, cross matching, typing or transfusions; **ee)** Services for calibration of automated laboratory equipment and monitoring overall results from such equipment; **ff)** Treatment or services for behavioral or learning disorders, including but not limited to Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD); **gg)** Treatment of "quality of life" or "lifestyle" concerns including but not limited to: smoking cessation; obesity; hair loss; **hh)** Sexual dysfunction including, but not limited to: sex transformations, penile implants, or any complications thereof; **ii)** Treatment used to improve memory or to slow the normal process of aging; **jj)** Illegal Occupation: We are not liable for any loss for which a contributing cause was the Insured Person's commission of or attempt to commit a felony or for which a contributing cause was the Insured Person's being engaged in an illegal occupation; **kk)** Laser vision correction, radial keratotomy or any eye Surgery when the primary purpose is to correct nearsightedness, farsightedness, astigmatism, or any other refractive error; **ll)** Eye refractions; vision therapy; routine vision exams to assess the initial need for, or changes to prescription eyeglasses or contact lenses; the purchase, fitting or adjustment of eyeglasses or contact lenses; frames or contact lenses for the treatment of aphakia; **mm)** Transportation charges, except as provided herein for Ambulance Transport Services benefits; **nn)** Any medicine or services

provided by a pharmacy or pharmacist, including but not limited to counseling and delivery, except as otherwise specifically provided herein for Immunizations; **oo)** Immunizations or vaccinations required or elected solely for personal travel; and **pp)** Treatment of complications arising from or connected in any way with a surgical or medical treatment or procedure that is not a covered surgical or medical treatment or procedure under the terms of this Policy, whether or not the Insured Person was insured under the Policy at the time the non-covered treatment or procedure was performed.

PART 5. RENEWABILITY

The coverage for each Insured Person will be guaranteed renewable up to the age of 65, subject to the Company's right to cancel, discontinue or terminate it.

CANCELLATION: We may cancel the policy at any time by written notice delivered to you, or mailed to your last address as shown by our records, stating when the cancellation is effective, which may not be earlier than five days after the date the notice is delivered or mailed. After the policy has been continued beyond its original term, you may cancel the policy at any time by written notice delivered or mailed to us, effective on receipt or on a later date specified in the notice.

TERMINATION. Coverage will terminate and no benefits will be payable:

1. On the date premiums are not received when due, subject to the Grace Period; or
2. At the end of the period through which premium has been paid:
   a. For a covered Spouse who gets divorced,
   b. For a covered child who turns 26 years old, or
   c. For a disabled dependent who is no longer disabled or dependent on you for more than one-half of their support; or
3. The Company discontinues offering this particular type of policy in the individual market; or
4. On the date an Insured Person or their representative performs an act or practice that constitutes fraud, or makes an intentional misrepresentation of material fact relating in any way to the Policy, including claims for Benefits; or
5. On the Policy Renewal date first following each Insured Person's 65th birthday.

PART 6. PREMIUM

The premiums for the policy are shown on the premium rate sheet. The Family Premium rate is based on the age of the oldest family member. We reserve the right to change the applicable table of premium rate on a Class Basis. The premium for the Policy may change in amount by reason of an increase in the age of an Insured Person.

A Grace Period is provided for each premium payment. The Grace Period will be 10 days for monthly modes and 31 days for other premium modes. If a billing mode other than the monthly direct or monthly bank draft is selected, the rates will be in multiples of the monthly premium rate:

- ☐ *Monthly Direct*
- ☐ *Monthly Bank Draft*
- ☐ *Quarterly*-3 times the monthly rate
- ☐ *Semi*-Annually-6 times the monthly rate
- ☐ *Annually*-12 times the monthly rate

Per Your application, your initial premium is $_____.

This includes a one-time, nonrefundable application fee of $25.00. The application fee must be submitted with your application.

Renewal premiums are $_____

DISCLOSURE OF AGENT'S LIMITED AUTHORITY Your application was taken by a soliciting agent whose authority is limited only to providing you with this outline of coverage and assisting you, if necessary, in filling out the application, and then transmitting your application and initial premium to the Home Office. Your agent does not have the authority to waive a complete answer to any question on your application, or to approve insurability, or to make or alter any provisions of the outline of coverage, application, or policy. Your agent does not have the authority to waive any rights of the Company. You will not be insured until a policy is actually issued by the Company. Submitting an application and paying an initial premium does not guarantee your insurability and does not mean that you are insured by the Company.

Receipt for Advance Premium Payment

Received of _____ $ _____

for the first premium and application fee beginning with the date of the policy. These amounts will be returned if a policy is not issued. Please notify our office if the policy is not received within 45 days. It is very important that the complete medical history be recorded on the application. It is distinctly understood that the policy applied for is not effective until actually issued by the Company, and the Company is not liable for any loss whatsoever sustained before the policy is actually issued by the Company, and is then liable only as provided and limited in the policy. All benefits are subject to policy provisions. No oral statement by or to the soliciting representative shall be effective to alter any written provisions of the application of the insurance policy, if any, when same may be issued by the Company.

SOUTHWEST SERVICE LIFE INSURANCE COMPANY

Date _____ 20 _____ . Soliciting Representative _____

License Number _____

Form No. HI-2019 CR