

# Security National

Family of Life Companies



# COVID-19 QUESTIONNAIRE

P.O. Box 57220 | Salt Lake City, UT 84157-0220

Phone (801) 264-1060 | Toll Free (800) 574-7117 | Fax (866) 422-0009

## COVID-19 Questionnaire Rules:

1. Questionnaire is only required on full benefit or first day coverage applications.
2. No questionnaire is required on full benefit applications under the age of 65.
3. If either question on the questionnaire is answered "yes" then we postpone the application for 25 days.

Name of Proposed Insured (please print): \_\_\_\_\_

Name of Owner (please print): \_\_\_\_\_

Application Date: \_\_\_\_\_

If the answer to any of these questions is "Yes", submission of the insurance application will be postponed for 25 days and subjected to further review.

- |  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| 1. Within the past 30 days has the proposed insured been examined, diagnosed, treated, been given medical advice, tested positive, or tested without results regarding COVID-19 by a member of the medical profession? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Within the past 30 days has the proposed insured been quarantined or self-isolated based upon the advice of a member of the medical profession regarding Covid-19?  | <input type="checkbox"/> | <input type="checkbox"/> |

To the best of my knowledge, the answers to the above questions are true and complete. Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

\_\_\_\_\_  
Proposed Insured's Signature

\_\_\_\_\_  
Date



**FIRST GUARANTY INSURANCE COMPANY**

5300 South 360 West • Salt Lake City, Utah 84123 or P.O. Box 57220 • Salt Lake City, Utah 84157-0220  
 Telephone: (801) 264-1060 or Toll Free: 1 (800) 574-7117

**iCare Plan**

<b>Name of Proposed Insured (please print)</b> First _____ Initial _____ Last _____			Gender _____	Birthdate _____	Age _____	Height _____	Weight _____
Street Address _____				City _____		State _____	Zip _____
Proposed Insured's Telephone Number _____	Driver's License # _____	State Issued _____	Social Security Number/TIN _____			Birth State _____	
Proposed Insured's Occupation: _____ Work Phone Number: _____						Annual Income \$ _____	
Name and Address of Employer: _____							

**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: \_\_\_\_\_

<p><b>Primary Beneficiary:</b> _____                  Address: _____                  Telephone: _____ Relationship: _____</p>	<p><b>Contingent Beneficiary:</b> _____                  Address: _____                  Telephone: _____ Relationship: _____</p>
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<p><b>Plan Amount:</b>  <input type="checkbox"/> Face Amount \$ _____  <input type="checkbox"/> ADB Amount \$ _____  <input type="checkbox"/> Child Amount \$ _____  <input type="checkbox"/> Waiver of Premium</p>	<p><b>Premium Payable:</b> <input type="checkbox"/> EFT <input type="checkbox"/> Direct Monthly Bill <input type="checkbox"/> Debit/Credit Card  <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Annual</p> <p><b>Amount of premium paid with the application: \$</b> _____                  (Check must be made payable to First Guaranty Insurance Company).</p>
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**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

<p><b>Draft Upon Approval</b>  <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Select First Billing Month: January – December _____                  Select Billing Day: 1<sup>st</sup> – 28<sup>th</sup> _____ OR Select Billing Week: <input type="checkbox"/> 2<sup>nd</sup> Wednesday <input type="checkbox"/> 3<sup>rd</sup> Wednesday <input type="checkbox"/> 4<sup>th</sup> Wednesday</p>
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**Replacement:** Do you have an existing life insurance policy or annuity contract? .....  Yes  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: \_\_\_\_\_  
 Date and reason last consulted with your physician? \_\_\_\_\_

**Tobacco/Nicotine Question:** Have you used tobacco and/or nicotine in any form within the past 2 years? .....  Yes  No

ADMINISTRATIVE OFFICE ADDITIONS OR CORRECTIONS

<b>Applicant's Name:</b>	<b>Social Security Number:</b>
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**Proposed Insured must answer all Medical Questions**

If "Yes" to any of the medical questions, please give complete details below:

<b>Within the past 5 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:</b>	<b>Yes</b>	<b>No</b>
1. Any disorder of the thyroid or lymph node system or any other glands? .....	<input type="checkbox"/>	<input type="checkbox"/>
2. Ulcers, colitis or any disorder of the stomach, rectum, gallbladder, liver or intestines?.....	<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 tested positive for HIV?.....	<input type="checkbox"/>	<input type="checkbox"/>
4. Angioplasty, stent implant, bypass surgery, heart valve surgery or pacemaker? .....	<input type="checkbox"/>	<input type="checkbox"/>
5. Any type of tumors or cancers? .....	<input type="checkbox"/>	<input type="checkbox"/>
6. Brain tumor, brain disorders, TIA (mini stroke) or strokes of any kind? .....	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you received medical advice by a licensed medical professional, treatment, been advised to have treatment or surgery, or taken medication for Alzheimer's, Dementia, ALS (Lou Gehrig's disease) or an organ transplant? .....	<input type="checkbox"/>	<input type="checkbox"/>
8. High blood pressure, heart disease of any type, angina, heart attack, heart murmur, chest pain, rheumatic fever, enlarged heart, congestive heart failure (CHF), circulatory disorder, sepsis, or other heart disorders or conditions? .....	<input type="checkbox"/>	<input type="checkbox"/>
9. Lung disease, asthma, tuberculosis, pleurisy, shortness of breath, emphysema, or chronic obstructive pulmonary disease (COPD)? Or any type of other pulmonary or lung disease or condition?.....	<input type="checkbox"/>	<input type="checkbox"/>
10. Kidney disease or failure, kidney dialysis, renal failure or insufficiency, kidney stones, liver disease, hepatitis, cirrhosis, disease of the pancreas or other organ failure, disease or disorder? .....	<input type="checkbox"/>	<input type="checkbox"/>
11. Diabetes of any kind?.....	<input type="checkbox"/>	<input type="checkbox"/>
12. Parkinson's disease, paralysis, multiple sclerosis, lupus, muscular dystrophy, epilepsy, seizures or any other neurological disorders? .....	<input type="checkbox"/>	<input type="checkbox"/>
13. Paranoia, schizophrenia, bipolar, depression, major depressive disorder, that includes suicide attempts, hospitalization, or any other mental disorder or disease? .....	<input type="checkbox"/>	<input type="checkbox"/>
14. Have you been advised by a licensed member of the medical profession to have tests, surgery, treatment or to be admitted into a hospital or medical facility of any kind? 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"/>
15. Have you received medical treatment, counseling or advised by a licensed member of the medical profession regarding abuse or excessive use of: alcohol, non-prescribed drugs, prescribed drugs, narcotics or any other habit forming substance? .....	<input type="checkbox"/>	<input type="checkbox"/>
16. Do you use a medical appliance such as a wheelchair, walker or hospital bed, or oxygen?.....	<input type="checkbox"/>	<input type="checkbox"/>
17. Have you ever had life or health insurance rated, declined, modified, cancelled or renewal refused? .....	<input type="checkbox"/>	<input type="checkbox"/>
If yes, give company name, date and reason: _____		
18. Have you engaged in any kind of scuba or sky diving, hang-gliding, para-sailing, racing, rodeo, rock climbing, or as a private pilot or in flight training? .....	<input type="checkbox"/>	<input type="checkbox"/>
19. In the last 5 years have you ever had a driver's license revoked or suspended or been convicted of a felony or misdemeanor? .....	<input type="checkbox"/>	<input type="checkbox"/>
If so, give the date and state it occurred in: _____		
20. Are you currently pregnant?.....	<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)

**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				

**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 \_\_\_\_\_

Signature of Agent \_\_\_\_\_ Agent # \_\_\_\_\_ 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: \_\_\_\_\_



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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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