NEW VISTA APPLICATION KIT

ALASKA

ALABAMA

ARIZONA

COLORADO

HAWAII

IOWA

LOUISIANA

MARYLAND

MISSISSIPPI

NEBRASKA

NEW MEXICO

NORTH CAROLINA

OREGON

SOUTH CAROLINA

TEXAS

VIRGINIA

WEST VIRGINIA

PROSPERITY LIFE GROUP®

❑ SBLI USA Life Insurance Company, Inc.
❑ S.USA Life Insurance Company, Inc.
❑ Shenandoah Life Insurance Company, Inc.
Members of the Prosperity Life Group†

GO GREEN PROGRAM - E-DELIVERY CONSENT FORM

Owner Name: _____

Date: _____ **Reference No. (if applicable):** _____

Help us GO GREEN by consenting to receive your Policy, if issued, and certain notices, disclosures and other documents relating to your Policy and its administration ("Documents") electronically rather than through the US Mail. By checking "I agree" below, you understand and agree that:

- E-delivered Documents will be posted to your Customer Center account, accessible at www.prosperitylife.com, "My Policies" tab.
- Notice of such postings will be sent from edelivery@prosperitylife.com to your email address.
- You are responsible for providing a valid email address and for notifying us if your email address changes. Because some important information may still be sent through the US Mail, you also must keep us informed of your current postal address. Addresses may be updated on Customer Center or by contacting the Home Office directly.
- Documents are considered delivered to you upon transmission of the posting notice to your email address. Once notified, you are responsible for timely retrieval of the information.
- You may request a paper copy of any e-delivered Document by written request to the Home Office.
- You may revoke this consent at any time by changing your preferences in Customer Center or by written request to the Home Office. Revocation will take effect within 15 days of receiving your request or as otherwise required by law. Revocation does not affect the legal effectiveness of a Document electronically delivered to you before the revocation is effective.
- If a notification email is returned as undeliverable, the referenced Document will be sent to you by US Mail.
- To access Documents delivered electronically, you will need:
  - Access to a device capable of running a current internet browser;
  - Access to internet service and an email account;
  - Software which permits you to receive and review PDF files (free software can be downloaded at adobe.com);
  - The ability to download or print documents.

Check one option below only:

❑ **I AGREE TO THE ELECTRONIC DELIVERY OF DOCUMENTS**

Email address: _____

❑ **I DO NOT AGREE TO THE ELECTRONIC DELIVERY OF DOCUMENTS**

Home Office Contact Information - Please include your full name, policy number, phone number and email address on any correspondence.

SBLI USA Life Insurance Company, Inc.
Attn: Customer Service
100 West 33rd Street, Suite 1007
New York, NY 10001-2914
1-877-725-4872

S.USA Life Insurance Company, Inc.
Attn: Customer Service
P.O. Box 1050
Newark, NJ 07101-1050
1-866-787-2123

Shenandoah Life Insurance Company
Attn: Customer Service
P.O. Box 12847
Roanoke, VA 24029
1-800-848-5433, ext. 62059

† Prosperity Life Group is a marketing name for insurance products and services provided by members of the Prosperity Life Insurance Group, LLC. Each member company is solely responsible for its own financial and contractual obligations. Only SBLI USA is authorized to do business in New York.

NEW VISTA℠

S.USA LIFE INSURANCE COMPANY, INC.

APPLICATION FOR INDIVIDUAL WHOLE LIFE INSURANCE

P.O. Box 1050, Newark, NJ 07101-1050 Toll Free: 1-866-SUSA-123 / 1-866-787-2123 website: www.susa.com

1. PROPOSED INSURED INFORMATION

Last Name	First Name	MI	Phone Number for Contact
			Day:

Social Security Number	Sex	Date of Birth	State of Birth	Country of Birth	Evening:
					Best Time To Call

Mailing Address (Number, Street, Apt. #)	City	State	Zip Code

Driver's License State and Number	E-Mail Address	Are you a United States citizen or legal permanent resident? ❑ Yes ❑ No

2. BENEFICIARY INFORMATION

Beneficiary ❑ Primary ❑ Contingent	Social Security # or Tax ID #

Address (Number, Street, Apt. #)	City	State	Zip Code

Date of Birth	Relationship	Percent of Proceeds	Telephone Number

Beneficiary ❑ Primary ❑ Contingent	Social Security # or Tax ID #

Address (Number, Street, Apt. #)	City	State	Zip Code

Date of Birth	Relationship	Percent of Proceeds	Telephone Number

Please attach another page for additional beneficiary information. The Percent of Proceeds for each type of beneficiary must equal 100%.

3. OWNER INFORMATION *(if other than Proposed Insured)*

Last Name	First Name	MI	Social Security # or Tax ID #

Address (Number, Street, Apt. #)	City	State	Zip Code

Date of Birth	Relationship	Telephone Number

4. REPLACEMENT INFORMATION

1. Is there any life insurance or annuity contract in force on the Proposed Insured with this or any other company? ..... ❑ Yes ❑ No
2. Is the insurance applied for intended to replace or change any life insurance or annuity contract in force with this or any other company? ..... ❑ Yes ❑ No
3. Are any other life insurance or annuity applications pending with this or any other company? ..... ❑ Yes ❑ No

List all current or pending life insurance or annuity coverage below.

Insured's Name	Company	Owner	Replacement	Face Amount	Accidental Death Benefit	Year Issued
			❑ Yes ❑ No			
			❑ Yes ❑ No			
			❑ Yes ❑ No			
			❑ Yes ❑ No			
			❑ Yes ❑ No			

5. HEALTH INFORMATION

SINCE THIS POLICY IS ISSUED WITH MINIMAL OR NO MEDICAL UNDERWRITING, THE PREMIUM RATE CHARGED INCLUDES AN EXTRA MORTALITY RISK CHARGE. IF YOU ARE HEALTHY ENOUGH TO QUALIFY AS A "STANDARD" RISK, PREMIUMS WOULD LIKELY HAVE BEEN LOWER IF YOU HAD APPLIED FOR A FULLY UNDERWRITTEN POLICY.

Has the Proposed Insured smoked cigarettes in the past 12 months? ..... ❑ Yes ❑ No

Please state the Proposed Insured's height _____ and weight _____.

Part A - if any question is answered "Yes", the Proposed Insured is not eligible for coverage

1. Is the Proposed Insured currently or in the last 30 days been: hospitalized, committed to a psychiatric facility, confined to a nursing facility, receiving hospice or home health care, confined to a wheelchair due to a disease, or waiting for an organ transplant? ..... ❑ Yes ❑ No
2. Does the Proposed Insured currently require human assistance or supervision with eating, dressing, toileting, transferring from bed to chair, walking, maintaining continence or bathing? ..... ❑ Yes ❑ No
3. Within the past 12 months has the Proposed Insured:
   a. been advised by a member of the medical profession to have a diagnostic test (other than an HIV test), surgery, home health care or hospitalization which has not yet started, been completed or for which results are not known? ..... ❑ Yes ❑ No
   b. used or been advised by a member of the medical profession to use oxygen equipment for assistance in breathing (excluding CPAP or nebulizer)? ..... ❑ Yes ❑ No
   c. had or been advised by a member of the medical profession to have Kidney Dialysis? ..... ❑ Yes ❑ No
4. Has the Proposed Insured ever been diagnosed or treated for Acquired Immune Deficiency Syndrome (AIDS) and/or Human Immunodeficiency Virus (HIV) infection by a licensed member of the medical profession? ..... ❑ Yes ❑ No
5. Has the Proposed Insured ever been diagnosed or received treatment by a member of the medical profession for Alzheimer's disease, dementia, Lou Gehrig's/Amyotrophic Lateral Sclerosis (ALS), Cirrhosis of the Liver (Stage C)? ..... ❑ Yes ❑ No
6. Has the Proposed Insured ever been diagnosed by a member of the medical profession with more than one occurrence of the same or different type of cancer or is the Proposed Insured currently receiving treatment (including taking medication) for any form of cancer (excluding basal cell skin cancer)? ..... ❑ Yes ❑ No

Part B - if any question is answered "Yes", the Proposed Insured may be eligible for the Modified Death Benefit Individual Whole Life Policy

1. In the past 2 years, has the Proposed Insured been diagnosed or received treatment from a member of the medical profession, or other practitioner, or been hospitalized for any of the following:
   a. the use of alcohol or drugs; or been advised by a physician, practitioner, health facility or counselor to restrict the use of alcohol or drugs? ..... ❑ Yes ❑ No
   b. complications of diabetes such as diabetic coma or insulin shock or had an amputation due to complications of any disease? ..... ❑ Yes ❑ No
   c. heart attack, angina (chest pain), congestive heart failure, cardiomyopathy stroke, transient ischemic attack (TIA), or aneurysm or had heart or circulatory surgery? ..... ❑ Yes ❑ No
2. In the past 3 years, has the Proposed Insured been diagnosed, treated, or prescribed medication by a member of the medical profession for: internal cancer, including but not limited to, malignant brain tumor, malignant melanoma (but excluding basal/squamous cell skin cancer), leukemia, or multiple myeloma? ..... ❑ Yes ❑ No
3. In the past 2 years, has the Proposed Insured had more than 1 conviction for reckless driving or for driving under the influence of alcohol or drugs (DUI or DWI)? ..... ❑ Yes ❑ No

Part C - if any question is answered "Yes", the Proposed Insured may be eligible for the Graded Death Benefit Individual Whole Life Policy

1. Has the Proposed Insured ever been diagnosed, treated, or prescribed medication by a member of the medical profession for:
   a. Parkinson's disease, Systemic Lupus (SLE) or sickle cell disease? ..... ❑ Yes ❑ No
   b. Cirrhosis (Stage A or Stage B) of the liver, chronic hepatitis or other liver disorder, kidney failure or other chronic kidney disease? ..... ❑ Yes ❑ No
   c. Chronic Obstructive Pulmonary Disease (COPD), which includes emphysema, black lung disease or tuberculosis? ... ❑ Yes ❑ No
   d. Bipolar Disorder or Schizophrenia or been hospitalized in the past 2 years for any mental or nervous disorder? ... ❑ Yes ❑ No

If all questions in Parts A, B and C are answered "No", the Proposed Insured may be eligible for the Level Death Benefit Individual Whole Life Policy

6. INSURANCE APPLIED FOR

a. ❑ Level Death Benefit Individual Whole Life Policy

❑ Modified Death Benefit Individual Whole Life Policy

❑ Graded Death Benefit Individual Whole Life Policy

b. Face Amount ..... $_____

7. RIDERS APPLIED FOR

❑ Accidental Death Benefit Rider ..... 1X Amount of Insurance

8. PREMIUM AND BILLING INFORMATION

1. Payment Options:

Who will be the payor?: ..... ❑ Proposed Insured ❑ Owner ❑ Other *(indicate below)*

Name	Relationship to Insured	Social Security # or Tax ID #

Address (Number, Street, Apt. #)	City	State	Zip Code

If Payor is other than Proposed Insured or Owner, please complete Application for Electronic Fund Transfer (EFT) Plan.

a. ❑ **I hereby authorize, until further notice, the deduction of the premium from my checking account.**

Please attach a voided check or provide the following information:

See Premium Payment Auth. Form
Transit Routing Number

See Premium Payment Auth. Form
Depositor Account Number

See Premium Payment Auth. Form
Financial Institution Name

b. ❑ **I hereby authorize, until further notice, the payment of the premium from my credit card.**

Please provide the following information:

See Premium Payment Auth. Form
Credit Card Number

See Premium Payment Auth. Form
Expiration Date

See Premium Payment Auth. Form
Cardholder Name

See Premium Payment Auth. Form
Cardholder Address

c. ❑ **I would like to be billed directly.** (not available for monthly premium mode)

8. PREMIUM AND BILLING INFORMATION (Continued)

2. Premium Mode:

❑ Monthly (Not available for direct bill) ❑ Quarterly ❑ Semi-Annual ❑ Annual

NOTE: If you choose to pay your policy premium in semi-annual, quarterly or monthly payments, you will pay more over the year than if you choose to pay your premium in one annual premium payment.

3. Payment with Application ..... $_____

4. Premium notices sent to: ..... ❑ Proposed Insured ❑ Owner ❑ Payor ❑ Other *(indicate below)*

Name	Relationship to Insured	Social Security # or Tax ID #

Address (Number, Street, Apt. #)	City	State	Zip Code

5. Automatic Premium Loan ..... ❑ Yes ❑ No

I understand that by selecting this option a loan may be made against the cash value of my policy to pay premiums due.

9. HOME OFFICE ENDORSEMENTS	SPECIAL REQUESTS

10. DECLARATIONS AND AUTHORIZATIONS

I understand and agree that the statements and answers in this application are complete and true to the best of my knowledge and belief and shall be attached to and form a part of the contract of insurance. I also understand and agree that the insurance applied for, if issued, shall be subject to such statements and answers and take effect on the effective date stated in the Policy Data page provided the applicable first premium has been paid.

I understand that the statements and answers in the application are the basis for any policy issued by the Company and that no information about the Proposed Insured will be considered to have been given to the Company unless it is stated in the application, and the Proposed Insured will notify the Company of any changes in the statements or answers given in the application between the time of application and delivery of the policy.

I understand that a sales representative does not have the Company's authorization to accept risk, pass on insurability, or make, void, waive or change any conditions or provisions of the application, policy or receipt, as applicable.

I understand that the amount applied for may be reduced or denied if other simplified issue policies from the company or its affiliates are in-force or pending on the life of the Proposed Insured.

I have received and read the required MIB, Inc. and Fair Credit Reporting Act Notices.

AUTHORIZATION: I, the Proposed Insured, authorize any physician, medical professional, hospital, clinic, pharmacy, pharmacy benefit manager, laboratory, medical care facility, insurer, reinsurer, MIB, Inc., or any other similar organization or person having knowledge of me or my health to release information about me to the Medical Director of S.USA Life Insurance Company, Inc. (the "Company"), or its reinsurers for underwriting or claims purposes. The information collected may relate to the symptoms, examination, diagnosis, treatment or prognosis of any physical or mental condition but excludes psychotherapy notes and records pertaining to treatment for drug use and alcoholism. If we need those records, we will ask for them on a separate authorization form. This authorization also includes information about prescription drug records. To facilitate rapid submission of such information, I authorize all said sources, except MIB, Inc., to give such records or knowledge to any agency employed by the Company to collect and transmit such information. I understand a telephone interview may be necessary to verify information given to the Company on this application. This interview may be from the Company or from a consumer-reporting agency by a trained interviewer acting on the Company's behalf.

I, the Proposed Insured, authorize the Company or its reinsurers to make a brief report of my personal health information to MIB, Inc.

I, the Proposed Insured, also authorize the Company to obtain an investigative consumer report as described in the Company's NOTIFICATION IN ACCORDANCE WITH FEDERAL AND STATE LAW. This Authorization is for the purpose of underwriting the life insurance. It is in effect for 24 months from the latest date shown below or for the maximum time allowed by the law of the state where the policy is delivered or issued for delivery if shorter than 24 months. A photocopy may be accepted as valid. The authorization will survive the Insured's death if it occurs while the Authorization is in effect.

I understand that this Authorization may be revoked by contacting us at the address listed at the top of this application; however, the Company retains the right to use any information obtained under my authorization prior to my revocation.

ACCELERATED DEATH BENEFIT: **Receipt of accelerated death benefits may affect eligibility for public assistance programs and may be taxable.** There is no premium charge for this benefit. However, upon election, the benefit is discounted because it is an early payment and a one-time processing fee of $150 is deducted.

LIMITED DEATH BENEFIT: I understand that if I am approved for the Modified or Graded benefit plan, during the first two years the insurance has a limited death benefit for death other than by accident.

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

By my signature below, I certify under penalties of perjury that my Social Security Number (Taxpayer Identification Number) above is correct and I am not subject to back-up withholding.

Signed by the Proposed Insured at _____ on _____ .
City, State Date

X_____
Signature of **Proposed Insured**

Signed by the Owner at _____ on _____ .
City, State Date

X_____
Signature of **Owner**, if other than Proposed Insured

11. AGENT CERTIFICATION

1. To the best of your knowledge and belief, is there an existing life insurance policy or annuity contract insuring the proposed insured's life? ..... ❑ Yes ❑ No
2. To the best of your knowledge and belief, replacement is or may be involved in this transaction. ..... ❑ Yes ❑ No

   If "Yes" to either of these questions, complete any required replacement forms.

I certify that the above statements and responses are true and accurate.

Agent Number	Email Address of Agent
Print Agent's Name	**X** Agent's Signature
Agency Name	Agency Number
Telephone Number of Agent	Date

Conditional Receipt provided? ..... ❑ Yes ❑ No

FOR S.USA USE ONLY

MK Code _____ Sales Number _____

GA Agency Name _____ GA Agency Number _____

NEW VISTA℠

S.USA LIFE INSURANCE COMPANY, INC.
CONDITIONAL RECEIPT AGREEMENT

P.O. Box 1050, Newark, NJ 07101-1050 Toll Free: 1-866-SUSA-123 / 1-866-787-2123 website: www.susa.com

(Detach and leave with applicant only if payment is accepted with application. Retain a copy.)

If any question in Part A of Section 5 of the application is answered YES, no payment may be accepted.

This agreement provides a limited amount of insurance coverage for a limited period of time, subject to the terms and conditions stated below. NO INSURANCE COVERAGE WILL BECOME EFFECTIVE BEFORE DELIVERY OF THE POLICY APPLIED FOR UNLESS ALL OF THE CONDITIONS SPECIFIED BELOW ARE MET. COVERAGE IS SUBJECT TO THE MAXIMUM AMOUNT STATED BELOW AND MAY BE LESS THAN THE AMOUNT OF INSURANCE APPLIED FOR. No Agent can determine insurability or alter or waive any of the terms or conditions of this agreement.

CONDITIONS UNDER WHICH INSURANCE MAY BECOME EFFECTIVE PRIOR TO POLICY DELIVERY.

No coverage will become effective prior to policy delivery unless ALL of the following conditions are met:

a) The amount paid with the application and shown below is equal to the first full modal premium for the coverage applied for and is honored for payment when first presented.
b) All required medical or paramedical tests and examinations are completed.
c) As of the Effective Date, all statements and answers given in the application as to health and insurability of the Proposed Insured (Parts I and II, if applicable) are true and complete.
d) The Proposed Insured is, on the Effective Date, a risk acceptable for coverage with us exactly as applied for, according to our rules and practices, without modification of plan, premium rate, benefits, class or amount.

EFFECTIVE DATE

Subject to satisfactory completion of all of the above conditions, coverage under this agreement will take effect on the latest of: (a) the date the application is signed, (b) the date requested in the application; or (c) the date all medical or paramedical tests and examinations are completed, if any are required under our underwriting rules.

MAXIMUM DEATH BENEFIT AMOUNT UNDER THIS AGREEMENT

If the Proposed Insured dies prior to delivery of the policy, the maximum death benefit under this agreement will be the lesser of: a) the total death benefit payable under the policy applied for in the application, or b) $150,000 in total with respect to all conditional receipts issued by us on all applications pending at the time of death. No amount shall be paid under any Accidental Death Benefit rider or other rider. **If any of the conditions of this agreement has not been met exactly or if a Proposed Insured dies by suicide, while sane or insane, the Company's only liability will be to refund the premium payment.**

END DATE

This agreement and any coverage provided by it will end on the earliest of the following dates: a) the date the policy is delivered to the Owner or Agent and delivery requirements have been completed, b) the date we mail or otherwise provide notice to the Proposed Owner or Agent that a policy cannot be issued as applied for, c) the date we mail or otherwise provide a refund of the premium to the Proposed Owner or Agent, or d) 60 days from the date the application is signed. In no event will coverage under this agreement be in force after 60 days from the date of the application.

Received $_____ from_____
for an application on the life of_____ dated this _____day of _____, 20_____.

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO S.USA LIFE INSURANCE COMPANY, INC. NO PREMIUM CHECKS SHOULD BE PAYABLE TO ANY AGENT OR A BLANK PAYEE.

X_____
Signature of **Agent**

I acknowledge that I have read the terms and conditions of this agreement, have had them explained to me by the Agent, and I understand them. I also understand that except as provided in this agreement, no coverage under the policy applied for will become effective unless and until a policy is delivered to me and all other conditions for coverage have been met.

X_____
Signature of **Proposed Insured**

NEW VISTA℠

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S.USA LIFE INSURANCE COMPANY, INC.
NOTICE OF DISCLOSURE OF INFORMATION

P.O. Box 1050, Newark, NJ 07101-1050 Toll Free: 1-866-SUSA-123 / 1-866-787-2123 website: www.susa.com

(Please detach and provide to applicant.)

IMPORTANT: Read The Information Below Before Completing Application.

NOTIFICATION IN ACCORDANCE WITH FEDERAL AND STATE LAW

This is to inform you that as part of our procedure for processing your insurance application, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends or others with whom you are acquainted. The inquiry includes information as to your character, general reputation, personal characteristics and mode of living. You have the right upon written request to be informed whether an investigative consumer report was requested, and if so, the name and address of the consumer reporting agency to whom the request was made. You may inspect and receive a copy of your investigative consumer report from the reporting agency.

NOTIFICATION IN ACCORDANCE WITH MIB, INC.

Information regarding your insurability will be treated as confidential. The Company or its reinsurers may, however, make a brief report thereon to MIB, Inc., a not for profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734.

The Company or its reinsurers may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

NOTICE OF INSURANCE INFORMATION PRACTICES

To issue an insurance policy, we need to obtain information about the proposed insured. Some of that information will come from the proposed insured, and some may be collected from other sources. Such information may in certain circumstances be disclosed to third parties without your specific authorization as permitted or required by law. You have the right to access and correct this information, except information that relates to a claim or civil or criminal proceeding. A more detailed written notice describing our information practices will be furnished to you upon request.

NEW VISTA℠

PROSPERITY LIFE GROUP®

SBLI USA Life Insurance Company, Inc.
S.USA Life Insurance Company, Inc.
Shenandoah Life Insurance Company
(Each the "Company")
Members of the Prosperity Life Group†

PREMIUM PAYMENT AUTHORIZATION FORM

Insured Name: _____ Policy Number: _____

☐ New Application

☐ Existing Policy
(This authorization shall replace any previous authorization)

AUTHORIZATION AND SIGNATURE

As a convenience to me, I hereby authorize the Company to make charges from my debit/credit card identified below or withdrawals from my bank account with the financial institution identified below ("withdrawals") for payment of insurance premiums becoming due. I understand that these charges will continue until my policy has been paid-up or until I revoke this Authorization. I also authorize the Company to verify account information by accessing a consumer report. This Authorization is subject to the following conditions:

- Authorized withdrawals constitute due notice of premiums being due.
- I must give the Company at least 7 days' written notice of a change to an upcoming withdrawal or revocation of this Authorization.
- Amounts not honored by the bank or credit card company shall constitute non-payment of premium, and coverage may lapse.
- The Company may discontinue withdrawals at any time and bill me directly.

Accountholder's Name: _____
(Name printed exactly as it appears on account)

Accountholder's Signature: _____ Date: _____

Address on Account: _____

SSN: _____

Relationship to Proposed Insured/Insured:

☐ Self

☐ Other, describe:_____

SECTION 1: PREMIUM PAYMENT DATE

The options below allow you to select the date that best fits your needs. If you are submitting this form with an application for a new policy, please note that coverage will not be effective until we receive your first premium payment.

Mode (choose one): ☐ **Monthly** ☐ **Quarterly** ☐ **Semi-Annual** ☐ **Annual**

Payment Date (choose one):

☐ Draft/charge on policy effective date and on same modal date thereafter (default if no selection made)

☐ Draft/charge on specific day of the month _____ (1 to 28) and on same modal date thereafter*

☐ Check this box if the 1st or 3rd was selected above and the draft/charge is linked to your monthly Social Security deposit**

☐ Draft/charge on the 2nd, 3rd, or 4th Wednesday of every month based on the payor's birthdate

(DOB: _____)

Birthdates: 1st to 10th (second Wednesday), 11th to 20th (third Wednesday), 21st to 31st (fourth Wednesday)

* For a new insurance application, the initial draft/charge date must occur within 35 days after the application is signed. For an existing policy, this form must be received at least 7 days prior to the requested draft/charge date, otherwise the draft/charge will begin the following month.

**** Note: For these selections, if the date you selected falls on a weekend or holiday, deduction will be on prior business day. All other selections, if draft/change date falls on a weekend or holiday, deduction will be on next business day.**

PREMIUM PAYMENT AUTHORIZATION FORM (Continued)

SECTION 2: PAYMENT METHOD

Select one of the three payment options below:

☐ **Electronic Fund Transfer (EFT)**

Bank Name: _____

Routing Number: _____ Account Number: _____

Checking or Savings:_____ (not all banks allow EFT debit to a savings account)

☐ **Direct Express Master Card**

Card Number: 5332 48 ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ OR

Card Number: 5115 63 ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Expiration Date: _____ CCV: _____

Address at time of card issuance: _____

City/State/Zip: _____

Phone Number: _____

☐ **Debit Visa or Debit Master Card Linked to a Bank Account**

Card Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Expiration Date: _____ CCV: _____

Address at time of card issuance: _____

City/State/Zip: _____

Phone Number: _____

Mail form to:

SBLI USA Life Insurance Company, Inc.
100 West 33rd Street, Suite 1007
New York, NY 10001-2914
1-877-725-4872

S.USA Life Insurance Company, Inc.
P.O. Box 1050
Newark, NJ 07101-1050
1-866-787-2123

Shenandoah Life Insurance Company
P.O. Box 12847
Roanoke, VA 24029
1-800-848-5433, ext. 62059

† *Only SBLI USA Life Insurance Company, Inc. is licensed in New York.*

SBLI USA
LIFE INSURANCE SINCE 1939

S.USA LIFE INSURANCE COMPANY, INC.

P.O. Box 1050, Newark, NJ 07101-1050 Toll Free: 1-866-SUSA-123 / 1-866-787-2123 website: www.susa.com

SUMMARY AND DISCLOSURE STATEMENT FOR ACCELERATED DEATH BENEFITS

This is a brief description of the accelerated death benefit in the policy applied for. Please consult the policy for actual contract provisions.

What it is: If the insured has a terminal illness, you may accelerate payment of a portion of the eligible proceeds, subject to stated maximum or minimum limits. The eligible proceeds are generally the death benefit at the time of acceleration. The accelerated death benefit does not and is not intended to qualify as long-term care insurance.

Amount: The amount payable as an accelerated death benefit will equal: (a) the amount of the eligible proceeds you request to accelerate adjusted by the discount factor stated in the policy, (b) minus an administrative fee, (c) minus the elected percentage applied to any outstanding policy loan and loan interest. Payment of the accelerated death benefit will be in one lump sum.

Requirements: In order to receive the benefit, you must provide us with:

a) a written request for the benefits during the lifetime of the insured and while the policy is in force;
b) written certification by a qualified physician that the insured suffers from a terminal illness; and
c) written consent of any assignee or irrevocable beneficiary.

We may require a second or third medical opinion to confirm benefit eligibility at our expense. Your policy outlines any other applicable conditions or exclusions.

Costs: There is no additional premium charged for this benefit. However, we will discount the benefit by the discount factor because it is an early payment of the death benefits and charge an administrative fee not to exceed the amount stated in the policy.

Effect of Acceleration: Upon acceleration, any policy values and the death benefit on the remaining policy will be reduced proportionately.

What follows is a hypothetical example of how an accelerated benefit payment of 50% of the eligible proceeds would affect a level premium policy with cash values, a policy loan and $100,000 face amount:

	Premium	Cash Value	Face Amount	Outstanding Loan
Before accelerated payment	$1,200.00	$16,000.00	$100,000.00	$4,000.00
After accelerated payment	$600.00	$8,000.00	$50,000.00	$2,000.00

Important Disclosure: Although accelerated death benefit payments are intended to qualify for favorable tax treatment, there are circumstances when receipt of the benefit payment MAY BE TAXABLE. Receipt of an accelerated death benefit payment may adversely affect the recipient's eligibility for Medicaid, Supplemental Security Income ("SSI") or other government benefits or entitlements. Consult your tax advisor and the appropriate social service agency before applying for this benefit.

Applicant's Signature

Agent's Signature

Date

Date

SBLI USA LIFE INSURANCE SINCE 1939

S.USA Life Insurance Company, Inc.

AUTHORIZATION FOR RELEASE OF HEALTH-RELATED INFORMATION

THIS AUTHORIZATION COMPLIES WITH THE HIPAA PRIVACY RULE

Print Name of Proposed Insured/Patient

Date of Birth

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("my providers") to disclose my entire medical record, prescription history, medications prescribed and any other health information concerning me ("protected health information") to **S.USA Life Insurance Company, Inc.**,("the Company"). I also authorize any insurance company or agent from which I have applied for or obtained insurance, any consumer reporting agency such as MIB, Inc., and any other entity or person having protected health information about me, to disclose it to the Company. Protected health information includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. Protected health information also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

Further, protected health information includes genetic information and genetic test results, and I specifically authorize my providers to disclose such information and results to the Company, subject to the terms and conditions of this Authorization.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this Authorization and I instruct my providers and other entities or persons referred to above to release and disclose my entire medical record without restriction.

I further authorize the disclosure of protected health information by the Company to its affiliates, service providers, reinsurers, agents and representatives, and to any consumer reporting agency such as MIB, Inc.

This protected health information is to be used or disclosed under this Authorization so that the Company may: 1) underwrite my application for insurance, make eligibility, risk rating, and policy issuance determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Company.

This Authorization shall remain in force for 24 months following the date of my signature below, and a copy of this Authorization is as valid as the original. I understand that I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to the Company at the address below, Attention: Underwriting Department. I understand that a revocation is not effective to the extent that any person or entity has already relied on this Authorization to disclose or use information about me or to the extent that the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that if any of my protected health information is re-disclosed, it may no longer be protected by federal rules governing privacy and confidentiality of health information.

I understand that my providers may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization. I further understand that if I refuse to sign this Authorization to release my complete medical record, the Company may not be able to process my application, or if coverage has been issued, may not be able to make any benefit payments. I understand and acknowledge that I or any authorized representative will receive or have received a copy of this Authorization.

Printed Name of the Proposed Insured/Patient or Personal Representative	Description of Personal Representative's Authority or Relationship to Proposed Insured/Patient (if applicable)
Signature of Proposed Insured/Patient or Personal Representative	Date (required)

P.O. Box 1050, Newark, NJ 07101-1050
1-866-SUSA-123 (1-866-787-2123) • www.susa.com

S.USA Life Insurance Co., Inc.
Customer Identification Program Notice

Important Information You Need to Know About Buying a Life Insurance Policy or Annuity

To help the government fight the funding of terrorism and money laundering activities, federal law requires financial institutions to obtain, verify, and record information that identifies each person who buys a life insurance policy or annuity.

This notice answers some questions about our Customer Identification Program.

What products are covered by this notice?

- A permanent life insurance policy, other than a group life insurance policy;
- An Annuity contract, other than a group annuity contract
- Any other insurance product with features of cash value or investment.

What types of information will I need to provide?

When you buy a life insurance policy or annuity, we are required to collect information such as the following from you:

- Your name
- Date of birth
- Address
- Identification number:
  - U.S. Citizen: taxpayer identification number (social security number or employer identification number)
  - Non-U.S. Citizen: taxpayer identification number, passport number, and country of issuance, alien identification card number, or government-issued identification showing nationality, residence and a photograph of you.

You may also need to show your driver's license or other identifying documents.

A corporation, partnership, trust or other legal entity may need to provide other information, such as its principal place of business, local office, employer identification number, certified articles of incorporation, government-issued business license, a partnership agreement, or trust agreement.

The U.S. Department of the Treasury already requires you to provide most of this information. We may also require you to provide additional information such as your net worth, annual income, occupation, and employment information.

What happens if I don't provide the information requested or my identity can't be verified?

We may not be able to issue a policy or annuity or carry out transactions for you. If you already have a policy or annuity, we may have to suspend transactions.

We thank you for your patience and hope that you will support the financial industry's efforts to deny terrorists and money launderers access to America's financial system.

S.USA LIFE INSURANCE COMPANY, INC.

P.O. Box 1050, Newark, NJ 07101-1050 Toll Free: 1-866-SUSA-123 / 1-866-787-2123 website: www.susa.com

IMPORTANT NOTICE: REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

(NOTE - This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant)

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A *replacement* occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on an existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A *financed purchase* occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interest. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? ..... ❑ Yes ❑ No

2. Are you considering using funds from your existing policies to pay premiums due on the new policy? ..... ❑ Yes ❑ No

If you answered "yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

NAME OF INSURER	NAME OF INSURED OR ANNUITANT	POLICY OR CONTRACT #	POLICY/CONTRACT TO BE REPLACED OR USED AS A SOURCE OF FINANCING
			❑ Replaced ❑ Financing
			❑ Replaced ❑ Financing
			❑ Replaced ❑ Financing

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because _____

_____

_____

I certify that the responses herein are, to the best of my knowledge, accurate:

X_____ X_____

Signature of **Applicant** Signature of **Producer**

_____ _____

Printed Name of **Applicant** Printed Name of **Producer**

_____ _____

Date Date

NOTICE OF 30-DAY RIGHT TO EXAMINE NEW POLICY

If you decide to replace an existing policy or contract with a new S.USA Life policy or contract, you have a right to return the new policy or contract. Within 30 days after delivery, your new policy or contract may be returned to S.USA Life for cancellation. Cancellation will be effective as of the policy date and any premium payment will be refunded. The policy must be returned to S.USA Life's home office, agency, or agent.

ATTENTION: You should discuss the following important information and questions with your agent.

I do not want this notice read aloud to me. _____ (Applicants must initial only if they do not want the notice read aloud.)

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

PREMIUMS:

- Are they affordable?
- Could they change?
- You're older - are premiums higher for the proposed new policy?
- How long will you have to pay premiums on the new policy? On the old policy?

POLICY VALUES:

- New policies usually take longer to build cash values and to pay dividends.
- Acquisition costs for the old policy may have been paid; you will incur costs for the new one.
- What surrender charges do the policies have?
- What expense and sales charges will you pay on the new policy?
- Does the new policy provide more insurance coverage?

INSURABILITY:

- If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.
- You may need a medical exam for a new policy.
- Claims on most new policies for up to the first two years can be denied based on inaccurate statements.
- Suicide limitations may begin anew on the new coverage.

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:

- How are premiums for both policies being paid?
- How will the premiums on your existing policy be affected?
- Will a loan be deducted from death benefits?
- What values from the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:

- Will you pay surrender charges on your old contract?
- What are the interest rate guarantees for the new contract?
- Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:

- What are the tax consequences of buying the new policy?
- Is this a tax free exchange? (See your tax advisor.)
- Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?
- Will the existing insurer be willing to modify the old policy?
- How does the quality and financial stability of the new company compare with your existing company?

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