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

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

LOYALTY PLAN

Proposed Insured

First Name	M.I.	Last Name	Gender ☐ Female ☐ Male	Birthdate ____ / ____ / _____	Age	Height ___ ft ___ in	Weight

Mailing Address	City	State	Zip

Phone # ( ) –	Email	SSN / TIN ___ ___ ___ – ___ ___ – ___ ___ ___ ___

Owner (if other than the Proposed Insured)

First Name	M.I.	Last Name	Phone # ( ) –	Email	Relationship

Mailing Address	City	State	Zip	SSN / TIN ___ ___ ___ – ___ ___ – ___ ___ ___ ___

Primary Beneficiary

First Name	M.I.	Last Name

Mailing Address

City	State	Zip

Phone # ( ) –	Email	Relationship

Contingent Beneficiary

First Name	M.I.	Last Name

Mailing Address

City	State	Zip

Phone # ( ) –	Email	Relationship

Have you used tobacco and/or nicotine in any form within the past 12 months? ☐ Yes ☐ No

Medical Questions – Section One

If any question in Section One is answered **"Yes"**, the Proposed Insured is **not eligible** for any Loyalty Plan.

1. **Within the past 30 days have you been bedridden, required assistance with activities of daily living, or admitted to a hospital, nursing home, long term care facility, hospice care or received dialysis treatment?** ☐ Yes ☐ No
2. **Within the past 90 days have you had a seizure or been diagnosed, tested, treated, or advised by a licensed medical professional for any type of tumors or cancer (except basal cell skin cancer)?** ☐ Yes ☐ No
3. **Have you ever 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?** ☐ Yes ☐ No
4. **Have you ever been diagnosed, tested positive for, or treated by a licensed medical professional for any of the following conditions:**
   A. Alzheimer's, dementia, ALS (Lou Gehrig's Disease), sickle cell anemia, cirrhosis of the liver, cystic fibrosis, uncorrected brain aneurysm, organ transplant, or untreated hepatitis C? ☐ Yes ☐ No
   B. As having a life expectancy of twelve (12) months or less? ☐ Yes ☐ No

Medical Questions – Section Two

If **any** question in Section Two is answered **"Yes"**, the proposed insured is only eligible for the **Modified Plan**.
If **more than 3** questions in Section Two are answered **"Yes"**, the proposed insured is **not eligible** for any Loyalty Plan.

5. **Within the past 2 years, have you been diagnosed, tested positive for, treated, prescribed medication, or been given advice by a licensed medical professional for any of the following conditions:**
   A. Any heart or circulatory diseases, or disorders including congestive heart failure (CHF), heart attack, or heart surgery? ☐ Yes ☐ No
   B. Any brain diseases, disorders, corrected brain aneurysm, or stroke? ☐ Yes ☐ No
   C. Any tumors or cancers, except basal cell skin cancer? ☐ Yes ☐ No
   D. Any lung or pulmonary diseases or disorders, including chronic obstructive pulmonary disease (COPD)? ☐ Yes ☐ No
   E. Diseases, disorders, or failures of kidney, liver, pancreas, renal or other organs, including hepatitis B or C? ☐ Yes ☐ No
   F. Diabetes with complications including: amputation, diabetic coma, eye disease or disorder, or insulin use prior to age 40? ☐ Yes ☐ No
   G. Any neurological or mental diseases or disorders? ☐ Yes ☐ No
   H. Alcohol or drug abuse, including prescription drugs? ☐ Yes ☐ No

Applicant Name:	*SSN / TIN:* ____ ____ ____ – ____ ____ – ____ ____ ____ ____

Medical Questions – Section Two (continued)

6. **Have you been advised by a licensed medical professional to have diagnostic tests, surgery, or treatments relating to any of the questions listed above which have not been completed or results have not been received, excluding those related to the Human Immunodeficiency Virus (AIDS virus)?** ..... ☐ Yes ☐ No

7. **Have you had an amputation due to an illness or depend on medical appliances such as wheelchair, walker, or oxygen?**.. ☐ Yes ☐ No

If all medical questions are answered "No", the proposed insured is eligible for Preferred Plan.

Medication List

Provide a complete list of medications (including oxygen), and the dosages and time periods for all medications.

Medical Condition(s)	Medication(s) – including oxygen	Dosage	Dates Taken (From/To)

Proposed Insured's Physician's Name: _____

Phone Number: (_____) _____ City: _____ State: _____ Zip: _____

Child Rider

If applying for the Child Rider, complete this section.

Answer "Yes" or "No" if the Proposed 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 Child ever been diagnosed, tested positive for, treated or prescribed medication by a licensed medical professional for any of the following 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. 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. 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 Each Proposed Child	Medical Condition Yes	Medical Condition No	Birthdate	Age	Gender	Relationship to Applicant
			___ / ___ / _____		☐ Female ☐ Male	
			___ / ___ / _____		☐ Female ☐ Male	
			___ / ___ / _____		☐ Female ☐ Male	
			___ / ___ / _____		☐ Female ☐ Male	
			___ / ___ / _____		☐ Female ☐ Male	
			___ / ___ / _____		☐ Female ☐ Male	

Plan and Premium

Plan: ☐ Preferred ☐ Modified *(2 year ROP + 10%)*

Premium Method: ☐ EFT ☐ Direct Monthly Bill ☐ Debit/Credit Card

Frequency: ☐ Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annual

Policy Face Amount: $_____

☐ ADB Rider Face Amount: $_____

☐ Child Rider Face Amount: $_____

Total Premium: $_____

Automatic Premium Loan Provision? ☐ Yes

Initial Withdrawal Date:

_____ _____

Month (January-December) *Date (1st-28th)*

AND Recurring Billing Day or Week:

☐ **Billing Day:** _____ *Date (1st-28th)*

Or **Billing Week:** ☐ 2nd Wednesday ☐ 3rd Wednesday ☐ 4th Wednesday

If the policy cannot be issued by the initial withdrawal date, the withdrawal will be processed on the next available date following approval.

Applicant Name:	*SSN / TIN:* ___ ___ ___ – ___ ___ – ___ ___ ___ ___

Payor ☐ Same as Insured ☐ Same as Owner

First Name	M.I.	Last Name	Phone # ( ) –
Mailing Address	City	State	Zip
Email	Relationship		

Payment

Name of Bank		
☐ Checking ☐ Savings	Account #	Routing #
☐ 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 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: _____

Secondary Addressee For the purpose of notification of a past due premium payment and possible lapse in coverage.

First Name	M.I.	Last Name	
Mailing Address	City	State	Zip

Other Coverage

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

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 belief, 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.

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Applicant Name:	*SSN / TIN:* ____ ____ ____ – ____ ____ – ____ ____ ____ ____

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 (FGI), 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. FGI may disclose such information to its reinsurer(s) or any other individual or 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 FGI 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 at any time upon submission of a written notice to the Home Office. Your failure to sign the Authorization, or subsequent revocation of this Authorization, may impair the ability of the 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

_____ Date: _____ / _____ / _____
Signature of Proposed Insured/Applicant

_____ Date: _____ / _____ / _____
Signature of Owner (if other than Proposed Insured)

Agent 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/Policy Owner (Parent/Legal Guardian) is what they are represented to be and were signed in my presence; and
4. Is the Proposed Insured a 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 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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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, 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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