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(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 I – Answer all health questions.

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(RED) Applicant Name and Social Security Number

(ORANGE) Medical Questions – Section 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.

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Applicant's Name:		Social Security Number:	
<p>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.</p> <p align="center">PRESCRIPTION AUTHORIZATION</p> <p>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, (including 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.</p> <p>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 authorized 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 the 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.</p> <p>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.</p>			
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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<p>AGENT'S STATEMENT – I certify that to the best of my knowledge:</p> <ol style="list-style-type: none"> I correctly asked all the Medical Questions in this application and correctly recorded all the answers given; and All answers given in this application are true and complete; and 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 Is the Proposed Insured an immediate family member? <input type="checkbox"/> Yes <input type="checkbox"/> No; and I know of no factor affecting the insurability of the Proposed Insured(s) except as stated in this application; and This insurance <input type="checkbox"/> WILL <input type="checkbox"/> WILL NOT change or replace any existing insurance policy or annuity contract. <p>Note: If "WILL" is checked for question 6, complete required replacement forms.</p>			
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 _____	
<p>FIRST GUARANTY INSURANCE COMPANY P.O. Box 57220 • Salt Lake City, Utah 84157-0220 Office: (801) 264-1060 • Toll Free: 1 (800) 574-7117</p>			
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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:	
<p>PAYOR INFORMATION AND ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION AGREEMENT TO FIRST GUARANTY INSURANCE COMPANY (FGIC)</p>			
Payor Name: _____		Phone #: _____	
Payor Address: _____			
Customer Name: _____			
Name of Bank: _____			
Address of Bank: _____			
Checking Account #: _____		or Savings Account #: _____	
Nine Digit Bank Transf #: _____		Exp.: _____ CVV#: _____	
Credit/Debit Card #: _____			
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			
<ol style="list-style-type: none"> 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)	