CHOICE MUTUAL
INSURANCE AGENCY

Final Expense Sample Application

This is a sample application, not a promise to issue coverage.

Important Notes:

You **cannot** buy this policy directly from Prosperity Life.

This policy is **sold only via licensed Prosperity Life agencies** such as Choice Mutual.

To apply, call us at 1-800-644-2926

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**