FREEDOM of CHOICE

Health Policy

Southwest Service Life Insurance Company,
Fort Worth, Texas

Providing Quality Health Insurance
Coverage to fellow Texans
for over 50 years.

PLAN C

Southwest Service Life Insurance Company Policy Form HI-2014

NO LIFETIME AGGREGATE

$200,000.00 Aggregate Per Person for Each Sickness
$250,000.00 Aggregate Per Person for Each Accident

Policy Year Deductible $400.00 No more than Two Deductible Per Family-Per Policy Year

Hospital Expenses
subject to daily hospital benefit.

CAN HELP PAY FOR

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

If a covered injury or sickness 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 $2,200.00 per day for hospital confinement, or $2,700.00 per day for confinement in an Intensive Care Unit.

Breast and Prostate Cancer Benefits

The Company will pay an additional $500.00 per day for hospital confinement for treatment of Breast Cancer and/or Prostate Cancer.

In-Hospital Physicians' Benefits
(Outpatient Surgery paid same as In-Hospital Surgery)

While confined in the hospital, we will pay $60 for each personal call by a physician at the hospital. Limit of one call per day with a maximum of $2,200.00 per year per insured. Surgical Expense In (or) Out of the Hospital - If, as a result of a covered injury or sickness an Insured shall have a surgical operation performed by a licensed surgeon, the Company will pay the amount listed in the Surgical Benefit Schedule for the surgical operation.

Outpatient Services Benefits

Covered outpatient medical benefits shown below are paid regardless of what your provider charges you for such covered treatment or services. If, as a result of "such injury" or "such sickness" the Insured requires any of the following itemized medical treatments or services or other services required by law, either in the physician's office, clinic, or outpatient department of a hospital or other places prescribed by such law.

Outpatient doctor's visits - $75 per day of visit

Well care visit - $35 per day of visit (limit three visits per Policy Year)

Immunizations - $50 on the day-or other period of time-of immunization (limit three per policy year)

MRI Scan - $750 per day of visit

PET Scan - $500 per day of visit

CT Scan - $250 per day of visit

X-ray or radiological exam - $100 per day of visit

Conventional Pap smear screening $150 per day of visit (limit one per Policy Year)

Emergency Room or Urgent Care facility visit $125 per day of visit (limit one visit per Policy Year)

Spine or Back treatment - $50 per policy year

Other covered outpatient medical events not itemized - $100 per day of visit (limit four per Policy year)

Outpatient Service Benefits are subject to a $2,200 maximum per insured per policy year.

MAMMOGRAPHY BENEFIT

An annual screening for the presence of occult breast cancer by low dose mammography is provided in the same as other radiological exams for female insured persons, age 35 and older.

Ambulance Services

We will pay a maximum of $100 for each day an ambulance service is used for the injured or sick Insured Person, up to three days of ambulance transport per Policy Year. The ambulance service must be to or from a Hospital.

Home Recuperation Benefit

We will pay a maximum of $150 for each day for any one Sickness or Accident immediately following a covered hospital confinement, but not to exceed the number of days the Insured Person was hospital confined.
Maximum benefit is $15,000.00 per sickness or accident.

SUBJECT TO POLICY LIMITATIONS, EXCLUSIONS AND AGGREGATES, the policy, if issued by the company, will provide benefits resulting from accidents that occur after the effective date of the policy, and from sicknesses which first manifested more than 30 days from the effective date of the policy.

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

WE RESERVE THE RIGHT TO CHANGE THE PREMIUMS ON A CLASS BASIS ON ANY RENEWAL DATE.

THE POLICY IS GUARANTEED RENEWABLE SUBJECT TO THE COMPANY'S RIGHT TO DISCONTINUE OR NONRENEW AS SET FORTH IN THE POLICY

The 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

Daily Hospital Confinement Indemnity Policy With Daily Indemnification for Medical and Surgery Events Required Outline of Coverage Policy Form HI-2014 (Plan C)

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 medical and 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. The policy covers Loss sustained by such accidents after the Effective Date of Coverage, and resulting from such sicknesses more than 30 days after the Effective Date of Coverage.

NO LIFETIME AGGREGATE

MAXIMUM AGGREGATE AMOUNT

$200,000 per person for each sickness.
$250,000 per person for each accident.

POLICY YEAR DEDUCTIBLE

Hospital Confinement $400.00 per insured, no more than two Deductibles per family per Policy Year.

DAILY HOSPITAL CONFINEMENT BENEFITS

1. Hospital Confinement	$2,200 per day
1. Intensive Care Unit Confinement	$2,700 per day
2. Breast Cancer and Prostate Cancer	We will pay an additional $500 per day for Hospital Confinement for treatment of these cancers
3. 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 the amount listed on the Surgical Benefit 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. $12,000.00 maximum surgery benefit per person for each sickness and accident.
4. 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.
5. Assisting Surgeon Benefit	If a Physician is required to assist the Surgeon during the procedure, We will pay $300.00 for the daily surgical benefit for the Primary Assisting Surgeon.
6. Anesthetist Benefit	We will pay $300.00 for the daily 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.
7. 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 $300.00 for services rendered by such licensed Pathologist for the day of a covered surgery.
8. 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 $300.00 for services rendered by such licensed Radiologist for the day of a covered surgery.
9. 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 $60 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 $2,200.00 per Year Benefit.
10. Mastectomy or Lymph Node Dissection	(Minimum Inpatient Stay): We will pay the amount shown on the daily Surgical Benefit Schedule if an Insured Person has either a mastectomy or a lymph node dissection due to treatment of breast cancer. 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.

OUTPATIENT BENEFITS

11. 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, subject to the Outpatient Services Benefit Maximum of $2,200.00: No Deductible

Doctor's Office Visit Benefit	$75 per day of visit	X-ray or Radiological Exam Benefit	$100 per day of exam
Well Care Visit Benefit	$35 per day of visit, limit three visits per Policy year	Conventional Pap Smear Screening Benefit	$150 per day of screening, limit one per Policy year
Immunizations	$50 on the day-or other period of time-of immunization (limit three per policy year)	Emergency Room/Urgent Care Facility Benefit	$125 per day of visit, limit one visit per Policy year
		Spine or Back Treatment	$50 per Policy year
MRI Scan Benefit	$750 per day of MRI scan	Other Covered Out-Patient Medical Events Not Itemized	$100 per day of event, limit four per Policy year
PET Scan Benefit	$500 per day of PET scan		
CT Scan Benefit	$250 per day of CT scan		

12. Other Outpatient Benefits	AMBULANCE SERVICE: We will pay a maximum of $100 for each day an ambulance service is used for the injured or sick Insured Person, up to three days of ambulance transport per Policy Year. The ambulance service must be to or from a Hospital. HOME RECUPERATION BENEFIT: We will pay a maximum of $150 for each day for any one Sickness or Accident immediately following a covered hospital confinement, but not to exceed the number of days the Insured Person was hospital confined. Maximum benefit is $15,000.00 per sickness or accident. MAMMOGRAPHY BENEFIT: An annual screening for the presence of occult breast cancer by low dose mammography is provided in the same manner as other radiological exams for female insured persons, age 35 and older.

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 _____

HI-2014 Plan ❑ C

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

Cancer Plan AC - 502
Standard Plan ... ❑ YES
Preferred Plan ... ❑ YES
Catastrophic Coverage
HI-2010-HC ..... ❑ YES
H&S-1 Coverage .. ❑ YES

DEDUCTIBLE _____

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 _____ Applicant's Occupation _____

Name of Spouse's Employer _____ 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-2014

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

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., 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 the applicant.

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

X _____
Representative's Signature

Address: _____

X _____
Applicant's Signature

X _____
Spouse's Signature

Amount paid for Policy form HI-2014 $ _____ 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 HI-2010-HC $ _____ for initial and First _____ Months Premium
Amount paid for Policy form H&S-1 $ _____ for initial and First _____ Months Premium
Amount paid for additional coverage $ _____ 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.										$	
8.											
9.											

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.

X _____

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

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

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, 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 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:____ / ____ / ____

Please Complete if Applicable:

Print name(s) of covered children

_____ Date of Birth: ____ / ____ / ____

_____ Date of Birth: ____ / ____ / ____

_____ Date of Birth: ____ / ____ / ____

SOUTHWEST SERVICE LIFE INSURANCE CO. *does not issue group health and accident policies nor does it offer health insurance plans as a Small Employer Health Benefit Plan under the provisions of Chapter 26 of the Insurance Code. For that reason it is necessary to complete the following form:*

EMPLOYER INSURANCE DISCLAIMER

You have applied for an insurance policy with the Southwest Service Life Insurance Company ("Company"). Please understand that:

(1) The policy is an individual fixed indemnity policy and not a group, blanket, franchise or Small Employer type coverage, even though your employer may be remitting a premium on your behalf to the Company. Benefits are limited, as shown in your Outline of Coverage.

(2) The Company assumes no responsibility for compliance with the Employee Retirement Income Security Act of 1974 and amendments thereto, nor does it maintain that the policy is designed or marketed to comply with the requirements contained therein. In particular, the policy provides no benefits for normal pregnancy and delivery and/or coverage for any individual, newborn, fetus or otherwise that was not extended coverage at the time the policy was originally issued and is subject to Company underwriting in (3) below. The Company also assumes no responsibility for compliance with any State Small Employer Health Insurance Law.

(3) The policy is not guaranteed issue and will be fully underwritten by the Company. This may result in the exclusion from coverage of certain family members (if applicable), and/or health conditions. Southwest Service assumes no responsibility for the collection of premiums and/or the failure of same to be remitted on a timely basis.

(4) I further acknowledge that the policy Benefits - Limitations & Exclusions have been explained to me individually and that an Outline of Coverage which explains the coverage which I have applied for has been left with me for my examination.

(5) If my employer is remitting the premium to the Company, I understand any policy issued on my behalf is on the premium paying mode requested by me. In the event the employer ceases to remit the required premium, for any reason, the policy coverage will terminate at such date and any further coverage after such date of termination of premium payment will become null and void.

Because this is an individual fixed indemnity benefit policy, I understand I may continue the policy if I personally desire to remit the premium required by the Company within the grace period provided in the policy.

I also understand that it is my personal obligation and responsibility to notify the Company in writing of my desire to arrange for the proper premium to be paid within the time period allowed. If such election is made after expiration of the grace period, the policy is subject to reinstatement review by the Company and coverage may or may not be allowed to remain in force. Any failure to request the privilege for this continuation of coverage will result in the policy being null and void. I understand the Company assumes no responsibility for notifying me that my employer has elected and/or is not remitting a premium on my behalf.

I hereby acknowledge my full understanding of the contents of this disclaimer

Applicant Signature_____ Agent's Signature_____

Date _____ Date _____

FORM W (1-99 rev)

4. LIMITATIONS AND EXCLUSIONS

PRE-EXISTING CONDITIONS: Subject to all the terms of the policy, after one year the policy covers Pre-existing Conditions made known to the Company during the underwriting process and not specifically excluded from coverage. "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.

REDUCTION OF BENEFITS AFTER AGE 65: If treatment for a covered sickness or injury commences after the Insured Person's 65th birthday, all Benefits will be 50 percent of the amount otherwise payable.

WAITING PERIODS: **1. FOR SUCH INJURIES, SUCH SICKNESSES**. The Policy provides benefits for **a)** Such Injuries occurring on or after the Policy Effective Date of Coverage, and **b)** Such Sickness, except Certain Sicknesses specifically described herein, first manifesting itself more than thirty (30) days after the policy's Effective Date of Coverage. **2. FOR CERTAIN SICKNESSES**. For the first six (6) months after the Effective Date of Coverage, the policy does not provide any benefits for services or expenses resulting in or from hernia, disorder of reproductive organs, varicose veins, hemorrhoids, appendix, tonsils, adenoids, or gallbladder. **3. FOR COMPLICATIONS OF PREGNANCY**. Complications of Pregnancy (as defined in the policy) will be covered as a Sickness if the Policy is in force a minimum of thirty (30) days before the inception of such pregnancy with respect to such Insured Person. We reserve the right to request that You furnish medical evidence from a Physician confirming the inception date of such 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 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 the 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)** Any routine physical examination; **m)** Elective abortion or any elective procedure or treatment; **n)** Aviation of any type, except as a fare-paying passenger on a regularly scheduled flight on a commercial airline; **o)** Services performed by an Insured Person on him- or herself. **p)** Breast augmentation or reduction mammoplasty unless necessary in connection with breast reconstructive surgery following a mastectomy; **q)** 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; **r)** Mental or nervous disorders without demonstrable organic disease; **s)** Prostheses of any kind; **t)** Occupational therapy; **u)** 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; **v)** Services which you are entitled to receive without incurring legal liability; **w)** Medical treatment incurred outside the United States of America. **x)** 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. **y)** Expenses incurred which exceed the maximum benefits of the policy; **z)** Corrective vision or hearing supplies or for the examination for prescribing or fitting such supplies, or any treatment of refractive disorders; **aa)** Confinement or treatment in any sanitarium, or in facilities for the aged, criminals, educational care, drug addiction or alcoholism; **bb)** Treatment of temporomandibular joint dysfunction (TMJ); **cc)** Transplants, unless otherwise provided by the Policy; **dd)** Rest cures, home hospice; **ee)** 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; **ff)** Confinement or treatment in any convalescent home, rest or nursing facility, unless specifically provided herein; **gg)** The cost of blood plasma or blood derivatives, cross matching, typing or transfusions; **hh)** Services for calibration of automated laboratory equipment and monitoring overall results from such equipment; **ii)** Treatment or services for behavioral or learning disorders, including but not limited to Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD); **jj)** Treatment of "quality of life" or "lifestyle" concerns including but not limited to: smoking cessation; obesity; hair loss; **kk)** Sexual dysfunction including, but not limited to: sex transformations, penile implants or any complications thereof; **ll)** Treatment used to improve memory or to slow the normal process of aging; **mm)** 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; **nn)** Laser vision correction, radial keratotomy or any eye Surgery when the primary purpose is to correct nearsightedness, farsightedness, astigmatism, or any other refractive error; **oo)** 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; **pp)** Transportation charges, except as provided elsewhere herein for Ambulance Transport Services benefits; and **qq)** 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 the 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. RENEWABILITY

- The coverage is guaranteed renewable up to the age of 75, subject to the Company's right to cancel, discontinue or terminate it as provided in the Cancellation and Termination provisions below.

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. In the event of cancellation, We will promptly return the unearned portion of any premium paid. If You cancel, the earned premium shall be computed by the use of the short-rate table last filed with the state official having supervision of insurance in the state where You resided when the policy was issued. If We cancel, the earned premium shall be computed pro rata. Cancellation is without prejudice to any claim originating before the effective date of cancellation.

TERMINATION - Your coverage will terminate and no Benefits will be payable under the policy: **1.** On the date premiums are not received when due, subject to the Grace Period; **2.** 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 of termination; **3.** 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; **4.** At the end of the period through which premium has been paid in which: **a)** Your spouse ceases to be a dependent, **b)** Your children marry or reach age 26, or **c)** Your disabled children are no longer disabled or dependent on You for more than one-half of their support. **5.** The Company elects to discontinue offering a particular type of Hospital Indemnity Policy in the individual market only if the Company: **a)** provides written notice to each covered individual of the discontinuation before the 90th day preceding the date of the discontinuation of the coverage; and **b)** offers to each covered individual on a guaranteed issue basis the option to purchase any other individual Supplemental Hospital Indemnity insurance coverage offered by the Company at the time of the discontinuation; and **c)** Acts uniformly without regard to any health-status related factors of a covered individual or dependents of a covered individual who may become eligible for the coverage. **6.** 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; Termination of coverage by the Company shall be without prejudice to any continuous loss which commenced while the Policy was in force, but the extension of benefits beyond the period the Policy was in force may be predicated upon the continuous total disability of the insured person limited to the duration of the Policy benefit period, payment of the maximum benefits, or to a time period of three months.

TERMINATION OF CHILDREN'S COVERAGE. When a covered child reaches the age of 26, they will discontinue being covered under the policy unless the child is both: (a) incapable of self-sustaining employment by reason of mental retardation or physical handicap, and (b) chiefly dependent upon the Policyholder and/or Primary Insured for support and maintenance. Proof of the incapacity and dependency shall be furnished to the Company by the Policyholder and/or Primary Insured within 31 days of the child's attainment of the limiting age and subsequently as may be required by the Company but not more frequently than annually after the two-year period following the child's attainment of the limiting age. If the Company accepts a premium for coverage extending beyond the date the child reaches age 26, then coverage for that child shall continue during the period for which the premium was accepted.

TERMINATION OF SPOUSE'S COVERAGE. The policy's coverage of the Spouse of the Policyholder and/or Primary Insured will terminate upon the dissolution of their marriage through divorce or other lawful means.

CONTINUATION OF COVERAGE AFTER CHANGE IN MARITAL STATUS: If an insured Spouse loses coverage under the policy due to a change in marital status, that individual shall be eligible for a conversion policy which the Company is then issuing which most nearly approximates the previous coverage of the policy which was in effect prior to the change in marital status. The new policy will be issued without evidence of insurability and will have the same effective date as the policy under which coverage was afforded prior to the change in marital status. Written request for conversion and payment of the first premium must be made within thirty-one days after termination of insurance under the policy.

6. PREMIUM

If You are not satisfied that the coverage will meet Your insurance needs, You may return the 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, the 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.

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 ☐ Monthly Bank Draft ☐ Quarterly - 3 times the monthly rate

☐ Semi-Annual - 6 times the monthly rate ☐ Annual - 12 times the monthly rate

Per your application, your initial premium is $_____. This includes the $50.00 application fee.

The application fee must be submitted with Your application. Subsequent premiums will be $_____.

DISCLOSURE OF LIMITED AUTHORITY Your application was taken by a soliciting agent who 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. HI-2014 CR