DISCLOSURE OF LIMITED AUTHORITY Your application was taken by a soliciting agent whose authority is limited only to providing you with an outline of coverage and an application, 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 nor the authority to make or alter any provisions of the outline of coverage, application, or Certificate. Your agent does not have the authority to waive any rights of the Company and You will not be insured until a Policy is actually issued by the Company. The making of an application and the payment of 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 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. DVH-101

Benefit Options DVH-101

Policy Year Maximum	Deductible Options	
☐ $1,000	☐ $0	☐ $100
☐ $1,500	☐ $0	☐ $100
☐ $2,000	☐ $0	☐ $100

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# 3495

PRINT

	Names of Applicants	Relationship to Applicant	Age	Sex	Date of Birth Mo.	Day	Yr.	Ht.	Wt.	Social Security Number
1.		Applicant								
2.										

2	ADDRESS:	City	State	Zip Code
3	Name of Applicant's Employer	Applicant's Occupation		
	Name of Spouse's Employer	Spouse's Occupation		
4	List other coverage or any pending Dental, Vision, or Hearing Insurance applicant may have. Name of Company.	Is Policy to be Replaced? Yes	No	When?
		☐	☐	
		☐	☐	
5	Applicant's Home Telephone	Work Telephone		
	Mobile Telephone	E-Mail Address		
	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?			
6	Are any applicants covered by Medicare or Medicaid? ☐ Yes ☐ No If "Yes", which applicant(s)			

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

	MEDICAL INFORMATION	APPLICANT
7	1. Do you currently wear dentures?	☐ Yes ☐ No
	2. Have you been advised to have any dental work which has not been completed? If "Yes", provide details:	☐ Yes ☐ No
	3. Do you currently wear eyeglasses or contact lenses?	☐ Yes ☐ No
	4. Have you received advice or treatment within the past nine (9) months for correction of a vision problem? If yes, provide details:	☐ Yes ☐ No
	5. Do you currently wear a hearing aid?	☐ Yes ☐ No
	6. Have you been treated for hearing loss within the past nine (9) months?	☐ Yes ☐ No
	7. Has a physician recommended the purchase of a hearing aid to correct a hearing deficiency?	☐ Yes ☐ No
8	Name of Applicant's Dentist Address	
	Name of Spouse's Dentist Address	
	Applicant's Signature **X**	

PAGE ONE OF TWO – APPLICATION CONTINUES ON REVERSE SIDE

9	"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 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. 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., P.O. 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 to the applicant. Dated at (City, State) (Month, Day, Year)	
Representative's Signature	**X**
Representative's Address	
Applicant's Signature **X**	Spouse's Signature **X**

Amount Paid for Policy form DVH-101	**$**	**for Initial and First**		**Months Premium**

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

TO: (BANK)	Checking Account ☐ or Savings Account ☐
Bank Address:	
Routing Number:	Account 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	Accountholder's Signature **X**
If personal account, need name & address of accountholder	
If business account, need name & address of business	

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 ______________________________

SOUTHWEST SERVICE LIFE INSURANCE CO.
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 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. is/are my physicians, medical practitioners, hospitals, clinics, medical facilities, 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.

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. 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 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., 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: ____ / ____ / ____