

DISTRICT 54	Family Group Number				Check Digit
AGENCY 04	3	5	4	0	0
STAFF 1	IF CREATING A NEW FAMILY GROUP ALSO COMPLETE PAYOR'S N/A FORM.				
LAST NAME OF AGENT SANCHEZ					

(PLEASE PRINT)  
APPLICATION TO THE  
**SOUTHERN LIFE  
AND HEALTH  
INSURANCE COMPANY**

H. O. CORRECTIONS AND AMENDMENTS

PROPOSED INSURED  
**DEANDRA G. Kelly**  
(first) (middle) (last)

BENEFICIARY Relationship  
(not applicable to types marked with "HUSBAND")  
**MUNEER DEEB (C-1)**

**7-26-68** Date of Birth  
**CLAY CO. TX** County, State of Birth  
**M** Sex  
**5' 13"** Ht. **130** Wt.

if more than one, pay in equal shares among survivors; if none living pay to contingent beneficiary.

CONTINGENT BENEFICIARY Relationship

Complete For Beneficiary, if Premium Ins. Is Applied For

If more than one, pay in equal shares among survivors.  
OCCUPATION AND DUTIES, APPLICANT  
**House Wife**

Date of Birth County, State of Birth Sex Ht. Wt. Age  
BENEFICIARY'S OCCUPATION, IF PREM. INS. IS APPLIED FOR

PLAN DESCRIPTION			Age Last Birth-day	Indicate Prem. Mode							Premium	Amt. Ins. or Daily Hosp. Ben.	POLICY NUMBER
Type	Prem. Ins. ?	Indicate Plan		W	M	Q	S	A	DC				
LIFE 85		142	0	4	3	2	1	7					
END. 65		150	0	4	3	2	1	7					
20 PAY		146	0	4	3	2	1	7					
20 END.		144	0	4	3	2	1	7					
ED. END.		147	0	4	3	2	1	7					
TERM		151	0	4	3	2	1	7					
10 PAY		148	0	4	3	2	1	7					
			0	4	3	2	1	7					
ACC. 110	HERB	11 12 14 16	16	0	4					10 <sup>00</sup>	20,000	40659	
S.H.B. *		55	0	4	3	2	1	7					
CANCER *		57 58	0	4	3	2	1	7					
HOSP. *		53 54 56	0	4								JUL 01 1982	

The following questions apply to each of those above who are proposed for insurance, including beneficiary, if premium insurance is applied for.

1. Have you ever been declined for insurance or been offered a policy of different kind or amount than applied for? **No** (If "Yes" explain in Remarks on reverse side.)

2. State the name and address of family physician  
Proposed Insured \_\_\_\_\_ Beneficiary \_\_\_\_\_

3. Are you now in good health and free from all disease? **Yes**  
Proposed Insured \_\_\_\_\_ Beneficiary \_\_\_\_\_

4. Have you within the past 5 years been under observation or treatment in a clinic or hospital? **No**  
Proposed Insured \_\_\_\_\_ Beneficiary \_\_\_\_\_

5. Have you any physical or mental defect or infirmity? **No**  
Proposed Insured \_\_\_\_\_ Beneficiary \_\_\_\_\_

6. Have you been attended by a physician during the past 3 years? **No**  
Proposed Insured \_\_\_\_\_ Beneficiary \_\_\_\_\_

what disease or injury? \_\_\_\_\_ When? \_\_\_\_\_  
Proposed Insured \_\_\_\_\_ Beneficiary \_\_\_\_\_

7. Have you ever suffered from any of the following diseases? High blood pressure; diabetes; asthma; tuberculosis or other lung diseases; stroke; paralysis; anemia; heart disease; alcoholism; convulsions; disease of liver, gall bladder or kidneys; cancer; peptic ulcer; disease of prostate or female organs; emotional or mental disorder; habitual use of narcotics? **No**  
Proposed Insured \_\_\_\_\_ Beneficiary \_\_\_\_\_

State which and when \_\_\_\_\_

8. If hospital coverage is applied for, what other hospital coverage do you have? **NONE**

9. I HEREBY DECLARE that all the statements and answers to the above questions, those on the reverse side, and to the questions on any medical examination required are complete and true and I AGREE (1) that they, together with this agreement, shall form the basis and be a part of any policy issued hereunder; (2) that except as otherwise provided in the Company's receipt for \$ **10.00** tendered with this application, the insurance herein applied for shall not take effect until a policy therefor is delivered to me and the first premium paid while each person proposed for insurance is in good health; (3) that no information acquired by any Company representative shall bind the Company unless set out in writing in this application; (4) that my acceptance of any policy issued on this application will constitute a ratification by me of any correction or amendment to this application made by the Company in the space provided for Home Office Corrections and Amendments; (5) Applicant reserves the right to change any beneficiary unless otherwise stated.

Proposed Insured if age 15 or older and other than Applicant. **Deandra G. Kelly** Applicant  
**6/22/82** Date **Alenc Sanchez** (To be signed by the Proposed Owner of the policy applied for)  
Witness to all Signatures (Soliciting Agent)

TEL  
755-7681

Box 6333

76706

~~Waco Texas~~

TELEPHONE NUMBER

FOR EACH APPLICATION  
SHOW PROPOSED INSURED'S ADDRESS:

P.O. Box 6333

PROPOSED INSURED'S STREET ADDRESS

WACO

PROPOSED INSURED'S CITY

TEXAS 76706

PROPOSED INSURED'S STATE, ZIP

NON-REPLACEMENT STATEMENT

Is the insurance applied for to replace existing insurance?  
If Yes, include company name and policy number:

Agent  Yes  No      Applicant  Yes  No (Use Forms 514 and 515 where required.)

Company

Policy number

*Alvaro Sanchez*

6/23/82

Signature of Agent

Date

*Deandra G. Kelley*

Signature of Applicant

ACKNOWLEDGEMENT, NOTIFICATION, AND AUTHORIZATION

I acknowledge receiving a copy of the Notice to Applicants Regarding the Medical Information Bureau and an Outline of Coverage (Texas, A&H plans only).

I understand that an investigative consumer report including information as to my character, general reputation, personal characteristics and mode of living may be made and that I have a right, upon written request, to be provided further information as to the nature and scope of such a report.

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 (or my child's) health, to give to the Southern Life and Health Insurance Company or its reinsurers any such information. A photocopy of this authorization shall be as valid as the original.

6/23/82

Date

*Deandra G. Kelley*

Signature of Applicant

Remarks

Empty rectangular box for Remarks.