Application for:
Individual Whole Life Benefit &
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

LOYALTY PLAN

Name of Proposed Insured (Print) First / Initial / 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)

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: _____
Email Address: _____
Telephone: _____ Relationship: _____

Payor's Name (if other than Proposed Insured)**:** _____
Address: _____
Email Address: _____
Telephone: _____ 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:
☐ EFT ☐ Direct Monthly Bill ☐ Debit/Credit Card
☐ Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annual

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

Policy Face Amount: $ _____
☐ **ADB Rider Face Amount: $** _____
☐ **Child Rider Face Amount: $** _____

Total Premium: $ _____

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: _____

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**
1. 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?	☐	☐
2. 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?	☐	☐
3. Do you need assistance or supervision with dressing, eating, personal hygiene (bathing or toilet), or transferring to or from a bed or chair?	☐	☐
4. 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 tumors or cancers (except basal cell skin cancer)?	☐	☐
5. 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?	☐	☐
6. 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?	☐	☐
7. Are you currently receiving dialysis treatment?	☐	☐
8. 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?	☐	☐

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:

10. Epilepsy or seizures, and have not had a seizure in over 2 years? Indicate date of last seizure ____/____/_____	☐	☐
11. Diabetic neuropathy?	☐	☐
12. 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
13. Angioplasty, stent implant, bypass surgery, heart valve surgery or pacemaker?	☐	☐
14. 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 professional that you were cancer-free: _____/_____	☐	☐
15. Brain tumor, brain disorders, corrected brain aneurysm, TIA (mini stroke) or strokes of any kind?	☐	☐
16. Heart disease of any type, angina, heart attack, enlarged heart, congestive heart failure (CHF), circulatory disorder, or other heart disorders or conditions?	☐	☐
17. 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?	☐	☐
18. 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?	☐	☐
19. 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?	☐	☐
20. Parkinson's disease, paralysis, multiple sclerosis, systemic lupus erythematosus, muscular dystrophy, down syndrome, cerebral palsy, epilepsy, seizures, or any other neurological disorders? Or had a seizure in the past 2 years? If seizures, indicate date of last seizure ____/____/_____	☐	☐
21. Paranoia, schizophrenia, major depressive disorder, that includes suicide attempts, hospitalization, or any other mental disorder or disease?	☐	☐
22. Have you 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)?	☐	☐
23. 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?	☐	☐
24. 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 dosages 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)

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 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, 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 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 a 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 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: _____ Date: _____
City State

_____
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 #: _____ FL License #: _____

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Office: (801) 264-1060 | Toll Free: 1 (800) 574-7117

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 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. Kidney or organ failure
8. Sickle Cell Anemia
9. Tested positive for HIV
10. Lung disorder or disease
11. Heart problems or disease
12. Any disorder of the nerves
13. Any inpatient stay, 48 hours or more (within 1 year)
14. Any disorder of the brain, motor skills or seizures

Name of Proposed Insured Child	Medical Condition Yes	Medical Condition 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:_____ CCU#:_____

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.

Date:_____ Signature of Authorized Account Holder:_____

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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