

*LA FGI Loyalty Plan - Page 1*

**(RED)** Should include name, gender, date of birth, age, height, weight, mailing address, phone number, email address, 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.

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

**FIRST GUARANTY LIFE INSURANCE COMPANY**  
P.O. Box 57220, Salt Lake City, Utah 84157-0220  
Telephone: (801) 264-1000 or Toll Free: 1 (800) 574-7117

**LOYALTY PLAN**

**Name of Proposed Insured (Print)**  
First, Last, Gender, Birthdate, Age, Height, Weight

**Mailing Address:** City, State, Zip

**Proposed Insured's Telephone Number:** Email address, Social Security Number/TIN, Maiden name (if applicable)

**Owner's Name (if other than the Proposed Insured):**  
Address: City, State, Zip  
Telephone Number: Email address: Relationship:

**Payor's Name (if other than the Proposed Insured):**  
Address: City, State, Zip  
Telephone Number: Email address: Relationship:

**Primary Beneficiary:** Mailing Address: Email Address: Telephone: Relationship:  
**Contingent Beneficiary:** Mailing Address: Email Address: Telephone: Relationship:

**Plan:**  Loyalty Plan – Preferred  Loyalty Plan – Standard  Loyalty Plan – Modified 2 year ROP – 10%  
**Premium Payable:**  EST  Direct Monthly Bill  Debit/Credit Card  Monthly  Quarterly  Semi-Annual  Annual  
**Policy Face Amount:** \$ \_\_\_\_\_  
**ADB Rider Face Amount:** \$ \_\_\_\_\_  
**Child Rider Face Amount:** \$ \_\_\_\_\_  
**Total Premium:** \$ \_\_\_\_\_

**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  2nd  3rd  4th **OR** Select Billing Week:  2nd Wednesday  3rd Wednesday  4th Wednesday

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

**Tobacco/Nicotine Question:** Have you used tobacco and/or nicotine in any form within the past 12 months?  Yes  No

**If all medical questions 1-24 are answered "No", the Proposed Insured is eligible for the Loyalty Preferred Plan.**  
**MEDICAL QUESTIONS (Section One)**  
If any medical question in Section One is answered "Yes", the Proposed Insured is not eligible for any Loyalty Plan.  
If all medical questions in Section One are answered "No", complete Sections Two and Three.

**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

- Are you now, or within the past 30 days been treated or admitted in a hospital, nursing home, health care facility, long-term care facility, hospice care, or been advised by a licensed member of the medical profession to be confined to a bed? Have you 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?
- Within the past 30 days, have you been medically diagnosed, tested or treated in a hospital by a licensed member of the medical profession for a seizure?
- Do you need assistance or supervision with dressing, eating, personal hygiene (bathing or toilet), or transferring to or from a bed or chair?
- Are you now, or within the past 90 days been diagnosed, tested or treated by a licensed member of the medical profession for any type of tumor or cancer (except basal cell skin cancer)?
- Within the past 6 months, have you been diagnosed or treated by a licensed member of the medical profession for Hepatitis C? Or has it been less than 90 days since completing treatment for hepatitis C by a licensed member of the medical profession?
- Have you ever been diagnosed by a licensed member of the medical profession as having Alzheimer's, dementia, ALS (Lou Gehrig's disease), sickle cell anemia, cirrhosis of the liver, cystic fibrosis, uncorrected brain aneurysm, or organ transplant?
- Are you currently receiving dialysis treatment?
- 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)?

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**Applicant's Name:** \_\_\_\_\_ **Social Security Number:** \_\_\_\_\_

**MEDICAL QUESTIONS (Section Two)**  
If all medical questions in Sections One and Three are answered "No", but any questions in Section Two are answered "Yes", the Proposed Insured is eligible for the Loyalty Standard Plan.

**Provide complete details below regarding all Section Two "Yes" answers.** Yes No

9. Do you use less than 121 units per day of any type of insulin medication for any type of diabetes?

**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

- Epilepsy or seizures, and have not had a seizure in over 2 years? Indicate date of last seizure: / /
- Diabetic neuropathy?
- COPD (chronic obstructive pulmonary disease) but not on oxygen and have not inhaled tobacco and/or nicotine in any form within the past 12 months?

**MEDICAL QUESTIONS (Section Three)**  
If one, two or three medical questions in Section Three are answered "Yes", the Proposed Insured is eligible for the Loyalty Modified Plan only. If more than three medical questions in Section Three are answered "Yes", the Proposed Insured is not eligible for any Loyalty Plan.

**Provide complete details below regarding all Section Three "Yes" answers.**

Within the past 2 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

- Angioplasty, stent implant, bypass surgery, heart valve surgery or pacemaker?
- Any type of tumors or cancers, except basal cell skin cancer?
- If now cancer-free, indicate the type of cancer: \_\_\_\_\_ and the month and year you were diagnosed by a licensed member of the medical profession that you were cancer-free: / /
- Brain tumor, brain disorders, cerebral brain aneurysm, TIA (mini stroke) or strokes of any kind?
- Heart disease of any type, angina, heart attack, enlarged heart, congestive heart failure (CHF), circulatory disorder, or other heart disorders or conditions?
- Lung disease, emphysema, or any other type of pulmonary or lung disease or condition? Or chronic obstructive pulmonary disease (COPD) with oxygen use or used tobacco and/or nicotine in any form within the past 12 months?
- Kidney disease or failure, renal failure or insufficiency, liver disease, hepatitis B, disease of the pancreas or other organ failure or disease? Or completed hepatitis C treatment?
- Diabetes with complications that could include: diabetic coma, insulin shock, eye disease or disorder, amputation, hospitalized for diabetes, take 121 units or more of insulin in a 24-hour period, or insulin use prior to age 40?
- Parkinson's disease, paralysis, multiple sclerosis, systemic lupus erythematosus, muscular dystrophy, down syndrome, cerebral palsy, epilepsy, seizures, or any other neurological disorder? Or had a seizure in the past 2 years? If seizures, indicate date of last seizure: / /
- Paranoia, schizophrenia, major depressive disorder, that includes suicide attempts, hospitalization, or any other mental disorder or disease?
- Have you been advised by a licensed member of the medical profession 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)?
- 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?
- Are you dependent on the use of a medical appliance such as a wheelchair, walker, hospital bed or oxygen? Or have an amputation due to an illness or disease?

**Provide a complete list of all medical conditions and medications (including oxygen), and the dosage and time periods for all medications. Please indicate which medical question each of your answers pertains to.**

Medical Question #	Medical Condition(s)	Medication(s) - including oxygen	Dosage	Time Period (from/to)

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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).



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**Applicant's Name:** \_\_\_\_\_ **Social Security Number:** \_\_\_\_\_

**NOTICE TO APPLICANT:** I hereby apply to First Guaranty Insurance Company in Salt Lake City, Utah, 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 this 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 insurer(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 authorized representative may receive a copy of this authorization upon request. This authorization may be revoked upon submission of a written notice to the Home 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 its claim under the policy or the policy itself. Your failure to sign the Authorization, or subsequent revocation of this Authorization, may impair the ability of Company to process your application or evaluate claims, and may be a basis for denying an application or claim for benefits.

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.

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 \_\_\_\_\_

**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 by presence; and  
4. Is the Proposed Insured an immediate family member?  Yes  No; and  
5. I have 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 Number: \_\_\_\_\_  
Agent's Printed Name: \_\_\_\_\_  
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**  
P.O. Box 57220 | Salt Lake City, Utah 84157-0220  
Office: (801) 264-1060 | Toll Free: 1 (800) 574-7117

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(RED) Applicant Name and Social Security Number

(TEAL) Disclosures & Signatures – City & state where the application was signed, Date of signature of insured, Signature and signature date 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

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

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

(PURPLE) EFT disclosures. Date and signature of authorized account holder.

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

**Applicant's Name:** \_\_\_\_\_ **Social Security Number:** \_\_\_\_\_

**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 conditions. 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 Yes/No	Birthdate	Age	Gender (M or F)	Relationship to Applicant

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

Payor Name: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Name of Bank: \_\_\_\_\_  
Address of Bank: \_\_\_\_\_  
 Checking  Savings Account # \_\_\_\_\_ Nine Digit Bank Transit # \_\_\_\_\_  
 Credit/Debit Card# \_\_\_\_\_ Exp \_\_\_\_\_ C/Z# \_\_\_\_\_

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 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.

Date: \_\_\_\_\_ Signature of 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 amount of \$ \_\_\_\_\_ subject to the following conditions:  
FIRST: The amount tendered is the correct first premium specified in the Application.  
SECOND: Each Proposed Insured would be acceptable and approved by First Guaranty Insurance Company ("FGIC"), as insurable under FGIC's underwriting rules for insurance on the plan and at the premium rate and the amount of insurance applied for in the Application for each Proposed Insured.  
THIRD: The premium funds for the correct premium amount for plan of insurance applied for, have been honored on the first presentation and have been credited to FGIC's bank account.  
FOURTH: The Application is approved within 60 days from the date it was signed.  
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 FGIC will have no liability.

Agent's Signature: \_\_\_\_\_ Agent's Printed Name: \_\_\_\_\_

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