



GUARDIAN PLAN

Proposed Insured

First Name	M.I.	Last Name	Gender <input type="checkbox"/> Female <input type="checkbox"/> 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	Contingent Beneficiary
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First Name	M.I.	Last Name	First Name	M.I.	Last Name
Mailing Address			Mailing Address		
City	State	Zip	City	State	Zip
Phone # () -	Email	Relationship	Phone # () -	Email	Relationship

Medical Questions – Section One

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

1. **Within the past 30 days have you been bedridden, required assistance with activities of daily living, admitted to a hospital, nursing home, long term care facility, hospice care, had a seizure or received dialysis treatment?** Yes No
2. **In the past 2 years have you been diagnosed, tested, treated, or advised by a licensed medical professional for any of the following conditions:**
 - A. Any type of tumor or cancer (except basal cell skin cancer), brain disease, disorders, stroke, or suicide attempts? Yes No
 - B. Any heart or circulatory diseases including congestive heart failure (CHF), heart attack, or heart surgery? Yes No
3. **In the past 5 years, have you been diagnosed, treated, prescribed medication, or been given advice by a licensed medical professional for any of the following:**
 - A. Alcohol or drug abuse, including prescription drugs? Yes No
 - B. As having a life expectancy of twelve (12) months or less? 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. Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV)? Yes No
 - B. 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

Medical Questions – Section Two

If any questions in Section Two are answered "Yes" the Proposed Insured is eligible for the Standard Plan.

5. **In the past 5 years, have you been diagnosed, treated, prescribed medication, or been given advice by a licensed medical professional for asthma, epilepsy, seizures, any tumors or cancers (except basal cell skin cancer), or taken blood thinning medication?** Yes No
6. **In the past 10 years, have you been diagnosed, treated, prescribed medication, or been given advice by a licensed medical professional for alcohol or drug abuse, including prescription drugs?** Yes No

Medical Questions – Section Three

If any questions in Section Three are answered "Yes" the Proposed Insured is eligible for the Modified Plan.

7. **Have you had an amputation by a licensed medical professional due to an illness or do you depend on a wheelchair, walker, or oxygen?** Yes No
8. **In the past 5 years, have you been diagnosed, 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

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Medical Questions – Section Three (continued)

- B. Diabetes? Yes No
 C. Any brain diseases, disorders, corrected brain aneurysm, or stroke? Yes No
 D. Any lung or pulmonary diseases, 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. Any neurological or mental diseases or disorders? Yes No
9. **Within the past 2 years 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

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 | 5. Rheumatic fever | 9. Tested positive for HIV | 13. Any inpatient stay, 48 hours or more (within 1 year) |
| 2. Diabetes | 6. Down Syndrome | 10. Lung disorder or disease | 14. Any disorder of the brain, motor skills, or seizures |
| 3. Hepatitis | 7. Kidney or organ failure | 11. Heart problems or disease | |
| 4. Cerebral Palsy | 8. Sickle Cell Anemia | 12. Any disorder of the nerves | |

Name of Each Proposed Child	Medical Condition		Birthdate	Age	Gender	Relationship to Applicant
	Yes	No				
			___ / ___ / ___		<input type="checkbox"/> Female <input type="checkbox"/> Male	
			___ / ___ / ___		<input type="checkbox"/> Female <input type="checkbox"/> Male	
			___ / ___ / ___		<input type="checkbox"/> Female <input type="checkbox"/> Male	
			___ / ___ / ___		<input type="checkbox"/> Female <input type="checkbox"/> Male	
			___ / ___ / ___		<input type="checkbox"/> Female <input type="checkbox"/> Male	
			___ / ___ / ___		<input type="checkbox"/> Female <input type="checkbox"/> Male	

Plan and Premium

Class: <input type="checkbox"/> Preferred <input type="checkbox"/> Standard <input type="checkbox"/> Modified (3 year graded)	Policy Face Amount: \$ _____
Payment: <input type="checkbox"/> 10-Pay <input type="checkbox"/> 20-Pay <input type="checkbox"/> Whole Life	<input type="checkbox"/> ADB Rider Face Amount: \$ _____
Premium Method: <input type="checkbox"/> EFT <input type="checkbox"/> Direct Monthly Bill <input type="checkbox"/> Debit/Credit Card	<input type="checkbox"/> Child Rider Face Amount: \$ _____
Frequency: <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Annual	Total Premium: \$ _____
Automatic Premium Loan Provision? <input type="checkbox"/> Yes	

Initial Withdrawal Date: _____ Month (January-December) Date (1 st -28 th)	AND Recurring Billing Day or Week: <input type="checkbox"/> Billing Day: _____ Date (1 st -28 th) Or Billing Week: <input type="checkbox"/> 2nd Wednesday <input type="checkbox"/> 3rd Wednesday <input type="checkbox"/> 4th Wednesday
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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 <input type="checkbox"/> Same as Insured <input type="checkbox"/> Same as Owner					
First Name		M.I.	Last Name		Phone # () -
Mailing Address			City	State	Zip
Email			Relationship		
Payment			Name of Bank		
<input type="checkbox"/> Checking <input type="checkbox"/> Savings		Account #		Routing #	
<input type="checkbox"/> 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: _____		
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? <input type="checkbox"/> Yes <input type="checkbox"/> No					
2. If yes, will proposed insurance replace or change any existing life insurance policy or annuity contract? <input type="checkbox"/> Yes <input type="checkbox"/> 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, 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 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 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 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 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 _____ 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.

Agent's Signature: _____
Agent's Printed Name: _____ Agent's Number: _____

If policy and commissions are 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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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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