

The Preferred Plus

FREEDOM OF CHOICE

The SD18

Permanent Health Insurance
and Guaranteed Renewable.

70/30 Plan

Health Policy



Southwest Service Life Insurance Company
Fort Worth, Texas

Providing Quality Health Insurance Coverage to fellow Texans for over 55 Years

ADV-1 SD18 70/30

Southwest Service Life Insurance Company Specified Diseases and Accident Policy Form SD18

70/30 PLAN

Lifetime Policy Aggregate is \$3,000,000

\$250,000.00 Aggregate Per Person for Each Covered Specified Disease

\$250,000.00 Aggregate Per Person for Each Accidental Injury

Vanishing Deductible • \$200.00 the 1st policy year, \$100.00 the 2nd policy year and Vanishes thereafter

Hospital Expenses subject to daily hospital benefit.

CAN HELP PAY FOR				
Hospital Room (Semi-Private)	Surgical Dressings	Intensive Care	Physical Therapy	Casts and Splints
Hypodermics	Use of Cystoscopic Room	Unit Facilities	Hydrotherapy	Basal Metabolism Tests
MRI	Medicines	Oxygen	X-Ray Photographs	Encephalograms
Central Supplies	Lung Capacity Tests	Iron Lung	Anesthesia	Cardiac Conversion Treatment
	Ultrasound Treatment	Operating Room	Recovery Room	CAT-Scan
		Surgical Trays		

If a covered injury or specified disease shall necessarily require you to be confined as a resident patient within a hospital, under the care and attendance of a licensed physician, the Company will Pay you 100% of the Facility charges up to \$1,800.00 Dollars a day for the Facility confinement or \$2,300.00 per day for confinement in an Intensive Care Unit. Outpatient Surgery: Facility charges for covered outpatient surgeries are covered the same as one day of confinement in an inpatient Facility.

Plus Extra Benefits for Critical Illness: For Heart Attack, Strokes or Malignant Cancers of the Breast or Prostate we will pay an extra \$600.00 a day when Hospital Confined for a total of \$2,400.00 per day for the Facility confinement or \$2,900.00 per day when confined in an Intensive Care Unit.

In-Hospital Physician's Benefits *(Outpatient Surgery paid same as In-Hospital Surgery)*

Physician's Services per Covered Event: Inpatient or Outpatient Surgery. We pay the greater of either: We pay 70% up to \$15,000 paid then 100% up to \$70,000 paid of your Primary Surgeon, Assistant Surgeon, and Anesthesiologist U&C Charges or Physicians calls while Hospital confined: 70% of the U&C Physicians charges up to \$75 per visit, one visit per day, up to 60 days.

\$1,800 per person per policy year for Outpatient Services Benefits For Non-Surgical Benefits

Pays necessary Outpatient treatment other than Physician's Office visits charges. After a \$100 deductible we pay 70% of the U&C Physicians charges. Outpatient services under this benefit include, but are not limited to: laboratory tests, x-rays, casts, splints, MRIs, testing, remediation and Emergency Ambulance Expenses.

Physician's Office Visits

After a \$20 co-pay we will pay up to \$75 of the remaining U&C Physician's Charges for an office visit in the Physician's Office, Urgent Care Facility or other similar outpatient ambulatory facility. Limit six (6) office visits per person per policy year. NOT subject to any deductible.

Outpatient Disease-Prevention Benefits

After a \$20.00 co-pay we will pay up to \$50 of the remaining U&C Physician's Charges, for a visit to the Physician's office. Limit six (6) office visits per person per year. Not subject to any deductible. Pays for Physician charges regardless of disease or injury, in lieu of other benefits. Immunizations: We will pay up to \$70 of U&C for the Day an Insured Person receives Immunization in a Physician's Office, or in a Pharmacy that is authorized by law to administer Immunizations. Limit 1 per person per policy year. Not subject to a co-payment.

Physician's Office Visits for Annual Physical

After a \$20 co-pay we will pay up to \$150.00 of the remaining U&C charges when an insured Person has an annual Physical (Well-Care Visit) Limit one Well-Care Visit per person per policy year. Not subject to any deductible.

This Is Not Your Policy. This Is A Summary Of The Policy Benefits.

Additional Benefits for the Prevention of Cancer and Cancer Treatment Lifetime Aggregate \$15,000.00 per Insured Person

Annual Pap smear screening for detection of human papilloma virus (HPV) and cervical cancer: For each female Insured Person who is 18 years of age or older, we will pay 100% for an annual medically recognized diagnostic examination for the early detection of cervical cancer.

Annual screening for breast cancer with low-dose mammography: For each female Insured Person who is 35 years of age or older, we will pay 100% for an annual screening by low-dose mammography for the presence of occult breast cancer.

Annual screening for detection of prostate cancer: For each male Insured Person who is at least 40 years of age and has family history of prostate cancer or is 50 years old or older. We will pay 100% for an annual medically recognized diagnostic examination for the detection of prostate cancer.

Reconstruction Surgery after Mastectomy: covered like other diseases up to the aggregate amount.

Outpatient Chemotherapy and Radiation benefits: After a \$50 co-pay per treatment, we pay 70% of the U&C Physician Charges up to the aggregate.

Orally administered anticancer medications: Orally administered anticancer medications are covered no less favorably than intravenously administered or injected cancer medications that are covered.

Inpatient Mastectomy or Lymph node Dissection due to Breast Cancer: Inpatient care for a minimum of 48 hours following lymph nodes Dissection.

Prosthetic Devices /Orthotic Devices Benefits

We pay for prosthetic devices and orthotic devices and professional services related to the fitting and use of those devices, coverage equals the coverage provided under particular provisions of the Social Security Act: subject to annual Inpatient and Outpatient deductibles, copayments and coinsurance, No Annual dollar limit. \$15,000.00 Lifetime Aggregate per insured.

Southwest Service Life Insurance Company Policy Form SD18

Your Body is made up of Major Health Systems. Our job is to cover those Major Systems so when one of those Health Systems fails, either by Sickness or Accident, we have you covered. Our Policy is designed to pay in the Hospital, Doctor's Office or Urgent Care Facility. We also pay for your Outpatient Surgeries as if you were in the Hospital, plus, benefits for Emergency Ambulance Expenses. Below are just a few examples of all the Sickness and Accidents our policy covers plus many, many more that are not listed here due to the limited space.....

Heart and Circulatory System Max Benefit \$250,000

- COVERED:**
- Rheumatic fever, rheumatic heart disease
 - Hypertension
 - Hypertensive kidney disease
 - Heart attack
 - Pulmonary embolism (lungs)
 - Heart valve disorders, mitral, aortic and tricuspid
 - Atrial fibrillation, atrial flutter
 - Congestive heart failure
 - Stroke, cerebral embolism and late effects [speech deficits, hemiplegia]
 - Aneurisms, thrombosis, phlebitis, varicose veins

Digestive System Max Benefit \$250,000

- COVERED:**
- Esophageal reflux
 - Ulcers, gastritis, appendicitis
 - Hernias-Inguinal, incisional, femoral, umbilical, and hiatal
 - Enteritis and colitis (inflammation of small intestine, large intestine)
 - Diverticulitis
 - Constipation
 - Liver disease and non-alcoholic cirrhosis
 - Disorder of the gallbladder &/or bile ducts, gallstones
 - Celiac disease [gluten sensitivity]

Malignant Cancer Max Benefit \$250,000

- COVERED:**
- Carcinoma-in-situ
 - Basal cell carcinoma
 - Squamous cell carcinoma of any size
 - Skin cancer of any size
 - Melanomas of any size and/or in-situ
 - Lip, mouth, tongue, gums, throat

- Stomach, esophagus
- Lungs
- Bone
- Breast (male or female)
- Genitourinary-cervical, bladder, colon, liver, pancreas, prostate, kidney
- Larynx (voice box)
- Eyes, brain, spinal cord
- Thyroid
- Lymph nodes
- Leukemia, lymphomas

Genitourinary System Max Benefit \$250,000

- COVERED:**
- Kidney disorders, kidney failure, kidney infection
 - Kidney stones, urinary bladder stones, bladder infection
 - Prostate disorders
 - Lump or mass in breast [male or female]
 - Endometriosis, uterine disorders
 - Menopause

Respiratory System Max Benefit \$250,000

- COVERED:**
- Cold, sinusitis, sore throat, strep throat, tonsillitis, laryngitis, bronchitis
 - Allergic rhinitis
 - Pneumonia, influenza
 - COPD [Chronic obstructive pulmonary disease]
 - Emphysema
 - Asthma

Endocrine System Max Benefit \$250,000

- COVERED:**
- Thyroid disorders [hyperthyroid & hypothyroid]
 - Goiter
 - Diabetes
 - Disorder of pituitary gland
 - Testicular hypofunction
 - Ovarian dysfunction
 - High cholesterol, hyperlipidemia
 - Gout
 - Dehydration, fluid overload

Musculoskeletal System Max Benefit \$250,000

- COVERED:**
- Arthritis, osteoarthritis, osteoporosis, joint disorders
 - Rheumatoid arthritis, rheumatism
 - Disorders of the knee, disorders of other joints
 - Spinal disease processes
 - Slipped discs
 - Cervical (neck) disorders
 - Sciatica
 - Ganglions, trigger finger, bursitis
 - Pathological fractures [caused by disease, not accidents]
 - Curvature of the spine [scoliosis]
 - Non-allopathic lesions [usually diagnosed by DO's and chiropractors]

Subject to Policy Limitations, Exclusions and Aggregates, the policy, if issued by the company, will provide benefits resulting from accidents that occur after the date of the Policy, and from sicknesses which manifested more than 30 days from the effective date of the policy.

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 INSURANCE POLICY FOR SPECIFIED DISEASES AND ACCIDENTAL INJURIES Required Outline of Coverage Policy Form SD18 (70/30 PLAN)

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. Specified disease coverage is designed to provide you with coverage paying benefits only when certain losses occur as a result of a specified disease or diseases. Accident only coverage is designed to provide you with coverage for hospital and medical care resulting from a covered accident only. Coverage is provided for the benefits outlined in Part Three. The benefits described in Part Three may be limited by Part Four.

Part 3. Benefits

70/30 Plan

.....
**Lifetime Policy Aggregate
is \$3,000,000**

.....
**Aggregate Amount
for Specified Diseases
of Each Covered
Bodily System and Injuries
Due to any one Accident
is \$250,000**

.....
**Aggregate Per Policy Year for
Outpatient Non-Surgical Benefits
\$1,800**

CATEGORY A**BENEFITS FOR HOSPITAL CONFINEMENT FOR SPECIFIED DISEASE OR ACCIDENTAL INJURY**

1	Hospital Confinement	We will pay 100% of Hospital Facility charges up to \$1,800 per day for Hospital confinement.
2	Additional Hospital Confinement Benefits	We will pay an extra \$600 a day when Hospital Confined For Stroke, Heart Attack or Malignant Cancers of the Breast or Prostate
3	Intensive Care Unit Confinement	Plus up to an additional \$600 per day for intensive care unit (ICU) confinement.
4	Outpatient Surgery	Facility charges for Ambulatory Surgical Facilities or other covered outpatient surgery facilities are covered the same as one day of confinement in a covered Hospital.
5	Vanishing Deductible	\$200 deductible per Period of Confinement during the first Policy Year. \$100 deductible per Period of Confinement during the second Policy year. No deductible per Period of Confinement during third Policy Year and thereafter.

CATEGORY B**BENEFITS FOR SERVICES BY PHYSICIANS FOR SPECIFIED DISEASE OR ACCIDENTAL INJURY**

1	Physician's Services Per Covered Event:	
	Inpatient or Outpatient Surgery	Physician's Services per Covered Event: Inpatient or Outpatient Surgery. We pay the greater of either: We pay 70% up to \$15,000 paid then 100% up to \$70,000 paid for your Primary Surgeon, Assistant Surgeon, and Anesthesiologist U&C Charges or Physicians calls while Hospital confined: 70% of the U&C Physicians charges up to \$75 per visit, one visit per day, up to 60 days.
	Pathologist	70% of U&C Pathologist charges, up to \$1,500 paid per surgical event.
	Radiologist	70% of U&C Radiologist charges, up to \$1,500 paid per surgical event.
2	Outpatient Aggregate • Subject to an Outpatient Aggregate of \$1,800 per Policy Year, We pay for:	
	Outpatient Services Benefit	[other than Physician's Office Visit or Annual Physical]: We pay 70% of outpatient U&C Physicians charges after \$100 per policy year deductible. Outpatient services under this benefit include, but not limited to: laboratory test, x-rays, tests, cast, splints, MRI's, CT scans, and Emergency Ambulance Expenses.
	Physician's Office Visits	[other than Annual Physical or Outpatient Service]: After a \$20 co-pay, We will pay up to \$75 of the remaining U&C Physician charges for an Office Visit in a Physician's Office, Urgent Care Facility or other similar outpatient ambulatory facility. Limit six (6) Office Visits per Insured Person per Policy Year. Not subject to any deductible.
	Prosthetic Devices, Orthotic Devices, and Professional Services	For prosthetic devices, orthotic devices, and professional services related to the fitting and use of those devices, coverage equals that provided under particular provisions of the Social Security Act; subject to annual inpatient and outpatient deductibles, copayments, and coinsurance. No annual dollar limit. \$15,000 Lifetime Aggregate.
	Outpatient Back/Neck/Spine Manual or Mechanical Manipulation	Fifty dollars (\$50) per Policy Year.

CATEGORY C**THE FOLLOWING ARE ADDITIONAL BENEFITS FOR CANCER**

	Lifetime Aggregate	\$15,000 per person
1	Outpatient Chemotherapy and Radiation Benefits	\$50 Co-pay per treatment. 70% of U&C Physician charges.
	Orally Administered Anticancer Medications	No less favorably than intravenously administered or injected cancer medications that are covered, and
	Inpatient Mastectomy or Lymph Node Dissection due to Breast Cancer	Inpatient care for minimum of 48 hours following mastectomy and 24 hours following lymph node dissection, and
	Reconstructive Surgery after Mastectomy	We pay Category A and Category B benefits, in a manner determined to be appropriate in consultation with your Attending Physician, and Medically Necessary Outpatient care, and
	Annual screening for HPV and Cervical Cancer	Pap smear: Each female Insured Person age 18 years or older is covered for an annual medically recognized diagnostic examination for the early detection of human papillomavirus (HPV) and cervical cancer, and
	Annual Screening for Breast Cancer	For each female Insured Person who is 35 years of age or older, We will pay for an annual screening by low-dose mammography for the presence of occult breast cancer, and
	Annual Screening for Prostate Cancer	For each male Insured Person, We will pay for an annual medically recognized diagnostic examination for the detection of prostate cancer.
2	One Family-Member Lodging Benefit	\$60/day up to 60 days. One per Policy Year.
3	Insured Person Transportation Benefit	[One round trip per Policy Year]: If by common carrier: We pay the usual charge. But if common carrier is not available: We pay \$.60/mile.

CATEGORY D**OUTPATIENT DISEASE-PREVENTION BENEFITS**

1	Annual Physical	[i.e. Well-Care Visit] [other than Outpatient Services or Physician's Office Visit]: After a \$20 co-pay, We will pay up to \$150 of the remaining U&C Physician's charges when an Insured Person has an annual physical [i.e. Well-Care Visit]. Limit one (1) Well-Care Visit per Insured Person per Policy Year. Not subject to any deductible.
	Other Outpatient Physician's Office Visits Benefits	After a \$20.00 co-pay we will pay up to \$50 of the remaining U&C Physician's Charges, for a visit to the Physician's office. Limit six (6) office visits per person per year. Not subject to any deductible. Pays for Physician charges regardless of disease or injury, in lieu of other benefits.
	Immunizations	We will pay up to \$70 of U&C for the Day an Insured Person receives Immunization in a Physician's Office, or in a Pharmacy that is authorized by law to administer Immunizations. Limit 1 per person per policy year. Not subject to a co-payment.

COVERED SPECIFIED DISEASES

Malignant Cancers. Maximum benefit of \$250,000.

DEFINITION: Malignant Neoplasms; abnormal growths or growth, such as tumors or a tumor, characterized by the uncontrolled spread of malignant cells to adjacent tissue. Such Malignant Cancers must be positively diagnosed while this Policy is in force, by a duly licensed Physician operating within the scope of his/her licensure, and either during the Insured Person's lifetime or post-mortem. The following Specified Malignant Cancers are covered:

- ✓ Malignant Carcinoma-in-situ
- ✓ Malignant Basal cell carcinoma
- ✓ Malignant Squamous cell carcinoma of any size
- ✓ Malignant Skin cancer of any size
- ✓ Malignant Melanomas of any size and/ or in-situ
- ✓ Malignant Neoplasms of lip, oral cavity, and pharynx
- ✓ Malignant Neoplasms of digestive organs
- ✓ Malignant Neoplasms of respiratory and intrathoracic organs
- ✓ Malignant Neoplasms of bone and articular cartilage
- ✓ Melanoma and other malignant neoplasms of skin
- ✓ Malignant neoplasms of mesothelial and soft tissue
- ✓ Malignant neoplasms of breast [Additional Hospital confinement benefit]
- ✓ Malignant neoplasms of female genital organs
- ✓ Malignant neoplasms of male genital organs
- ✓ Malignant neoplasms of prostate [Additional Hospital confinement benefit]
- ✓ Malignant neoplasms of urinary tract
- ✓ Malignant neoplasms of eye, brain, and other parts of central nervous system
- ✓ Malignant neoplasms of thyroid and other endocrine glands
- ✓ Malignant neuroendocrine tumors
- ✓ Secondary neuroendocrine tumors
- ✓ Malignant neoplasms of ill-defined, other secondary and unspecified sites
- ✓ Malignant neoplasms of lymphoid, hematopoietic and related tissue

Specified Diseases of the Heart and Circulatory System. Maximum benefit of \$250,000.

- ✓ Acute rheumatic fever
- ✓ Chronic rheumatic heart diseases
- ✓ Hypertensive diseases
- ✓ Ischemic heart diseases
- ✓ Heart attack/Myocardial infarction [Additional Hospital confinement benefit: see Part 3, Category A, ¶12]
- ✓ Pulmonary heart disease and diseases of pulmonary circulation
- ✓ Other forms of heart disease
- ✓ Cardiac arrest [Additional Hospital confinement benefit: see Part 3, Category A, ¶12]
- ✓ Heart Failure [Additional Hospital confinement benefit: see Part 3, Category A, ¶12]
- ✓ Cerebrovascular diseases
- ✓ Stroke/Cerebrovascular infarction/Intracranial Hemorrhage/Cerebral Emboli [Additional Hospital confinement benefit: see Part 3, Category A, ¶12]
- ✓ Diseases of arteries, arterioles and capillaries
- ✓ Diseases of veins, lymphatic vessels and lymph nodes, not elsewhere classified
- ✓ Other and unspecified disorders of the circulatory system

Specified Diseases of the Genitourinary System. Maximum benefit of \$250,000.

- ✓ Glomerular diseases
- ✓ Renal tubulo-interstitial diseases
- ✓ Acute kidney failure and chronic kidney disease
- ✓ Urolithiasis
- ✓ Other disorders of kidney and ureter
- ✓ Other diseases of the urinary system
- ✓ Diseases of male genital organs
- ✓ Disorders of breast
- ✓ Inflammatory diseases of female pelvic organs
- ✓ Non-inflammatory disorders of female genital tract
- ✓ Intraoperative and post-procedural complications and disorders of genitourinary system, not elsewhere classified

Specified Diseases of the Musculoskeletal System and Connective Tissue. Maximum benefit of \$250,000.

Osteopathies, Chondropathies, and Acquired Musculoskeletal Deformities:

- ✓ Infectious arthropathies
- ✓ Inflammatory polyarthropathies
- ✓ Osteoarthritis
- ✓ Other joint disorders
- ✓ Dentofacial anomalies [including malocclusion] and other disorders of jaw
- ✓ Systemic connective tissue disorders
- ✓ Deforming dorsopathies
- ✓ Spondylopathies
- ✓ Other dorsopathies
- ✓ Disorders of muscles
- ✓ Disorders of synovium and tendon
- ✓ Other soft tissue disorders
- ✓ Disorders of bone density and structure
- ✓ Other osteopathies
- ✓ Chondropathies
- ✓ Other disorders of the musculoskeletal system and connective tissue
- ✓ Intraoperative and post-procedural complications and disorders of musculoskeletal system, not elsewhere classified
- ✓ Biomechanical lesions, not elsewhere classified.

Specified Diseases of the Endocrine System. Maximum benefit of \$250,000.

- ✓ Disorders of thyroid gland
- ✓ Diabetes mellitus
- ✓ Other disorders of glucose regulation and pancreatic internal secretion
- ✓ Disorders of other endocrine glands
- ✓ Intraoperative complications of endocrine system
- ✓ Malnutrition
- ✓ Other nutritional deficiencies

Specified Diseases of the Digestive System. Maximum benefit of \$250,000.

- ✓ Diseases of esophagus, stomach and duodenum
- ✓ Diseases of appendix
- ✓ Hernia
- ✓ Non-infective enteritis and colitis
- ✓ Other diseases of intestines
- ✓ Diseases of peritoneum and retroperitoneum
- ✓ Diseases of liver
- ✓ Disorders of gallbladder, biliary tract and pancreas
- ✓ Other diseases of the digestive system

Specified Diseases of the Respiratory System. Maximum benefit of \$250,000.

- ✓ Acute upper respiratory infections
- ✓ Influenza and pneumonia
- ✓ Other acute lower respiratory infections
- ✓ Other diseases of upper respiratory tract
- ✓ Chronic lower respiratory diseases
- ✓ Lung diseases due to external agents
- ✓ Other respiratory diseases principally affecting the interstitium
- ✓ Suppurative and necrotic conditions of the lower respiratory tract
- ✓ Other diseases of the pleura
- ✓ Intraoperative and post-procedural complications and disorders of respiratory system, not elsewhere classified
- ✓ Other diseases of the respiratory system



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.

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 76182-6005.

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:..... / /



SOUTHWEST SERVICE LIFE INSURANCE COMPANY
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 Company.

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 COMPANY
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.....

SD18 **70/30 PLAN**

SWLT-10 & CCLB Rider.... Yes
 Non-Tobacco User..... Yes
 Tobacco User..... Yes
 Accident Plan - AO..... Yes



		Policy Number				Special Request				REP #	
1. Deductible		Billing Mode <input type="checkbox"/> Monthly <input type="checkbox"/> Monthly Bank Draft				Mail Policy To:					
Print	Names of Applicant and each member of Family Group	Relationship to Applicant	Age	Sex	Date of Birth			Ht.	Wt.	Amount of Life Insurance	Social Security Number
		Applicant			Mo.	Day	Yr.			\$	
										\$	
										\$	
										\$	
										\$	
2. Applicant's Mailing Address		City				State		Zip			
3. Name of Applicant's Employer		Applicant's Occupation									
Name of Spouse's Employer		Spouse's Occupation									
4. Beneficiary (for Life Insurance)		Relationship		6. Applicant's Home Telephone							
5. List Other Health Insurance or Any Pending Applications Any Applicant May Have		Applicant's Work Telephone									
Will this Policy REPLACE Another One? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Then When?		Applicant's Cell Phone Number									
7. Are any Applicants Covered by Medicare or Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Then Which Applicant(s)?		Has Any Applicant Ever Been Declined, Restricted, Rated Up, or Postponed for Any Kind of Personal Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Then Name the Company and Why?									

HEALTH QUESTIONNAIRE INSTRUCTIONS: APPLICANT OR SPOUSE MUST ANSWER ALL QUESTIONS COMPLETELY. THE AGENT OR YOUR REPRESENTATIVE DOES NOT HAVE AUTHORITY TO WAIVE OR OMIT ANY INFORMATION FROM YOUR APPLICATION. If you answer YES to any of the following health questions, please use space provided on Page 2, Number 14 to explain.

Health questionnaire: Have you or any of the applicants ever had the following:

8. A. Malignant cancer?..... Yes No
 Ever had a disease or disorder of:

B. The hips, knees, ankles or foot/feet? Yes No

C. The back, neck, or spine?..... Yes No

D. Any muscles, tendons, ligaments, or soft tissues?
 Any Arthritis?..... Yes No

E. Any bones or cartilage?..... Yes No

F. Any applicant ever had Diabetes? Hyperglycemia?..... Yes No

G. Ever had a disease or disorder of the thyroid or pancreas? Yes No

H. Ever had a disease or disorder of any other hormone glands, such as:

I. The Pituitary? Thymus? Adrenals? Ovaries? Testicles?... Yes No

J. High Blood Pressure? Chest Pain?..... Yes No

K. Disease or disorder of the veins or arteries?..... Yes No

L. Any heart disease? Any cerebrovascular disease?..... Yes No

M. Heart dysrhythmia? Arrhythmia? Stroke? Yes No

N. Any other diseases or disorders of the heart or blood?.. Yes No

O. Disease or disorder of the kidneys? Bladder? Urethra?... Yes No

P. Any male applicant had a disease or disorder of the prostate? Yes No

Q. Disease or disorder of the male reproductive organs?... Yes No

R. Any applicant had a disease or disorder of the breasts? Yes No

S. Disease or disorder of any female reproductive organs? Yes No

T. Any applicant had a disease or disorder of the stomach or colon? Yes No

U. Any appendicitis? Hernia? Colitis? Anal fistula?..... Yes No

V. Ever had a disease or disorder of the liver? Or lungs? Yes No

W. Ever had pneumonia? Tuberculosis? Emphysema? COPD?..... Yes No

X. Ever had asthma? Bronchitis?..... Yes No

Y. Any other breathing disease or disorder?..... Yes No

Z. Is any female applicant currently pregnant? Yes No

1. Has any female applicant had a Caesarean section?.. Yes No

2. Has any female applicant had a high-risk pregnancy? Yes No

AA. Any AIDS, HIV, or ARC diagnoses?
 Any positives on an HIV-related test? Yes No

BB. In the past 5 years, has any applicant ever sought medical advice or treatment for any disease or disorder not specified here? Yes No

9. CC. Declaration of hazardous work or activities: Do you or any applicant operate a motorcycle or trail bike? Engage in weight lifting? Underwater diving? Racing of any motorized vehicles? Rodeo? Any other high-risk, hazardous, or other sports activities not listed? ... Yes No
 If YES, please list which applicant and the activity:

10. DD. Name and Address of Applicant's doctor: _____
 Spouse's doctor: _____
 Children's doctor: _____

11. EE. Current health status: Are you and all other applicants currently in good health and free of diseases or disorders?..... Yes No
If NO, please explain (using space provided below on Page 2, Number 14 if needed):

X _____
 Applicant's Signature

12. List all hospital confinements or surgeries (outpatient and inpatient) in the past five (5) years for every applicant. Include any other diseases, disorders, or ailments for which you have sought medical advice or treatment in the past five (5) years. (Confinements for routine childbirth need not be listed).

Name of Person	Nature of illness or injury	Dates treated	Names/Addresses of doctors and hospitals	Recovery Complete?
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

13. LIST ALL PRESCRIPTIONS CURRENTLY BEING TAKEN BY:

APPLICANT:

SPOUSE:

CHILDREN:

14. **SPACE PROVIDED FOR DETAILS TO ANSWERS ON HEALTH QUESTIONNAIRE AND ANY OTHER INFORMATION:**

If you answered YES to any health question A-EE on Page 1, give full details here. You may also use this space to continue answering the questions at the top of this page or to provide any other relevant details you need us to consider:

15. **Amount paid for Policy Form SD18 Plan** \$ for initial and first month Premium.
Amount paid for Policy Form SWLT-10 & CCLB Rider \$ for initial and first month Premium.
Amount paid for Policy Form AO \$ for initial and first month Premium.

16. **Applicant's representations of understanding:** By signing below, I represent and understand that:

- I am applying for a **SPECIFIED DISEASES AND ACCIDENTAL INJURY** policy that is not Minimum Essential Coverage (MEC) under the Patient Protection and Affordable Care Act of 2010;
- The insurance will not take effect unless this Application has been accepted and approved by the Company and until the Effective Date of the Policy;
- All my answers on the health questionnaire and other questions are true and accurate;
- The Company solely and entirely relies on my answers when deciding to issue this policy;
- Intentional misrepresentations on this Application may cause my policy, if issued, to be rescinded or might otherwise restrict or bar my coverage if such answers materially affect the acceptance of the risk or hazard assumed by the Company;
- 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 a SPECIFIED DISEASES AND ACCIDENTAL INJURY policy; and
- 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 rights or requirements.

Dated at 20.....
City & State Month/Day Year
X
Applicant's Signature
X
Spouse's Signature

Agent's/Representative's certification: I certify that I have accurately recorded herein the information supplied by the Applicant and that an Outline of Coverage has been given to the Applicant.

X
Agent's/Representative's Signature Agent's/Representative's address

ADDITIONAL FAMILY MEMBERS

Print	Names of Applicant and each member of Family Group	Relationship to Applicant	Age	Sex	Date of Birth			Ht.	Wt.	Amount of Life Insurance	Social Security Number
					Mo.	Day	Yr.				
1.		Applicant								\$	
2.										\$	

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

Bank Name Checking Savings

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.

X
Applicant's Signature exactly as it appears on Bank Records

This is a [Choose One]:
 Personal Account Date
 Business Account
Accountholder's address [If business account, please provide the name and address of the business here]

Part 4. EXCLUSIONS, LIMITATIONS AND REDUCTIONS

[1] The policy, if issued by the Company will provide benefits for its specifically names diseases that are first diagnosed more than thirty (30) days after the Effective Date of Coverage, and for Injuries caused by Accidents that happen while the Policy is in effect.

This Policy does not permit adding any Eligible Individual after the Effective Date of Coverage.

[2] Diseases not specified are not covered.

[3] **OUTPATIENT BACK/NECK/SPINE LIMITATION:** In the event that an Insured Person incurs expenses due to covered outpatient treatment of the back, neck, or spine—i.e. detection and correction by manual or mechanical means of structural imbalance, distortion or subluxation of or in the neck, back, or vertebral column—outpatient coverage for such treatment shall be limited to fifty dollars [\$50] per Policy Year.

[4] GENERAL EXCLUSIONS:

[a] Dental treatment except that dental treatment caused by a covered Injury within 90 days thereof;

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

[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] Any disease or disorder due to abuse of or addiction to alcohol or drugs;

[h] 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;

[i] 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;

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

[k] Normal pregnancy, except for Complications of Pregnancy as defined

herein;

[l] Elective abortion or any elective procedure or treatment;

[m] Aviation of any type, except as a fare-paying passenger on a regularly scheduled flight on a commercial airline;

[n] Services performed by an Insured Person on him- or herself.

[o] Breast augmentation or reduction mammoplasty unless necessary in connection with breast reconstructive surgery following a mastectomy;

[p] 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;

[q] Mental or nervous disorders without demonstrable organic disease;

[r] Occupational therapy;

[s] Outpatient treatment of the back, neck, or spine, i.e. detection and correction by manual or mechanical means of structural imbalance, distortion or subluxation of or in the neck, back, or vertebral column; coverage for such outpatient treatment shall be limited to fifty dollars [\$50] per Policy Year;

[t] Services which you are entitled to receive without incurring legal liability;

[u] Medical treatment incurred outside the United States of America.

[v] 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;

[w] Expenses incurred which exceed the maximum benefits of this Policy;

[x] Cataracts. Corrective vision or hearing supplies or for the examination for prescribing or fitting such supplies, or any treatment of refractive disorders;

[y] Confinement or treatment in any sanitarium, or in facilities for the aged, criminals, educational care, drug addiction or alcoholism;

[z] Treatment of temporomandibular joint dysfunction (TMJ);

[aa] Transplants, unless otherwise provided by the Policy;

[bb] Rest cures, home hospice;

[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] Transportation charges, except as provided herein for Ambulance Transport Services benefits; and

[ll] Any medicine or services provided by a pharmacy, including but not limited to counseling and delivery, except as otherwise specifically provided herein for Immunizations;

[mm] Immunization or vaccinations required or elected for personal travel; and

[nn] 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 covered person was insured under the Policy at the time of the non-covered treatment or procedure was performed.

[5] The following Specified Diseases are excluded:

[a] Excluded cancers:

(i) Benign Neoplasms;

(ii) Neoplasms of Uncertain Behavior and Neoplasms of Unspecified Nature;

(iii) Hyperkeratosis; and

(iv) All Neoplasms in the presence of HIV infection.

[b] **Excluded Musculoskeletal System diseases:** Diseases or symptomatic complaints of the feet/foot or toe[s] that are specific to the feet/foot or toe[s].

[c] **Excluded Endocrine System diseases:**

(i) Congenital hypothyroidism;

(ii) Overweight, obesity and other hyperalimentation.

[d] **Excluded Digestive System diseases:** Non-cancerous diseases of the oral cavity, salivary glands, and jaws.

[e] Excluded Genitourinary System diseases: Diseases or disorders of male or female infertility, sterility, or impotence.

[6] **PRE-EXISTING CONDITIONS:** This Policy limits coverage for Pre-Existing Conditions. "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. Disclosed Pre-existing Conditions: Subject to all the terms of this Policy, after one [1] year this Policy covers Pre-existing Conditions made known to the Company during the application process and not otherwise excluded from coverage.

Part 5. GUARANTEED RENEWABILITY.

a. Coverage will terminate and no Benefits will be payable under the Policy:

- (i) On the date premiums are not received when due, subject to the Grace Period;
- (ii) If Your mode of premium is monthly, at the end of the period through which premium has been paid following Our receipt of Your request for termination;
- (iii) If Your mode of premium is other than monthly, upon the next monthly anniversary day following Our receipt of Your request for termination. Premium will be refunded for any amounts paid beyond the termination date;
- (iv) the date We elect to discontinue this plan or type of coverage. We will give You at least 90 days written notice before the date coverage will be discontinued. You will be offered an option to purchase any other coverage We offer without regard to health status;
- (v) On the date We elect to discontinue all health insurance policies in Your state, We will give You and the proper state authority at least 160 days written notice before the date coverage will be discontinued; or
- (vi) On the date You perform an act or practice that constitutes fraud, or make an intentional misrepresentation of material fact, relating in any way to the Policy, including claims for Benefits under the Policy;

b. We reserve the right to change the premiums on a class basis on any renewal date.

c. TERMINATION OF COVERAGE AT AGE 65. On the Renewal Date immediately following an Insured Person's 65th birthday, that individual's coverage will terminate. Nothing in this provision prohibits an individual over the age of 65 from being the Policy Owner.

Part 6. PREMIUM.

a. If You are not satisfied that this coverage will meet Your insurance needs, You may return this Policy to the Company at Our administrative office in Fort Worth, Texas within 10 days after You receive it. If returned during this 10-day period, this Policy will be cancelled as of the Effective Date, any premiums paid on the Policy will be refunded and the Policy will be treated as if never issued.

b. The premiums for this 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.

c. 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 application fee of \$25.00.

The application fee must be submitted with Your application.

Renewal premiums are

\$.....

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 Policy. 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 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. SD18 CR

**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.