Final Expense

INSURANCE POLICY *for ages under 45*

HURRIED EMERGENCY HELP LIFE PAYMENT

FEATURING:

H.E.L.P. is available
when your loved ones need it most!

Southwest Service Life Insurance Company

HOME OFFICE
Fort Worth, Texas

PLAN NOW FOR THOSE YOU LOVE

Very affordable rates

Full and immediate benefit after issue.*

Policy is good anywhere in the world.

Benefits do not reduce.

Proceeds are tax free.

Up to $15,000.

Accidental Death Benefit Included**

There are many separate decisions to be made within just a few hours after a death in the family. This plan will free your loved ones from the financial worry over final expenses by providing your beneficiary with H.E.L.P. when they need it most!

In addition to the normal claim payment procedure in effect from the policy effective date, your policy will qualify for Southwest Service's emergency claim service after it has been in force two years.

A phone call from your beneficiary, or funeral director starts the claim process immediately.

Within 48 hours, 50% of the total benefit (not to exceed $5,000) will be paid to your beneficiary or designated funeral home.

The remaining balance of the claim will be paid promptly after the death certificate is received.

Your Agent will help you identify the plan that you qualify for.

*IMMEDIATE DEATH BENEFIT PLAN with ADB
(Form No. L-254IBP) *applied for* ❑

- 100% of face amount paid immediately

RETURN OF PREMIUM PLAN with ADB
(Form No. L-256RPP) *applied for* ❑

- Return of premium plus 20% interest for the first 3 years
- 100% paid after graded period
- 100% paid for accidental death, all years**

**Benefits for death from suicide during the first two policy years are limited to the total amount of premiums paid.*
*** Accidental Death Benefit is payable from date of issue and ends at age 75.*

Your Plan … Death Benefit … $_____

SOUTHWEST SERVICE LIFE INSURANCE COMPANY
P.O. Box 982005, Fort Worth, TX 76182

CONDITIONAL RECEIPT:

THIS RECEIPT DOES NOT PROVIDE ANY INSURANCE UNTIL ITS CONDITIONS ARE MET:

Received from _____ on this date of _____, __ __, __ __ __ __ the sum of $ _____ the correct first premium contained in the application subject to the following conditions:

(1) If each Applicant would be acceptable to and approved by the Company as insurable under the Company's underwriting rules the insurance shall become effective as of the policy delivery date. (2) If any Applicant is not acceptable to and approved by Company, as above specified, then no insurance shall become effective on any Applicant and the Company shall incur no liability hereunder except to return the amount shown by this receipt. (3) The Company is not liable for any loss whatsoever sustained before a policy is actually issued and delivered, and is then liable only as provided and limited in the policy.

Signature of Soliciting Agent _____

All premium checks must be made payable to the Company. Do not make payable to the agent or leave payee blank.

CR L-254

Southwest Service Life Insurance Company
HOME OFFICE
Fort Worth, Texas

Mail Policy to ○Policyholder ○Agent

LIFE INSURANCE APPLICATION POLICY FORM L-254/L-256

BILLING MODE	CWA	SPECIAL REQUEST	POLICY NUMBER
			AGENT NUMBER

PLEASE PRINT

PROPOSED INSURED	RELATION-SHIP	AGE	SEX	DATE OF BIRTH MO. DAY YR.	HT.	WT.	AMT. OF BENEFITS	SOCIAL SECURITY #
1.								

PROPOSED INSURED
Telephone Number (_____) _____
Daytime Telephone Number (_____) _____
Address _____
City, State, Zip _____

OWNER
Name _____
Address _____
City, State, Zip _____
SS# _____
Relationship to Proposed Insured _____

FAMILY PHYSICIAN
Name _____
Address _____
City, State, Zip _____

(b) Will the life insurance being applied for replace or change any existing life insurance or annuity? ..... ○YES ○NO

Telephone interview completed _____ ○YES ○NO
Phone # _____
Best Time to Call _____ ○AM ○PM

Occupation _____

Mode of Premium Payment (check):
○Annual ○Semi-Annual ○Quarterly ○Monthly
○Monthly Bank Draft

Premium: $ _____

BENEFICIARY (FULL NAME) RELATIONSHIP

Primary _____
Contingent _____

PLAN APPLIED FOR
○Immediate Death Benefit L-254IBP
○Return of Premium Death Benefit L-256RPP

HEALTH INFORMATION *of* PROPOSED INSURED

1. Have you been medically treated or diagnosed by a medical professional as having Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC), or any immune deficiency related disorder or tested positive for the Human Immunodeficiency Virus (HIV)? ..... ○Yes ○No
2. Within the past 12 months have you been convicted of driving under the influence of alcohol or drugs or had your driver's license suspended or are you currently on probation, parole or currently disabled? ..... ○Yes ○No
3. Within the past 2 years have you used heroin, cocaine, opium, methadone, LSD or been medically diagnosed, treated, or taken medication for alcohol abuse or drug abuse, been confined to a medical facility or missed work or school for 10 consecutive days for a mental or nervous disorder? ..... ○Yes ○No
4. Within the past 5 years have you been medically diagnosed or treated, or taken medication for internal cancer, melanoma, Hodgkin's disease, or lymphoma? ..... ○Yes ○No
5. Have you been medically diagnosed, treated, or taken medication for diabetes prior to age 21, or do you currently take insulin shots, or been medically diagnosed with diabetes combined with a medical history of any of the following: retinopathy, nephropathy, neuropathy, insulin shock, or diabetic coma? ..... ○Yes ○No
6. Have you been medically diagnosed, treated, or taken medication for stroke, angina (chest pain), heart attack, congestive heart failure, cardiomyopathy, heart valve disease, sickle cell anemia, leukemia, hemophilia, Marfan's syndrome, muscular dystrophy, Huntington's disease, cystic fibrosis, motor neuron disease, systemic lupus (SLE), connective tissue disease, liver or kidney failure (including dialysis), had an amputation caused by disease or had or been advised to have an organ transplant? ..... ○Yes ○No

IF ANY ANSWER TO QUESTIONS 1 THROUGH 6 IS ANSWERED "YES" THE PROPOSED INSURED IS NOT ELIGIBLE FOR ANY COVERAGE.

7. Have you been medically diagnosed, treated, or taken medication for mental retardation, paralysis of two or more extremeties or any neuro-muscular disease (including cerebral palsy, multiple sclerosis, or Parkinson's disease) cirrhosis, liver disease, chronic hepatitis or chronic pancreatitis, Crohn's disease or ulcerative coitis prior to age 21? ..... ○Yes ○No
8. Within the past 12 months have you:
   a. had surgical treatment for morbid obesity or been hospitalized for high blood pressure, irregular heart beat, seizures, chronic obstructive pulmonary disease (COPD), asthma, diabetes, or any heart or circulatory procedure to improve circulation to the heart, brain, or legs? ..... ○Yes ○No
   b. been declined for life insurance or had any diagnostic testing or surgery by a medical professional which has not been completed or for which the results have not been received? ..... ○Yes ○No
9. Within the past 3 years have you been medically diagnosed or treated, or taken medication for a blood clot or aneurysm? ..... ○Yes ○No

IF ANY ANSWER TO QUESTIONS 7 THROUGH 9 IS ANSWERED "YES" THE PROPOSED INSURED IS ELIGIBLE FOR THE RETURN OF PREMIUM DEATH BENEFIT PLAN.

IF ALL ANSWERS TO QUESTIONS 1 THROUGH 9 ARE ANSWERED "NO" THE PROPOSED INSURED IF APPLICABLE, IS ELIGIBLE FOR IMMEDIATE COVERAGE.

ANY MISSTATEMENTS AS TO HEALTH OR PHYSICAL CONDITION, THAT SHALL MATERIALLY INCREASE THE RISK ASSUMED, SHALL CAUSE THIS POLICY TO BECOME NULL AND VOID WITHIN THE CONTESTABLE PERIOD.

AGREEMENT: I hereby apply to Southwest Service Life of Fort Worth, Texas, for a policy solely and entirely in reliance upon the written answers to the foregoing questions and I expressly agree on behalf of myself and any person who shall claim any interest in any policy issued on this application as follows: (1) All statements and answers contained herein are full, complete and true to the best of my knowledge and belief. (2) The insurance hereby applied for shall not be considered in force until a policy is issued and manually received and accepted by me and the full first premium paid thereon while the proposed Insured's health and other conditions remain as described in this application. (3) On behalf of myself, each of us, and of every person who shall have or claim an interest in any policy issued as a result of my application, I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau, or other organization, institution or person, that has any records or knowledge of me or my health, to give Southwest Service Life Insurance Company, or its reinsurers, any such information. I also agree that all provisions of law prohibiting or exempting physicians or hospital officials from testifying or disclosing information are waived in favor of Southwest Service Life Insurance Company. A photocopy of this authorization is to be considered as valid as the original. **I UNDERSTAND THIS POLICY HAS NO CASH OR LOAN VALUES.**

Dated at _____ (CITY & STATE)
On _____ (MONTH AND DAY) , _____ (YEAR)
Agent _____

Signed _____ (PROPOSED INSURED)
Signed _____ (SIGNATURE OF OWNER IF OTHER THAN PROPOSED INSURED)
No. _____

Southwest Service Life Insurance Company

Premium Rates for Policy Form L-254IBP and L-256RPP
Premium Rates per $1,000 face amount for Policy Form L-254IBP and L-256RPP
Male and Female - same rate.
Policy Fee: Annually $30.00, Semi-annually $15.00, Quarterly $7.50, Monthly $2.50
Minimum amount of coverage sold Per Applicant - $5,000
Maximum amount of coverage - $15,000 per applicant.

Policy Form L-254IBP with ADB

AGES	ANNUAL	SEMI-ANNUAL	QTRLY	MONTHLY	MONTHLY DRAFT
1-21	8.50	4.42	2.25	0.85	0.77
22	8.82	4.59	2.34	0.88	0.79
23	9.21	4.79	2.44	0.92	0.83
24	9.64	5.01	2.55	0.96	0.87
25	10.10	5.25	2.68	1.01	0.91
26	10.60	5.51	2.81	1.06	0.95
27	11.14	5.79	2.95	1.11	1.00
28	11.72	6.09	3.11	1.17	1.05
29	12.35	6.42	3.27	1.24	1.11
30	13.02	6.77	3.45	1.30	1.17
31	13.74	7.14	3.64	1.37	1.24
32	14.51	7.55	3.85	1.45	1.31
33	15.33	7.97	4.06	1.53	1.38
34	16.20	8.42	4.29	1.62	1.46
35	17.12	8.90	4.54	1.71	1.54
36	18.11	9.42	4.80	1.81	1.63
37	19.19	9.98	5.09	1.92	1.73
38	20.32	10.57	5.38	2.03	1.83
39	21.52	11.19	5.70	2.15	1.94
40	22.75	11.83	6.03	2.28	2.05
41	24.12	12.54	6.39	2.41	2.17
42	25.51	13.27	6.76	2.55	2.30
43	26.97	14.02	7.15	2.70	2.43
44	28.50	14.82	7.55	2.85	2.57

Policy Form L-256RPP with ADB

AGES	ANNUAL	SEMI-ANNUAL	QTRLY	MONTHLY	MONTHLY DRAFT
1-21	10.13	5.27	2.68	1.01	0.91
22	10.53	5.47	2.79	1.05	0.95
23	11.01	5.73	2.92	1.10	0.99
24	11.55	6.01	3.06	1.16	1.04
25	12.13	6.31	3.21	1.21	1.09
26	12.75	6.63	3.38	1.28	1.15
27	13.43	6.98	3.56	1.34	1.21
28	14.15	7.36	3.75	1.42	1.27
29	14.94	7.77	3.96	1.49	1.34
30	15.78	8.20	4.18	1.58	1.42
31	16.68	8.67	4.42	1.67	1.50
32	17.64	9.17	4.67	1.76	1.59
33	18.66	9.70	4.95	1.87	1.68
34	19.75	10.27	5.23	1.98	1.78
35	20.90	10.87	5.54	2.09	1.88
36	22.14	11.51	5.87	2.21	1.99
37	23.49	12.21	6.22	2.35	2.11
38	24.90	12.95	6.60	2.49	2.24
39	26.40	13.73	7.00	2.64	2.38
40	27.94	14.53	7.40	2.79	2.51
41	29.65	15.42	7.86	2.97	2.67
42	31.39	16.32	8.32	3.14	2.82
43	33.21	17.27	8.80	3.32	2.99
44	35.13	18.27	9.31	3.51	3.16

Policy reserves are based on 1956 Chamberlain Mortality Table at 3 1/2%

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

To: _____

Bank Address: _____

Bank Number: _____

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

_____

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

Form No. L-254IBP/L-256RPP (6/2006)