COMPLETING YOUR LIFE APPLICATION:

This packet contains the following forms needed to complete a life application. Please review the following information and complete all needed forms:

- Application for Life Insurance (Form 5320-Rev.1/03) **To be used only for Mortgage Protector ®**
- Summary and Disclosure Statement for Accelerated Benefit Rider (Form 5130-Rev.7/01TX for Traditional). Copy signed by applicant/owner and agent must accompany each application, if requesting the Accelerated Benefit Rider.
- Electronic Funds Transfer Form (Form 1019)
- Texas Supplement to Application (4683-1/95 TX)
- HIPAA – Authorization For Release of Health-Related Information (Form 5539-Rev.7/03). Copy signed by Proposed Insured must accompany each application.
- You may need to submit the appropriate HIV form for your state. Please refer to Underwriting Guidelines or contact our underwriters for HIV requirements. Please check the StarNet forms database, consult your Supply List or contact Marketing Services, 800-848-5433, ext. 4320, for assistance in finding the correct form.
- If you are replacing other life insurance coverage, you will also need to submit the appropriate replacement form for your state. Please check the StarNet forms database, consult your Supply List or contact Marketing Services, 800-848-5433, ext. 4320 for assistance.

Application For Life Insurance

SHENANDOAH LIFE INSURANCE COMPANY

1. PROPOSED INSURED INFORMATION

Last Name	First Name	MI	Phone Number for Contact
			Day
			Evening
			Best Time To Call

Social Security Number or Tax ID #	Age	Sex	Date of Birth	State of Birth	Height	Weight

Occupation and Duties	E-mail Address	Driver's License #

Primary Street Address	City	County	State	Zip Code

2. BENEFICIARY INFORMATION – PROPOSED INSURED

Primary Beneficiary as to Proposed Insured, *with right of revocation*	Relationship	Telephone Number

Address of Primary Beneficiary	City	County	State	Zip Code

Contingent Beneficiary as to Proposed Insured	Relationship	Telephone Number

Address of Contingent Beneficiary	City	County	State	Zip Code

3. OTHER INSURED (CO-BORROWER) INFORMATION (*if applicable*)

Last Name	First Name	MI	Phone Number for Contact
			Day
			Evening
			Best Time To Call

Social Security Number or Tax ID #	Age	Sex	Date of Birth	State of Birth	Height	Weight

Occupation and Duties	E-mail Address	Driver's License #

Primary Street Address	City	County	State	Zip Code

4. BENEFICIARY INFORMATION – OTHER INSURED (CO-BORROWER)

Primary Beneficiary as to Other Insured (Co-Borrower), *with right of revocation*	Relationship	Telephone Number

Address of Primary Beneficiary	City	County	State	Zip Code

Contingent Beneficiary as to Other Insured (Co-Borrower)	Relationship	Telephone Number

Address of Contingent Beneficiary	City	County	State	Zip Code

5. OWNER *(if other than Proposed Insured)*

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

Relationship to Proposed Insured	Date of Birth	E-mail Address	Telephone Number

Address	City	County	State	Zip Code

6. FAMILY MEMBER(S) AND BENEFICIARY INFORMATION *(if applying for Children Term Insurance Rider)*

Name	Age	Sex	Date of Birth	State of Birth	Relationship to Proposed Insured	Height	Weight	Social Security Number
Child 1								
Child 2								
Child 3								
Applicant								

Beneficiary as to Children Term Insurance Rider, *with right of revocation*	Relationship	Contingent Beneficiary as to Children Term Insurance Rider	Relationship

7. REPLACEMENT INFORMATION

a. Are there any existing life insurance policies or annuity contracts in force on any person proposed for coverage? ❑ None ❑ Listed Below

b. Will insurance applied for replace any now in force? ❑ Yes ❑ No

c. Are any other applications pending with other companies? ❑ Yes ❑ No

Insured's Name	Company	Owner	Replacement	Life Amount	Accidental Death Benefit	Policy Date (Mo/Day/Year)
			❑ Yes ❑ No			
			❑ Yes ❑ No			
			❑ Yes ❑ No			

8. INSURANCE APPLIED FOR

Plan Mortgage Term – Level Period (years): ❑ 10 ❑ 15 ❑ 20 ❑ 25 ❑ 30 Face Amount ..... $_____

❑ Non-Tobacco ❑ Tobacco ❑ Select Tobacco

9. RIDERS APPLIED FOR

❑ Non-Occ Disability Income (Insured) ..... $_____ mo.

❑ Disability Income (Insured) ..... $_____ mo.

Complete the following if either rider above is selected

Current monthly gross income from occupation .... $_____

Amount of Disability Ins. currently in force ..... $_____

Average number of hours worked each week ..... _____

Worker's Compensation or any other form of similar on-the-job disability coverage ..... ❑ Yes ❑ No

❑ Non-Occ Disability Income (Other Insured – Co-Borrower) ..... $_____ mo.

❑ Disability Income (Other Insured – Co-Borrower) ..... $_____ mo.

Complete the following if either rider above is selected

Current monthly gross income from occupation .. $_____

Amount of Disability Ins. currently in force ..... $_____

Average number of hours worked each week ..... _____

Worker's Compensation or any other form of similar on-the-job disability coverage ..... ❑ Yes ❑ No

❑ Other Insured Mortgage Term Rider (Co-Borrower) ..... $_____

❑ Non-Tobacco ❑ Tobacco ❑ Select Tobacco

❑ Children Term Insurance Rider ..... $_____

❑ Return of Premium Rider

❑ Waiver of Premium Rider

❑ Accidental Death Benefit Rider ..... $_____

❑ Other _____

Accelerated Benefit Rider – *automatically included unless you check "no" here* ..... ❑ No

10. PREMIUM AND BILLING INFORMATION

1. Premium Mode – **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.**

   ❑ Monthly EFT *(complete form 1019)* ❑ Annual ❑ Quarterly ❑ Semi-Annual

   ❑ Other _____

2. Amount paid in exchange for Conditional Receipt subject to the terms and conditions thereof *(Agent: consult Underwriting Guidelines prior to acceptance of initial premium and issuance of Conditional Receipt)*: ..... $_____

11. HOME LOAN INFORMATION

Home Loan Number _____ Home Loan Amount ..... $_____

Home Loan Date _____ Home Loan Payment ..... $_____

Financial Institution _____

I understand that I am applying for a life insurance policy that is available to individuals who have obtained a loan in connection with the purchase of a home in the last 24 months. I hereby certify that I am the borrower/co-borrower on the loan.

X _____ _____

Signature of **Applicant** Date

X _____ **X** _____

Signature of **Other Insured (Co-Borrower)**, if applicable Signature of **Agent**

12. HOME OFFICE ENDORSEMENTS	SPECIAL REQUESTS

13. HEALTH INFORMATION *(circle any condition which applies to any applicant)*

1. Within the last 10 years, have any persons proposed for coverage been diagnosed or treated by a member of the medical profession for heart disease, stroke, chest pain, chronic respiratory disorder, liver disease including hepatitis, tumor or cancer, kidney disease, mental or nervous disorder, alcohol or drug dependency? ❑ Yes ❑ No

2. Have any persons proposed for coverage ever been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or tested positive for the Human Immunodeficiency Virus (HIV) through implementation of the ELISA, ELISA Western Blot Testing Procedure, or tested positive for antibodies to the AIDS virus? ❑ Yes ❑ No

3. Within the past 5 years, have any persons proposed for coverage:

a. been diagnosed or treated by a member of the medical profession for disorder of the blood or blood vessels, glandular disorder, digestive or intestinal disorder or bleeding, diabetes, high blood pressure, seizure, disorder of the muscles or bones or a sexually transmitted disease? ❑ Yes ❑ No

b. been hospitalized? ❑ Yes ❑ No

c. been advised to have any diagnostic test or hospitalization or surgery which has not been done? *(Previous AIDS testing disclosure not included)* ❑ Yes ❑ No

d. had a weight change of more than 10 pounds? ❑ Yes ❑ No

e. applied for life, disability or health insurance which was declined, postponed, rated or modified or received disability benefits? ❑ Yes ❑ No

f. had a driver's license restricted or revoked, been cited for driving under the influence of alcohol or drugs or been cited for more than two moving violations? ❑ Yes ❑ No

g. been convicted of a felony or currently on probation? ❑ Yes ❑ No

h. traveled or lived outside the U.S. or Canada, or made plans to do so within the next year? ❑ Yes ❑ No

i. engaged or intend to engage in aviation activities or sports including but not limited to stock or sports car, drag strip, motorcycle or boat racing, scuba or sky diving, rock or mountain climbing? *(Please complete the appropriate questionnaire)* ❑ Yes ❑ No

j. used cocaine, marijuana, heroin, or any other illegal, restricted or controlled substances? ❑ Yes ❑ No

4. a. In the past 12 months, have you used tobacco in any form? ❑ Yes ❑ No
If yes, have you smoked cigarettes in the past 36 months? ❑ Yes ❑ No

b. In the past 12 months, has the co-borrower used tobacco in any form? ❑ Yes ❑ No
If yes, has the co-borrower smoked cigarettes in the past 36 months? ❑ Yes ❑ No

5. Is any person proposed for coverage currently on medication or under treatment, therapy or observation? ❑ Yes ❑ No

6. Does any person proposed for coverage have a family history of Huntington's Chorea? ❑ Yes ❑ No

7. Name, address and telephone number of your personal physician _____

_____

Date and reason last consulted _____

Please provide details of all "YES" answers in the area below.
(Attach a separate sheet if more space is needed.)

Question #	Person	Explanation	Dates/ Duration	Name, Address and Telephone Number of Medical Professional

14. DECLARATIONS AND AUTHORIZATIONS

By this application, I am applying to Shenandoah Life Insurance Company ("SHENANDOAH") for a policy of life insurance. **I agree that:**

1. My statements and answers to the questions in this SHENANDOAH application are complete, true and accurately recorded to the best of my knowledge and belief, and are the basis for issuing any policy.
2. **No insurance shall become effective unless a policy has been issued and delivered to me, the first premium tendered and honored for payment and the insurability as stated in this application remains unchanged.**
3. Acceptance of any policy issued on this application shall constitute agreement to any correction or amendment of this application made by SHENANDOAH and noted on this application. However, no change in amount, age at issue, classification, plan of insurance or benefits applied for shall be made unless agreed to in writing by me.
4. No broker or agent has the authority to waive any of SHENANDOAH's rights or requirements, or to make or alter any contract or policy.
5. During the contestable period, SHENANDOAH has the right to rescind any policy issued upon statements or answers in this application that are not correct.

I authorize any medical professional, hospital, clinic, medical care institution, insurer or reinsurer, the Medical Information Bureau (MIB), consumer reporting agency, employer, relative, friend or neighbor to disclose to SHENANDOAH, its reinsurers, and, except for the Medical Information Bureau, any consumer reporting agency acting on behalf of SHENANDOAH, medical and other information pertaining to me. The information that may be disclosed includes information relating to employment; other insurance coverage; past and present physical, mental, drug and/or alcohol conditions; character; habits; avocations; finances; general reputation; credit or other personal characteristics.

I understand that SHENANDOAH may collect information for the purpose of determining eligibility for insurance. I agree that this authorization will be valid for two and one-half years from the date it is signed. I know that I or my authorized representative have a right to receive a copy of this authorization upon request. I agree that a photographic copy of this authorization is as valid as the original.

I certify that I am the borrower/co-borrower in good standing of the loan obtained for the purchase of a home which closed on the date and in the amount as provided in Section 11.

Any person who, knowingly and with intent to defraud any insurance company or other persons, files an application for insurance or statement of claim containing any materially false information, or conceals information for the purpose of misleading, concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Note: The following state requires that an alternate statement regarding insurance fraud be given. If you are a resident of the following state, please consider the following statement as a replacement for the above statement.

Tennessee – It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

I acknowledge that I have received the Investigative Consumer Report Notice and Medical Information Bureau Disclosure Notice attached to this application.

Signed at _____ on _____
City, State Date

X _____ X _____
Signature of **Proposed Insured** Signature of **Owner**, if other than Proposed Insured

X _____ X _____
Signature of **Applicant**, if other than Proposed Insured Signature of **Other Insured (Co-Borrower)**, if applicable

15. AGENT CERTIFICATION

To be completed by agent. I certify that I have asked the persons proposed for coverage all of the questions contained in this application and have accurately recorded on this application the information supplied by the persons proposed for coverage.

Do you have knowledge or reason to believe that replacement of existing life insurance policies or annuity contracts may be involved? ..... ❑ Yes ❑ No

Is the agent an immediate relative of the proposed insured? .... ❑ Yes ❑ No Relationship _____

_____ X _____
Name of Agent (please print) Agent's Code Signature of **Agent**

_____ X _____
Name of Agent (please print) Agent's Code Signature of **Agent**

SHENANDOAH LIFE INSURANCE COMPANY

CONDITIONAL RECEIPT (Please detach and leave with applicant)

Prior to the delivery of the policy, coverage will be effective only when ALL of the following conditions are met:

a) The full first premium according to the mode of payment specified in the said application has been tendered and honored for payment;

b) A later date is not requested in the application;

c) The Proposed Insured is on that date an acceptable risk under the Company's rules, limits and standards as to plan, benefits, class, and amount for the policy applied for;

d) The Company receives all medical requirements (such as examinations, tests, x-rays and electrocardiograms) which the Company requests; and

e) There is no material misrepresentation in the application furnished to the Company.

Subject to satisfactory completion of all of the above conditions, coverage under this receipt will begin on the date the application is signed.

The maximum death benefit and all other supplemental benefits provided by this receipt will be the lesser of a) the total death benefit payable under the policy(ies), including any Accidental Death Benefit, on all pending applications with the Company or b) $250,000. If two or more persons are proposed for coverage, this maximum applies to each person proposed for coverage.

If any condition under this receipt is not met, the Company's only liability will be to refund the premium payment. Either the Company or the proposed owner may terminate coverage under this receipt by notice to the other. In no event will coverage under this receipt be in force after 60 days from the date of the application.

No broker, agent or medical examiner may waive a complete answer 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.

If there is material misrepresentation in the application (or in any medical information furnished to the Company), the Company's only liability will be limited to refunding the premium payment.

If any person proposed for coverage commits suicide, whether sane or insane, the Company's only liability will be limited to refunding the premium payment.

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

Received $_____ from _____ for an application on _____ dated _____.

X_____ X_____

Signature of **Owner** Signature of **Agent**

INVESTIGATIVE CONSUMER REPORT PRE-NOTIFICATION

As part of our procedure for processing your initial 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. This inquiry includes information as to your character, general reputation, personal characteristics and mode of living, except as may be related directly or indirectly to your sexual orientation. You may request to be interviewed for the consumer report. You may, upon written request, be informed whether or not the report was ordered, and if so, the name and address of the consumer reporting agency which made the report. Upon furnishing proper identification, you have the right to make a written request within a reasonable period of time to inspect and/or receive a copy of the report and/or to receive additional, detailed information about the nature and scope of this investigation. For this information you may write to the Underwriting Department, Shenandoah Life Insurance Company, P.O. Box 12847, Roanoke, Virginia 24029. This notice is in compliance with the Fair Credit Reporting Act (Public Law 91-508).

Note: Within 60 days of the date of this application you will be notified as to whether or not this application has been accepted or else be given the reason for any further delay.

MEDICAL INFORMATION BUREAU PRE-NOTIFICATION

Information regarding your insurability will be treated as confidential. Shenandoah Life Insurance Company or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau (MIB), a non-profit membership organization of life 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 it may have 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 (TTY 866-346-3642). 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 Credit Reporting Act. The address of MIB's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112.

Shenandoah Life Insurance Company or its reinsurers may also release information in our 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.

SHENANDOAH LIFE INSURANCE COMPANY

TRADITIONAL

SUMMARY AND DISCLOSURE STATEMENT FOR ACCELERATED BENEFIT RIDER

THE ACCELERATION-OF-LIFE-INSURANCE BENEFITS OFFERED UNDER THIS RIDER MAY OR MAY NOT QUALIFY FOR FAVORABLE TAX TREATMENT UNDER THE INTERNAL REVENUE CODE OF 1986. WHETHER SUCH BENEFITS QUALIFY DEPENDS ON FACTORS SUCH AS YOUR LIFE EXPECTANCY AT THE TIME BENEFITS ARE ACCELERATED OR WHETHER YOU USE THE BENEFITS TO PAY FOR NECESSARY LONG-TERM CARE EXPENSES, SUCH AS NURSING HOME CARE. IF THE ACCELERATION-OF-LIFE-INSURANCE BENEFITS QUALIFY FOR FAVORABLE TAX TREATMENT, THE BENEFITS WILL BE EXCLUDABLE FROM YOUR INCOME AND NOT SUBJECT TO FEDERAL TAXATION. TAX LAWS RELATING TO ACCELERATION-OF-LIFE-INSURANCE BENEFITS ARE COMPLEX. YOU ARE ADVISED TO CONSULT WITH A QUALIFIED TAX ADVISOR ABOUT CIRCUMSTANCES UNDER WHICH YOU COULD RECEIVE ACCELERATION-OF-LIFE-INSURANCE BENEFITS EXCLUDABLE FROM INCOME UNDER FEDERAL LAW.

RECEIPT OF ACCELERATION-OF-LIFE-INSURANCE BENEFITS MAY AFFECT YOUR, YOUR SPOUSE OR YOUR FAMILY'S ELIGIBILITY FOR PUBLIC ASSISTANCE PROGRAMS SUCH AS MEDICAL ASSISTANCE (MEDICAID), AID TO FAMILIES WITH DEPENDENT CHILDREN (AFDC), SUPPLEMENTARY SOCIAL SECURITY INCOME (SSI), AND DRUG ASSISTANCE PROGRAMS. YOU ARE ADVISED TO CONSULT WITH A QUALIFIED TAX ADVISOR AND WITH SOCIAL SERVICE AGENCIES CONCERNING HOW RECEIPT OF SUCH A PAYMENT WILL AFFECT YOU, YOUR SPOUSE AND YOUR FAMILY'S ELIGIBILITY FOR PUBLIC ASSISTANCE.

This is a brief summary intended to help you understand the Accelerated Benefit Rider and its effect on your policy. Please refer to the rider form for actual contract provisions.

WHAT BENEFIT DOES THIS RIDER PROVIDE?

We will pay to the Owner up to 80% of the Eligible Death Benefit, but not more than $250,000, if the Insured is medically certified with a Terminal Condition resulting in a life expectancy of 12 months or less; or if the Insured is medically certified as having been admitted to a Qualified Institution due to the inability to perform any two Activities of Daily Living, or due to the Impairment of Cognitive Ability as defined in the rider. The benefit will be paid as a lump sum or upon your request, in equal monthly installments.

WHAT IS THE COST OF THE BENEFIT?

No additional premium is assessed for this benefit. However, we will deduct an Interest Charge and a Premium Charge at the time of acceleration since the payment is made while the Insured is still alive. These charges will be refunded if death occurs within 60 days of acceleration. In addition, we will deduct an administrative fee not to exceed the amount guaranteed and stated in the rider.

HOW IS THE POLICY AFFECTED BY THE PAYMENT OF AN ACCELERATED BENEFIT?

All amounts included in determining the Eligible Death Benefit and any cash value will be reduced by the ratio of the Accelerated Amount to the Eligible Death Benefit. Any required premium after acceleration will be based on the reduced amount and must be paid in accordance with the terms of the policy.

Below is an example of how the Accelerated Benefit Rider works:

Here is the policy prior to acceleration:

Policy Face Amount:	$100,000
Policy Loan (if applicable):	$10,000
Cash Value (if applicable):	$25,000
Monthly Premium:	$100

The Eligible Death Benefit is $90,000 (this equals the policy death benefit less the policy loan). The maximum amount that may be accelerated is $72,000. If you requested less than the maximum amount, for example, 50% or $45,000, then you would receive $40,184. This amount reflects an Interest Charge of $4,091 (assuming a 10% interest rate), a Premium Charge of $575 and an administrative charge of $150.

The policy death benefit, cash value, and policy loan would be reduced by 50%. The table below shows the policy before and after payment of the accelerated benefit:

	Before Payment	After Payment
Policy Face Amount:	$100,000	$50,000
Policy Loan:	$10,000	$5,000
Cash Value:	$25,000	$12,500
Monthly Premium:	$100	$60

All figures in the above example are hypothetical and should not be construed as guarantees.

WHAT CONDITIONS MUST BE MET BEFORE THIS BENEFIT CAN BE PAID?

Prior to any payment of an accelerated benefit, the following conditions must be met:

- You must have a Terminal Condition resulting from bodily injury or disease or you must have been admitted to a Qualified Institution due to your inability to perform any two Activities of Daily Living, or due to Impairment of Cognitive Ability. **Terminal Condition** is defined as a medical condition that can reasonably be expected to result in death within 12 months from the date of the Physician's certification. **Qualified Institution** is a facility or part of a facility that: (1) is licensed by the state in which it is located as a skilled nursing facility or intermediate care facility; and (2) is operated pursuant to state and federal law. **Activities of Daily Living** shall mean bathing, continence, dressing, eating, toileting, and transfering. *Bathing* – Washing oneself by sponge bath or in either a tub or shower, including the task of getting into or out of the tub or shower. *Continence* – The ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag). *Dressing* – Putting on and taking off all terms of clothing and any necessary braces, fasteners or artificial limbs. *Eating* – Feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously. *Toileting* – Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene. *Transferring* – Sufficient mobility to move into or out of a bed, chair or wheelchair or to move from place to place, either via walking, a wheelchair or other means. **Impairment of Cognitive Ability** is a clinical diagnosis of deterioration or loss of intellectual capacity requiring supervision for protection of self and others.
- The policy and rider must be in force at the time benefits are requested.
- The policy must not be legally or equitably assigned except to us as security for a policy loan.
- The Terminal Condition or permanent confinement cannot result from intentionally self-inflicted injuries within two years from the effective date of the rider.
- We must receive consent from all irrevocable beneficiaries. We may also require consent from any other person who, in our opinion, may have an interest in the policy.
- If the Insured is not the Owner, the Insured cannot be a director, officer, or employee of the Owner or be financially interested in any trade or business carried on by the Owner.
- A request for acceleration will not be approved if the Owner or Insured is required by law to use policy benefits to meet creditor claims.
- A request for acceleration will not be approved if the Owner or Insured is required by a government agency to use this benefit in order to apply for, obtain, or keep a government benefit or entitlement.
- A request for acceleration will not be allowed on any term insurance policy which is within two years of termination.

There are no restrictions or limitations on your use of the Accelerated Proceeds.

I acknowledge that I have read this Summary and Disclosure Statement.

X_____ _____

Signature of **Applicant/Owner** Date

X_____ _____

Signature of **Agent** Agent Code

_____

Application or Policy Number

SHENANDOAH LIFE INSURANCE COMPANY

ELECTRONIC FUND TRANSFER AUTHORIZATION

REQUEST FOR PREAUTHORIZED WITHDRAWAL OR A CHANGE TO AN EXISTING EFT

❑ Start New Deduction

❑ Change Routing Number or Account Number

❑ Add to Existing EFT Policy Number _____

I hereby authorize Shenandoah Life Insurance Company to make withdrawals from my account for the purpose of paying insurance premiums on the policies listed:

Depositor Name (First, MI, Last)	Financial Institution Name
Mailing Address of Depositor	Financial Institution Address
Telephone Number of Depositor	Telephone Number of Financial Institution
Depositor Account Number	Transit Routing Number

Check one: Checking ❑..... **For a Checking account, please attach a voided check.**

Savings ❑..... **For a Savings account, please ask your financial institution to verify that this EFT will be accepted and that the above information is correct.** *This verification is necessary as not all financial institutions will acknowledge an EFT debit to a savings account.*

Policy Number (if issued)	Amount	Policy Number (if issued)	Amount
1.		3.	
2.		4.	

Please withdraw a total of $_____ on the _____ of each month (please choose a day between the 1st and the 28th). If a day is not selected, Shenandoah Life will select the day nearest the premium due date.

This authorization will not apply to an alternate or additional policy until the alternate or additional policy has been delivered and the initial premium settled. Notification to discontinue EFT withdrawal should be received by Shenandoah Life Insurance Company five (5) days prior to the day of withdrawal.

I agree that the withdrawals on such Financial Institution shall constitute due notice of premiums being due upon the policy. The withdrawals reflected on my bank statement will constitute a receipt. This authorization is revocable only upon receipt by Shenandoah Life Insurance Company of a written notice of revocation. I understand that if any account withdrawal is not paid upon presentation and any premiums due on the policy are not paid within the time stipulated in the policy, insurance coverage may lapse or may be terminated by Shenandoah Life Insurance Company.

_____
Date

_____
Name of Depositor (please print)

X_____
Signature exactly as it appears on bank signature card

_____
Name of Co-signer (please print)

X_____
Signature of Co-Signer (if applicable)

SHENANDOAH LIFE INSURANCE COMPANY

P.O. BOX 12847 ◆ ROANOKE, VIRGINIA 24029 ◆ (540) 985-4400

TEXAS SUPPLEMENT TO APPLICATION FOR INDETERMINATE PREMIUM TERM INSURANCE POLICY OR RIDER

I understand that the basic life insurance policy, or a rider to that policy, for which I have made application to Shenandoah Life Insurance Company, provides term insurance with indeterminate premiums. This means that:

(1) The initial premium is guaranteed to apply only during the policy's (or rider's) guaranteed period as set out in the policy (or rider).

(2) For policy years beyond the guaranteed period, the Company may change the schedule of premium rates but not more frequently than annually.

(3) The premium payable during any policy year will not exceed the guaranteed maximum premium for that year; a table of guaranteed maximum premiums for each year will be set out in the policy.

_____

Signature of Proposed Insured (or Owner, if different)

Witness _____ _____

Agent Agent Code

SHENANDOAH LIFE INSURANCE COMPANY

INDIVIDUAL UNDERWRITING

AUTHORIZATION FOR RELEASE OF HEALTH-RELATED INFORMATION TO SHENANDOAH LIFE INSURANCE COMPANY

THIS AUTHORIZATION COMPLIES WITH THE HIPAA PRIVACY RULE

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services on my behalf within the past 10 years ("Providers") to disclose the entire medical record and any other protected health information concerning me to Shenandoah Life Insurance Company and its agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements made to restrict such protected health information do not apply to this Authorization, and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose such entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that Shenandoah Life Insurance Company may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) 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 that I have applied for with Shenandoah Life Insurance Company.

This Authorization shall remain in force for 30 months following the date of my signature below, and a copy of this Authorization is as valid as the original. Except I understand that if I reside in Kansas, Kentucky, New Mexico, or Oklahoma, this Authorization shall remain valid for 24 months; and for 26 months if I reside in Minnesota; and, if I reside in Arizona as to HIV-related information only this Authorization shall remain valid for 180 days. I understand that I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to Shenandoah Life Insurance Company at P.O. Box 12847, Roanoke, VA 24029, Attention: Chief Privacy Official. I understand that a revocation is not effective to the extent that any of the Providers has relied on this Authorization or to the extent that Shenandoah Life Insurance Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this Authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that if I refuse to sign this Authorization to release the complete medical record, Shenandoah Life Insurance Company may not be able to process my application. I understand that I or my authorized representative may request a copy of this Authorization.

_____ _____

Name of Proposed Insured (please print) Date

X_____

Signature of Proposed Insured

_____ _____

Name of Proposed Insured (please print) Date of Birth

TO BE COMPLETED BY AGENT OR HOME OFFICE ONLY