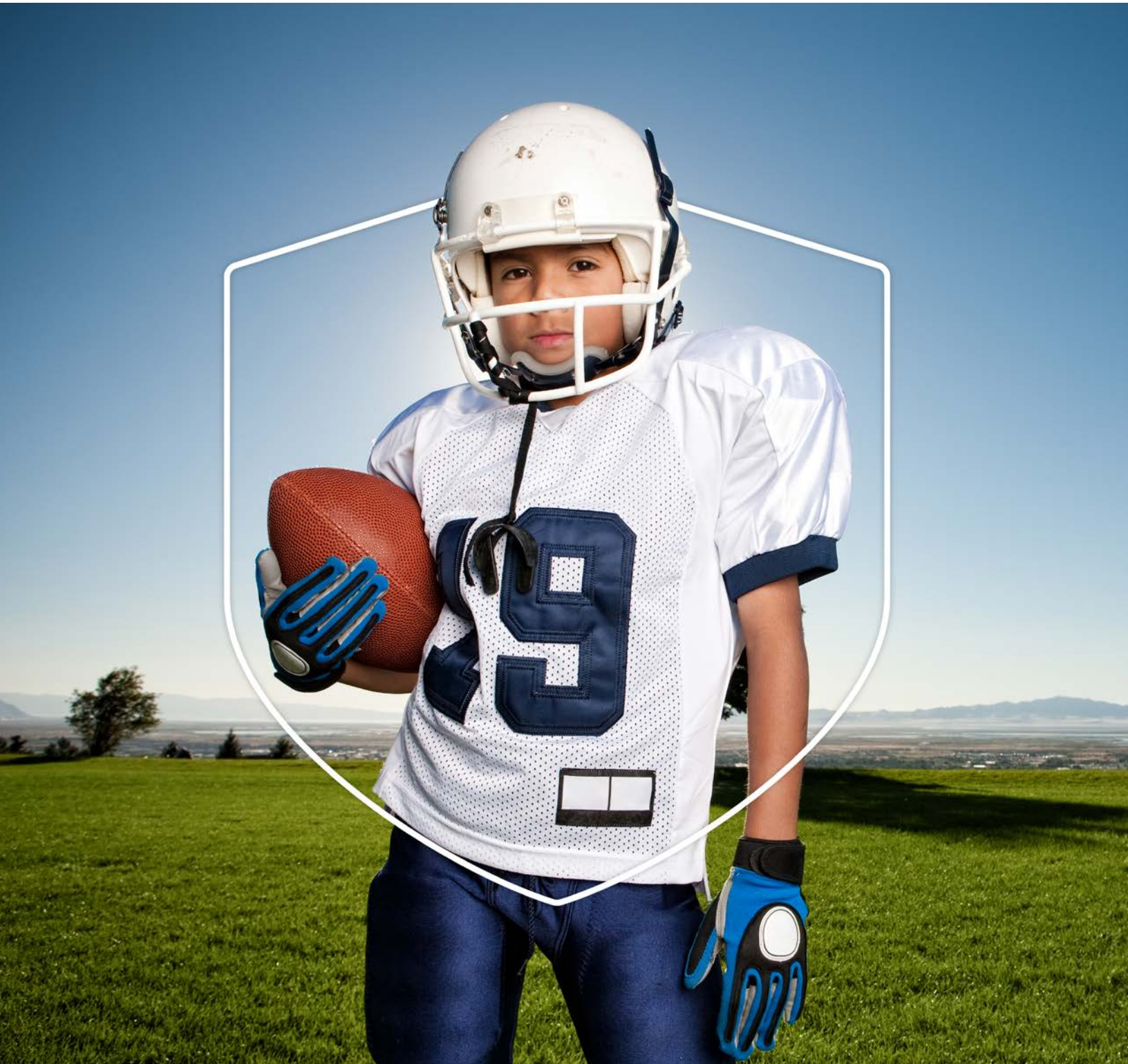




INTRODUCES  
**ScholarGuard™**

Innovative insurance protection  
designed for peace of mind.





ScholarGuard™ protects the future of any covered youth in all activities.



DESIGNED FOR: —————○

**ALL YOUTH**  
AGES 6-21

The **ScholarGuard™** policy can be purchased for individuals from age 6 to age 21 and renewed through age 25.

**ALL ACTIVITIES**  
ACADEMIC & ATHLETIC

**ScholarGuard™** provides protection no matter their individual interests, activities or skill level.

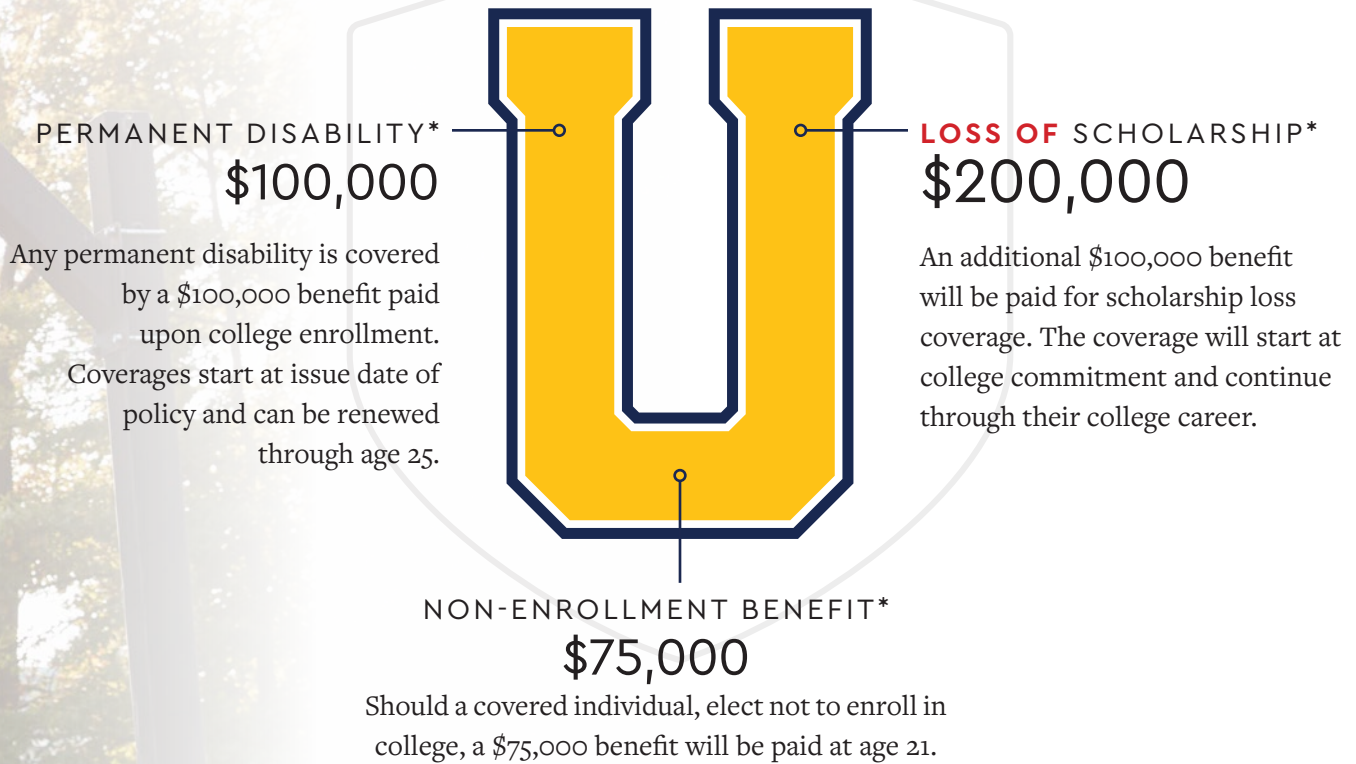
**ALL FUTURES**  
ALL LIFE'S PATHS

**ScholarGuard™** futures are bright. No matter if that includes college, professional athletics or joining the workforce.

Protect tomorrow with our accident disability product. Get started today.

ScholarGuard™

All coverages are paid on scholarship loss or disability, even if the injury is not sports related.



Age Issued	Annual Premium	Age Issued	Annual Premium
6	\$468.00	14	\$705.00
7	\$482.00	15	\$758.00
8	\$495.00	16	\$814.00
9	\$508.00	17	\$871.00
10	\$522.00	18	\$931.00
11	\$562.00	19	\$992.00
12	\$603.00	20	\$1,055.00
13	\$653.00	21	\$1,084.00

**Enroll early, and lock in your rates.**

Premiums are based on issue age and guaranteed not to increase for lifetime of the policy.\*

\*To qualify, disability must be result of accident or condition specified in policy benefits. Eligibility has one year waiting period and benefits begin upon enrollment in college or eligibility to enroll and are paid in four annual installments.



# ScholarGuard™ in Montana

Casey FitzSimmons and Matt Kegel are Montana's state ambassadors for ScholarGuard™. Together, these leaders are connected to coaches and athletes across the entire state. They understand the dynamics of being a young athlete and the desire for parents to protect their future, on and off the field.



**CASEY FITZSIMMONS**  
Casey, a Montana athlete, was a star at Carroll College and played for the Detroit Lions from 2003-2009.



**MATT KEGEL**  
Matt is a Montana athlete that went on to play quarterback for Washington State, and is currently in medical device sales.



<b>APPLICATION FOR DISABILITY INSURANCE</b>		<b>BIG SKY LIFE INSURANCE COMPANY</b>	
		<b>Administrative Office: P.O. Box 40 Brownwood, TX 76804 Toll Free 1-800-321-5264</b>	
POLICY NO.		APPLICATION NO.	
<b>1. PROPOSED INSURED:</b> (Print Full Name)		<input type="checkbox"/> Male <input type="checkbox"/> Female	Age: _____
		Driver's License #: _____ (if available)	State: _____
Residence Address: _____			
Birth State/Country: _____	Birth Date:    /    /	Social Security #: _____	Phone: _____
<b>2. PLAN OF INSURANCE:    ScholarGuard Accident Only Disability Income</b>			
<b>3. PREMIUM:</b> MODE: <input type="checkbox"/> Annual <input type="checkbox"/> S-A <input type="checkbox"/> Quarterly			
PAYMENT METHOD: <input type="checkbox"/> Direct <input type="checkbox"/> Bank Draft <input type="checkbox"/> Mode Premium Amount    \$ _____			
<b>4. BENEFICIARIES:</b>			
Primary Name: _____ Relationship: _____ Soc Sec # _____			
Contingent Name: _____ Relationship: _____ Soc Sec # _____			
<b>5. SPECIAL REQUESTS / ADDITIONAL REMARKS:</b>			
<b>6. POLICYOWNER:</b> Complete only if Owner is other than Primary Insured (Payor/Owner for children ages 0-18)			
Full Name: _____		Birth Date: _____	Age: _____
Address: _____			
City, State, ZIP: _____		Social Security #: _____	
Birth State/Country: _____	Occupation: _____		
<b>7. Has the Proposed Insured ever been diagnosed as having, or treated by a medical practitioner for:</b>			
a) Traumatic brain injury with persistence of neurologic symptoms for greater than four weeks after Injury? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No			
b) Amputation or loss of neurologic function of any limb? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No			
c) Cervical spine fracture? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No			
d) Failed anterior cruciate ligament (ACL) repair? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No			
e) Failed shoulder stabilization procedure? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No			
f) Non-union or malunion of fracture any limb? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No			
g) Complete and irrecoverable loss of speech, Deafness, or Blindness? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No			
h) Thoracic or lumbar vertebral fracture with persistent instability or non-union, with or without related neurologic symptoms? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No			
i) Traumatic or post-traumatic amputation or loss of neurologic function of two or more digits from a single hand or foot? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No			
j) Unilateral irrecoverable loss of vision? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No			
k) Traumatic, persistent loss of renal function requiring dialysis? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>8. Will the insurance applied for replace or change any existing insurance or annuity?</b>			
<input type="checkbox"/> Yes <input type="checkbox"/> No    If "Yes," please give name of company and policy number(s).			

**I the undersigned, by my signature set forth hereunder:**  
 AGREE to the following

- a) All statements and answers in this application are completed and true to the best of my knowledge and belief.
- b) Except as stated in the Receipt bearing the same number as this application, no insurance will take effect unless the first full mode premium is paid and a policy is delivered while the health of any proposed insured continues, without material change, to be as represented in this application.
- c) No Big Sky associate has authority to waive any answer or otherwise modify this application or to bind BIG SKY LIFE INSURANCE COMPANY, hereinafter called "Company," in any way by making promise or representation which is not set out in writing in this application.
- d) \$ \_\_\_\_\_ has been given to the associate whose name appears below as payment of the first mode premium on the policy applied for, and the terms of the Receipt bearing the same number as this application are accepted by the proposed insured.

Signed at (City and State):	Date:	Signature of Proposed Insured:
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Signature of Licensed Associate/ Agent #:	Signature of Applicant & Relationship (if other than Proposed Insured):
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NOTICE: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Any insurance company or associate of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from the insurance proceeds shall be reported to the appropriate state regulatory agency(ies).

USE THIS PAGE FOR PROVIDING ADDITIONAL INFORMATION ABOUT ANY NUMBERED OR ALPHABETIC QUESTION ON THE APPLICATION WHEN ADDITIONAL SPACE IS NEEDED. BE SURE TO IDENTIFY SECTION AND QUESTION BY NUMBER OF LETTER.


**AGENT'S REPORT: (PROVIDE DETAILS IN "ADDITIONAL REMARKS" SECTION 5 ABOVE)**

- a) Was this application taken in person by you?.....Yes No
- b) Do you know anything about the proposed insured(s) not disclosed which might affect the underwriting of this risk?.....Yes No
- c) Has the Proposed Insured applied elsewhere for any insurance coverage within the past 6 months?.....Yes No

**I certify I have accurately recorded all information given by the Proposed Insured. The above statements are correct to the best of my knowledge.**

Agent's Signature:	Agent #:	Date:	Total Premium Submitted: \$
			Mode of Premium Payment: <input type="checkbox"/> A <input type="checkbox"/> SA <input type="checkbox"/> Q
Agent's Signature:	Agent #:	Date:	Method of Premium Payment: <input type="checkbox"/> BANK DRAFT <input type="checkbox"/> DIRECT







“You may lose your scholarship, but  
don’t lose your education.”