

Application for:
Individual Whole Life & Limited
Death Benefit Life Insurance



FIRST GUARANTY INSURANCE COMPANY
P.O. Box 57220, Salt Lake City, Utah 84157-0220
Telephone: (801) 264-1060 or Toll Free: 1 (800) 574-7117

SECURITY CARE PLAN

| | | | | | | | |
|--|--|--|--------------------------------------|--------------|---|--------------------------|--------------------------|
| Name of Proposed Insured (Print) First _____ Initial _____ Last _____ | | Gender _____ | Birthdate _____ | Age _____ | Height _____ | Weight _____ | |
| Street Address _____ | | | City _____ | State _____ | Zip _____ | | |
| Proposed Insured's Telephone Number _____ | | | Social Security Number/TIN _____ | | | Birth State _____ | |
| Owner's Name (if other than the Proposed Insured): _____ | | | | | | | |
| Address: _____ | | City: _____ | | State: _____ | | Zip: _____ | |
| Telephone Number: _____ | | | Relationship: _____ | | | | |
| Payor's Name (if other than the Proposed Insured): _____ | | | | | | | |
| Address: _____ | | City: _____ | | State: _____ | | Zip: _____ | |
| Telephone Number: _____ | | | Relationship: _____ | | | | |
| Primary Beneficiary: _____ | | | Contingent Beneficiary: _____ | | | | |
| Address: _____ | | | Address: _____ | | | | |
| Telephone: _____ Relationship: _____ | | | Telephone: _____ Relationship: _____ | | | | |
| All Premiums are Level | | Premium Payable: | | | Face Amount: \$ _____ | | |
| Class: <input type="checkbox"/> Select <input type="checkbox"/> Special <input type="checkbox"/> Limited | | <input type="checkbox"/> EFT <input type="checkbox"/> Direct Monthly Bill <input type="checkbox"/> Debit/Credit Card | | | Premium: \$ _____ | | |
| Payment: <input type="checkbox"/> 10-Pay <input type="checkbox"/> 20-Pay <input type="checkbox"/> Whole Life | | <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Annual | | | Rider Face Amount: | | |
| Amount of Premium paid with the Application: \$ _____ | | | | | <input type="checkbox"/> ADB \$ _____ | | |
| (Check must be made payable to First Guaranty Insurance Company). | | | | | <input type="checkbox"/> Child \$ _____ | | |
| Please Choose a Billing Option: Select Billing Month <u>AND</u> Select Billing Day <u>OR</u> Billing Week | | | | | | | |
| Does the Proposed Insured receive Social Security, Social Security Disability, SSI, VA Retirement and/or VA Disability? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| Draft Upon Approval <input type="checkbox"/> Yes <input type="checkbox"/> No | | Select First Billing Month: January – December _____ | | | | | |
| | | Select Billing Day: 1 st – 28 th _____ OR Select Billing Week: <input type="checkbox"/> 2 nd Wednesday <input type="checkbox"/> 3 rd Wednesday <input type="checkbox"/> 4 th Wednesday | | | | | |
| Replacement: Do you have an existing life insurance policy or annuity contract? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| If "Yes", please fill out and submit the notice regarding the replacement of life insurance or annuities. | | | | | | | |
| Proposed Insured's Physician's Name: _____ Phone Number: _____ | | | | | | | |
| Address: _____ | | City: _____ | | State: _____ | | Zip: _____ | |
| Please answer all Medical Questions for the Proposed Insured | | | | | | | |
| If all answers to the Medical Questions in all 3 sections are "NO", then the Proposed Insured qualifies for Select Class | | | | | | | |
| Section I – Any "Yes" answers, Proposed Insured is not eligible for coverage. | | | | | | | |
| Has the Proposed Insured been diagnosed, tested positive for, treated or been given medical advice by a licensed member of the medical profession for any of the following medical conditions: | | | | | | | |
| | | | | | Yes | No | |
| 1. Have you ever been diagnosed, tested or treated by a licensed member of the medical profession as having Alzheimer's disease, dementia, hepatitis C, ALS (Lou Gehrig's disease), or been medically diagnosed, tested or treated by a licensed member of the medical profession with having a terminal illness resulting in death within the next 12 months? | | | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you been diagnosed, tested or treated by a licensed member of the medical profession for an organ transplant, dialysis treatment, cystic fibrosis, cirrhosis of the liver or sickle cell anemia? | | | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever been diagnosed by a licensed member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or have you tested positive for the Human Immunodeficiency Virus (HIV)? | | | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. In the past 5 years have you been treated for alcohol or drug addiction or abuse (including prescription drugs) by a licensed member of the medical profession? | | | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. In the past 2 years been diagnosed, tested or treated by a licensed member of the medical profession for any internal cancer, melanoma or brain tumor? | | | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. In the past 2 years been diagnosed, tested or treated by a licensed member of the medical profession for any type of heart disease, CHF, heart attack or heart surgery? | | | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. In the past 2 years been diagnosed, tested or treated by a licensed member of the medical profession for any type of stroke, brain aneurysm, seizure, any other brain disorders or suicide attempt? | | | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Are you now, or within the past 30 days been treated or admitted in a hospital, nursing home or any other type of health care facility, hospice care or been advised by a licensed member of the medical profession to be confined to a bed? | | | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you need assistance or supervision with dressing, eating, personal hygiene (bathing or toilet), or transferring to or from a bed or chair? | | | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| ADMINISTRATIVE OFFICE ADDITIONS OR CORRECTIONS | | | | | | | |

Applicant's Name:

Social Security Number:

Section II – Any “Yes” answers, Proposed Insured qualifies for Special class.

In the past five years, has the Proposed Insured been diagnosed, tested positive for, treated, prescribed medication or been given medical advice by a licensed member of the medical profession for any of the following medical conditions:

- | | | |
|--|--------------------------|--------------------------|
| | Yes | No |
| 10. Diabetes with no complications, good control, takes under 100 units of insulin in a 24-hour period and was diagnosed with diabetes after age 40? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Lung disorders, emphysema, asthma or COPD? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Chest pain, heart attack, heart surgery, other heart or circulatory disorder, including uncontrolled high blood pressure (takes more than 2 medications), takes blood thinning medication, brain aneurysm or stroke? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Diagnosed, tested or treated by a licensed member of the medical profession for any internal cancer, melanoma or brain tumor? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Recovered alcohol or drug abuser? If applicable, list date of recovery: | <input type="checkbox"/> | <input type="checkbox"/> |

Section III – Any “Yes” answers, Proposed Insured qualifies for Limited Death Benefit Plan.

In the past five years, has the Proposed Insured been diagnosed, tested positive for, treated, prescribed medication or been given medical advice by a licensed member of the medical profession for any of the following medical conditions:

- | | | |
|--|--------------------------|--------------------------|
| | Yes | No |
| 15. Diabetes with complications, including retinopathy, neuropathy, amputation onset of diabetes under age 40, but not on dialysis? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Disease of the liver, kidney, pancreas, other internal organs or hepatitis B? | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Parkinson's disease, paralysis, multiple sclerosis, lupus, muscular dystrophy, epilepsy, seizures or any other neurological disorders? | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Paranoia, schizophrenia, major depressive disorder, suicide attempts, hospitalization, or any other mental disorder or disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Congestive heart failure (CHF), heart attack, circulatory disorder, or other heart disorders or conditions? | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Brain tumor, brain disorders, TIA (mini stroke) or strokes of any kind? | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Within the last 2 years , have you ever been advised by a licensed member of the medical professional to have tests, surgery, treatment or do you have any medical test results pending or any additional medical evaluations that have not been performed, excluding tests related to the Human Immunodeficiency Virus (AIDS virus)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Do you use a medical appliance such as a wheelchair, walker, hospital bed or oxygen? | <input type="checkbox"/> | <input type="checkbox"/> |

If “Yes” to any Medical Question, please indicate which medical question your answer pertains to and write down all medical condition(s), medication(s) including oxygen, the dosage and duration of said medication(s).

| Medical Question # | Medical Condition(s) | Medication(s) - including oxygen | Dosage | Duration (from/to) |
|--------------------|----------------------|----------------------------------|--------|--------------------|
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If applying for the Child Rider – Complete this Section

Please complete the Proposed Insured Child information for each child. Answer “Yes” or “No” if the Proposed Insured Child has any of the following medical condition(s). If any of the medical questions are answered “Yes”, the Proposed Child is not eligible for the Child Rider.

Child rider cannot exceed the Base Plan or \$10,000, whichever is lower.

Has the Proposed Insured Child ever been diagnosed, tested positive for, treated or prescribed medication by a licensed member of the medical profession for any of the following medical conditions:

- | | | | | |
|--------------|--------------------|----------------------------|--------------------------------|--|
| 1. Cancer | 4. Cerebral Palsy | 7. Kidney or organ failure | 10. Lung disorder or disease | 13. Any inpatient stay, 48 hours or more (within 1 year) |
| 2. Diabetes | 5. Rheumatic fever | 8. Sickle Cell Anemia | 11. Heart problems or disease | 14. Any disorder of the brain, motor skills or seizures |
| 3. Hepatitis | 6. Down Syndrome | 9. Tested positive for HIV | 12. Any disorder of the nerves | |

| Name of Proposed Insured Child | Medical Condition | | Birthdate | Age | Gender (M or F) | Relationship to Applicant |
|--------------------------------|-------------------|----|-----------|-----|-----------------|---------------------------|
| | Yes | No | | | | |
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Applicant's Name:

Social Security Number:

NOTICE TO APPLICANT: I hereby apply to First Guaranty Insurance Company for insurance to be issued upon the truth and completeness of the answers to the above questions to the best of my knowledge, and agree that: (1) no agent has the authority to waive the answer to any question in the application; (2) no insurance will be effective until the premium for the mode selected has been paid in full and the policy delivered; and (3) the policy effective date will be the date this application is received by the company at the above address.

PRESCRIPTION AUTHORIZATION

I hereby authorize any health care provider, including any physician, practitioner, pharmacy, prescription vendor, pharmacy benefit manager, hospital or medically-related facility, and any insurance company, or other consumer reporting agency, institution or person that has my records or knowledge of me or my dependent(s) to disclose to First Guaranty Insurance Company (FGIC), or its authorized representative, any such records or information. Records or information may include medical records in their entirety, which may contain mental health records, (excluding psychotherapy notes), prescription drug records, use of alcohol, or use of controlled or prohibited substances and driving records. Such records or information will be used by Company personnel to determine eligibility for insurance and/or benefits. FGIC may disclose such information to its reinsurer(s) or any other organization which performs services in connection with the insurance relationship, including but not limited to, the insurance agent, or as lawfully required. There may be certain circumstances under which the information received may be disclosed to third parties who are not subject to the regulations under federal health privacy law. We contractually require such persons to agree to protect the confidentiality of the information. I understand that I have the right to request access to all personal information collected and, upon written request, I may ask FGIC to correct, amend or delete any incorrect personal information. A copy of the Company's "Privacy Notice and Notice of Insurance Information Practices" is available upon request.

This authorization shall be valid for a period of two years from the date signed to determine eligibility for insurance, as permitted by applicable law in the state where the policy is issued for delivery. A photocopy of this authorization shall be as valid as the original. I understand that I, or my authorize representative may receive a copy of this authorization upon request. This authorization may be revoked upon submission of a written notice to the Administrative Office. If this authorization was obtained as a condition of obtaining insurance coverage, your right to revoke also is subject to the rights of the Company under any law granting the Company the right to contest a claim under the policy or the policy itself.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Dated at _____ City _____ State _____ Date: _____

Proposed Insured/Applicant's Printed Name _____

Signature of Proposed Insured/Applicant _____

Date _____

Signature of Owner (if other than Proposed Insured) _____

Date _____

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AGENT'S STATEMENT – I certify that to the best of my knowledge:

1. I correctly asked all the Medical Questions in this application and correctly recorded all the answers given; and
2. All answers given in this application are true and complete; and
3. The signature of the Proposed Insured(s) and/or the Applicant/Policyowner (Parent/Legal Guardian) is what they are represented to be and were signed in my presence; and
4. Is the Proposed Insured an immediate family member? Yes No; and
5. I know of no factor affecting the insurability of the Proposed Insured(s) except as stated in this application; and
6. This insurance **WILL** **WILL NOT** change or replace any existing insurance policy or annuity contract.

Note: If "Will" is checked for question 6, complete required replacement forms.

Agent's Signature: _____

Agent's Printed Name: _____

Agent's Number: _____

If policy and commissions are being split between multiple agents, then each additional agent must sign and notate commission split.

Agent's Signature: _____

Agent's Number: _____

Agent's Printed Name: _____

Commission Split: _____



FIRST GUARANTY INSURANCE COMPANY
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Office: (801) 264-1060 • Toll Free: 1 (800) 574-7117

Applicant's Name:

Social Security Number:

**PAYOR INFORMATION AND ELECTRONIC FUNDS TRANSFER (EFT)
AUTHORIZATION AGREEMENT TO FIRST GUARANTY INSURANCE COMPANY (FGIC)**

Payor Name: _____ Phone #: _____

Payor Address: _____

Customer Name: _____

Name of Bank: _____

Address of Bank: _____

Checking Account #: _____ or Savings Account #: _____

Nine Digit Bank Transit #: _____

Credit/Debit Card #: _____ Exp.: _____ CVV#: _____

I authorize FGIC to initiate debit entries to my checking or savings account, or charge my credit or debit card indicated above, and authorize the financial institution (bank) named to debit my account for payment of my FGIC account(s). I understand this authorization is subject to the terms and conditions of the EFT agreement.

TERMS AND CONDITIONS

1. This arrangement may be terminated with respect to any or all contracts listed below by FGIC or by me upon written notice to the other party. Until such notice is actually received by FGIC, FGIC shall be fully protected in drawing the EFT.
2. I understand that if any EFT is dishonored by my bank and if any monthly amount due FGIC is not paid within the time stipulated on the contract, the contract shall lapse except as otherwise provided therein.
3. During the continuance of this arrangement FGIC shall not be required to send payment notices on any contract I have authorized to be included hereunder.
4. If I change banks or bank accounts and I want to continue using EFT, I must sign a new Authorization Agreement.
5. This authorization shall not be effective for any contract for which an application is pending, unless and until such contract is actually issued and the down payment there under paid in cash to FGIC.
6. I will pay a returned-item fee as specified by the bank or FGIC for any debit entry that is returned to FGIC for insufficient funds.
7. The EFT will apply to the following contract(s):

Name: _____ Contract #: _____

Name: _____ Contract #: _____

Date: _____ Signature: _____

Authorized Account Holder

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CONDITIONAL RECEIPT

**THIS RECEIPT DOES NOT PROVIDE ANY INSURANCE UNTIL AFTER ITS CONDITIONS ARE MET.
NO AGENT OF THE COMPANY OR BROKER OR ANY OTHER PERSON(S) MAY WAIVE ANY OF THESE CONDITIONS.**

Received from _____ on _____ (date) the sum of \$ _____, the correct first premium specified in the application, subject to the following conditions:

FIRST: If each Proposed Insured would be acceptable and approved by First Guaranty Insurance Company as insurable under the company's underwriting rules for insurance on the plan and at the premium rate and the amount of insurance applied for on the application for all Proposed Insured(s).

SECOND: The premium funds for the correct premium amount for plan of insurance applied for, have been honored on the first presentation and result in the funds being credited to First Guaranty Insurance Company's bank account.

THIRD: If the application is not approved within 60 days from the date it was signed, the application will be deemed to have been rejected and First Guaranty Insurance Company will have no liability.

Agent's Signature

Agent's Name (Please Print)

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