First Guaranty Insurance Company

FIRST GUARANTY INSURANCE APPLICATION BROCHURE

Security Care Plan - Page 1

(RED) Should include name, gender, date of birth, age, height, weight, mailing address, phone number, social security number, & birth state.

(ORANGE) If owner and/or payor is different than insured complete these sections entirely.

(YELLOW) Primary beneficiary info is required and contingent beneficiary is recommended.

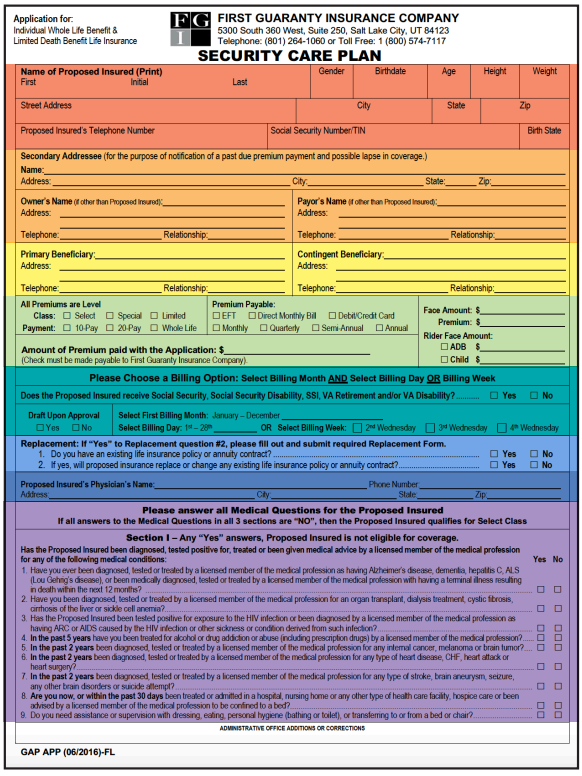
(GREEN) Plan Selection. Enter Plan, Premium Payable, Amount of Premium, Face Amount, and Rider info.

(TEAL) Billing Info. Answer yes/no income question. If payor wants their premium to be drafted immediately upon underwriting approval then choose "Yes" on Draft Upon Approval, otherwise answer "No". Choose either a billing date or 2nd, 3rd, or 4th Wednesday option to coordinate with their pay date.

(LIGHT BLUE) Replacement – Answer replacement question(s) and complete additional replacement forms if required.

(DARK BLUE) Physician Name – Enter the insured's primary care physician contact information.

(PURPLE) Medical Questions – Section 1 – Answer all health questions.



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

FIRST GUARANTY INSURANCE COMPANY
5300 South 360 West, Suite 250, Salt Lake City, UT 84123
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

Secondary Addressee (for the purpose of notification of a past due premium payment and possible lapse in coverage.)
Name:
Address: City: State: Zip:

Owner's Name (if other than Proposed Insured):
Address:
Telephone: Relationship:

Payor's Name (if other than Proposed Insured):
Address:
Telephone: Relationship:

Primary Beneficiary:
Address:
Telephone: Relationship:

Contingent Beneficiary:
Address:
Telephone: Relationship:

All Premiums are Level
Class: ☐ Select ☐ Special ☐ Limited
Payment: ☐ 10-Pay ☐ 20-Pay ☐ Whole Life

Premium Payable:
☐ EFT ☐ Direct Monthly Bill ☐ Debit/Credit Card
☐ Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annual

Face Amount: $
Premium: $
Rider Face Amount:
☐ ADB $
☐ Child $

Amount of Premium paid with the Application: $
(Check must be made payable to First Guaranty Insurance Company).

Please Choose a Billing Option: Select Billing Month AND Select Billing Day OR Billing Week

Does the Proposed Insured receive Social Security, Social Security Disability, SSI, VA Retirement and/or VA Disability? ☐ Yes ☐ No

Draft Upon Approval ☐ Yes ☐ No
Select First Billing Month: January – December
Select Billing Day: 1st – 28th OR **Select Billing Week:** ☐ 2nd Wednesday ☐ 3rd Wednesday ☐ 4th Wednesday

Replacement: If "Yes" to Replacement question #2, please fill out and submit required Replacement Form.
1. Do you have an existing life insurance policy or annuity contract? ☐ Yes ☐ No
2. If yes, will proposed insurance replace or change any existing life insurance policy or annuity contract? ☐ Yes ☐ No

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? ☐ ☐
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? ☐ ☐
3. Has the Proposed Insured been tested positive for exposure to the HIV infection or been diagnosed by a licensed member of the medical profession as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection? ☐ ☐
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? ☐ ☐
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? ☐ ☐
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? ☐ ☐
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? ☐ ☐
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? ☐ ☐
9. Do you need assistance or supervision with dressing, eating, personal hygiene (bathing or toilet), or transferring to or from a bed or chair? ☐ ☐

ADMINISTRATIVE OFFICE ADDITIONS OR CORRECTIONS

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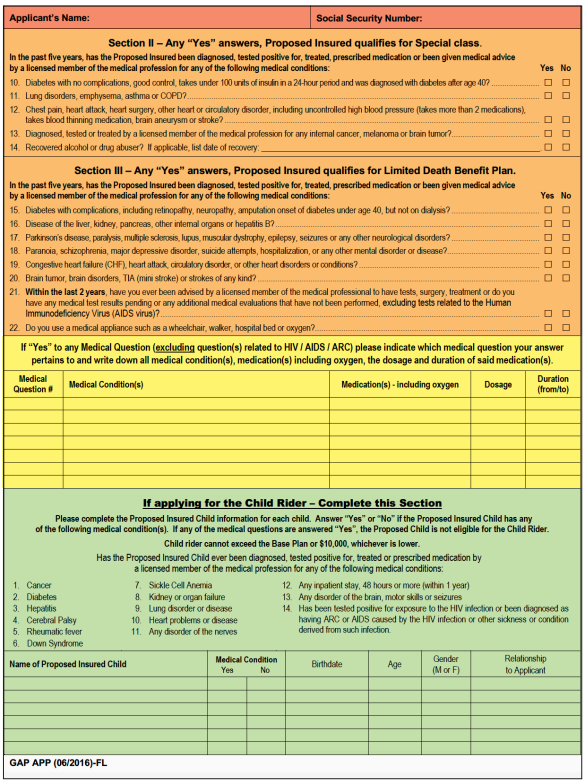

Applicant's Name: | **Social Security Number:**

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? ☐ ☐
11. Lung disorders, emphysema, asthma or COPD? ☐ ☐
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? ☐ ☐
13. Diagnosed, tested or treated by a licensed member of the medical profession for any internal cancer, melanoma or brain tumor? ☐ ☐
14. Recovered alcohol or drug abuser? If applicable, list date of recovery: ☐ ☐

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? ☐ ☐
16. Disease of the liver, kidney, pancreas, other internal organs or hepatitis B? ☐ ☐
17. Parkinson's disease, paralysis, multiple sclerosis, lupus, muscular dystrophy, epilepsy, seizures or any other neurological disorders? ☐ ☐
18. Paranoia, schizophrenia, major depressive disorder, suicide attempts, hospitalization, or any other mental disorder or disease? ☐ ☐
19. Congestive heart failure (CHF), heart attack, circulatory disorder, or other heart disorders or conditions? ☐ ☐
20. Brain tumor, brain disorders, TIA (mini stroke) or strokes of any kind? ☐ ☐
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)? ☐ ☐
22. Do you use a medical appliance such as a wheelchair, walker, hospital bed or oxygen? ☐ ☐

If "Yes" to any Medical Question (excluding question(s) related to HIV / AIDS / ARC) 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)

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
2. Diabetes
3. Hepatitis
4. Cerebral Palsy
5. Rheumatic fever
6. Down Syndrome
7. Sickle Cell Anemia
8. Kidney or organ failure
9. Lung disorder or disease
10. Heart problems or disease
11. Any disorder of the nerves
12. Any inpatient stay, 48 hours or more (within 1 year)
13. Any disorder of the brain, motor skills or seizures
14. Has been tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection.

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

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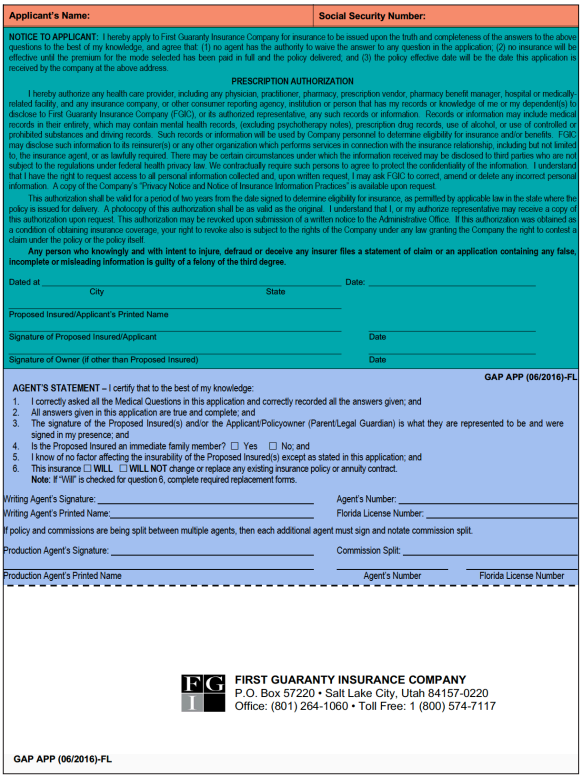
(RED) Applicant Name and Social Security Number

(ORANGE) Medical Questions – Sections 2 and 3 – Answer all health questions.

(YELLOW) Prescriptions – enter all current prescriptions taken and provide all pertinent information to any "Yes" health question(s).

(GREEN) Child Rider – If applying for a Child Rider, provide all information.



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 and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

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.

Writing Agent's Signature: _____ Agent's Number: _____

Writing Agent's Printed Name: _____ Florida License Number: _____

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

Production Agent's Signature: _____ Commission Split: _____

_____ _____ _____
Production Agent's Printed Name Agent's Number Florida License Number

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

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(TEAL) Disclosures & Signatures – City & state where the application was signed. Signature of insured. Signature of owner, if different than insured.

(LIGHT BLUE) Agent's Statement –

Answer 2 questions

1. Is the proposed insured a family member of the agent?
2. An additional replacement question.

Agent's signature, printed name, and agent number.

If commissions are being split, both agents must sign the application and provide split information.

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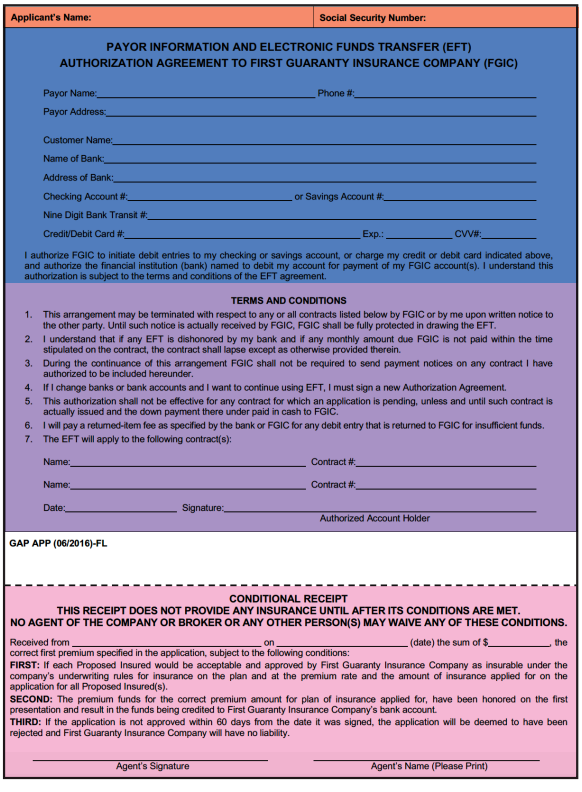
(RED) Applicant Name and Social Security Number

(DARK BLUE) Payor Name, Phone, and Address. Customer Name is Payor's Name. Enter banking information.

(PURPLE) EFT disclosures. Name is Insured and leave contract # blank if it's a new application. Have payor sign and date the form.

(PINK) Conditional Receipt: Payor Name, Date, Cash With App, Agent Signature and Agent Name.



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)