Sagicor

LIFE INSURANCE COMPANY

INDIVIDUAL LIFE INSURANCE APPLICATION

SECTION 1 – Proposed Insured Information

Name: _____ Sex: ☐ Male ☐ Female
(First) (MI) (Last)

Street Address: _____
City State ZIP Code

Former Address: _____
(If at current address less than 2 years) City State ZIP Code

Telephone No. : Home _____ Work _____ Other _____

Social Security Number: _____ Driver's License Number/State: _____

E-Mail Address: _____ Marital Status: _____

Date of Birth: _____ Place of Birth: _____ Height: _____ Weight: _____

Employer's Name: _____ Occupation: _____ Annual Earned Income: $ _____

Is the Proposed Insured a U.S. Citizen? ☐ Yes ☐ No Alien Registration Number: _____

*(If **NO**, please complete a Foreign Travel & Residence Questionnaire and provide an Alien Registration Number.)*

SECTION 2 – Additional Proposed Insured Information

(If there are Additional Proposed Insureds, please attach information on a separate sheet of paper.)

Name: _____ Sex: ☐ Male ☐ Female
(First) (MI) (Last)

Street Address: _____
City State ZIP Code

Former Address: _____
(If at current address less than 2 years) City State ZIP Code

Telephone No. : Home _____ Work _____ Other _____

Social Security Number: _____ Driver's License Number/State: _____

E-Mail Address: _____ Marital Status: _____

Date of Birth: _____ Place of Birth: _____ Height: _____ Weight: _____

Employer's Name: _____ Occupation: _____ Annual Earned Income: $ _____

Is the Additional Proposed Insured a U.S. Citizen? ☐ Yes ☐ No Alien Registration Number: _____

*(If **NO**, please complete a Foreign Travel & Residence Questionnaire and provide an Alien Registration Number.)*

BC100022

SECTION 3 – Proposed Owner Information

(If it is different from the Proposed Insured. If this is a Trust, please provide a copy of the Title and Signature page.)

Name: _____ Date of Birth/Trust Date: _____

(First) (MI) (Last)

Street Address: _____ SSN/Tax ID #: _____

City State ZIP Code

Telephone No. : Home _____ Work _____ Other _____

E-Mail Address: _____ Driver's License Number/State: _____

Is the Proposed Owner a U.S. Citizen? ☐ Yes ☐ No Alien Registration Number: _____

*(If **NO**, please complete a Foreign Travel & Residence Questionnaire and provide an Alien Registration Number.)*

SECTION 4 – Beneficiary Information

(If there are Additional Beneficiaries, attach information on a separate sheet of paper.)

Primary Beneficiary Name: _____ Relationship: _____

Street Address: _____

City State ZIP Code

Social Security Number/Tax ID: _____ Date of Birth/Trust Date: _____

Is the Primary Beneficiary a U.S. Citizen? ☐ Yes ☐ No Alien Registration Number: _____

*(If **NO**, please complete a Foreign Travel & Residence Questionnaire and provide an Alien Registration Number.)*

Contingent Beneficiary Name: _____ Relationship: _____

Street Address: _____

City State ZIP Code

Social Security Number/Tax ID: _____ Date of Birth/Trust Date: _____

Is the Contingent Beneficiary a U.S. Citizen? ☐ Yes ☐ No Alien Registration Number: _____

*(If **NO**, please complete a Foreign Travel & Residence Questionnaire and provide an Alien Registration Number.)*

SECTION 5 – Select Coverage

Face Amount Applied For: $ _____

Platinum Series Products

☐ Fixed Indexed Universal Life

☐ No Lapse Universal Life (over $75,000)

☐ 10 Year ☐ 20 Year ☐ 30 Year Term Life

Gold Series Products

☐ Whole Life (over $75,000)

☐ Other Gold or Platinum Series Plan Not Listed _____

Not all of the riders are available for all products in all states

Optional Riders Applied For:

☐ Accidental Death Benefit $ _____

☐ Accident Disability Income Benefit $ _____

☐ Additional Insured Term $ _____

☐ Primary Insured Term $ _____

☐ Children's Term (Complete Children's Term Rider Application and attach)

☐ Waiver of Premium ☐ Waiver of Monthly Deductions ☐ Guaranteed Insurability Option

Universal Life Elections (select one)

Guideline Premium Test ☐

Cash Value Accumulation Test ☐

Death Benefit Option (select one)

☐ A ☐ B

Automatic Premium Loan Option (select one) ☐ Yes ☐ No (Whole Life Only)

SECTION 6 – Premium Information

Do you intend to finance the premium for this policy? ☐ Yes ☐ No

Premium Class Quoted: _____ (Policy will be issued in the premium class quoted unless advised otherwise.)

Premium Collected with Application: $ _____ Transfer/1035 Exchange: ☐ Yes ☐ No Amount: $ _____

Billing Method: ☐ Individual ☐ List/Group Bill

Planned Modal Premium: $ _____ Draft Initial Premium: ☐ Yes ☐ No

Mode: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly EFT (*Complete an Electronic Funds Transfer (EFT) Authorization)*

SECTION 7 – Payor Information

(If different from the Proposed Owner. If this is a Trust, please provide a copy of the Title and Signature page.)

Name: _____ Date of Birth/Trust Date: _____

(First) (MI) (Last)

Street Address: _____ SSN/Tax ID #: _____

City State ZIP Code

Telephone No. : Home _____ Work _____ Other _____

E-Mail Address: _____ Driver's License Number/State: _____

Is the Payor a U.S. Citizen? ☐ Yes ☐ No Alien Registration Number: _____

*(If **NO**, please complete a Foreign Travel & Residence Questionnaire & provide an Alien Registration Number.)*

Relationship to the Proposed Owner(s)/Proposed Insured(s): _____

NOTICE: State insurance law may prohibit the owner of a life insurance policy from entering into an agreement to sell, transfer, or assign a life insurance policy prior to the date the policy was issued, or within a period of time specified by state law after the date the policy was issued. You should consult with legal advisors if you have any questions about these matters.

SECTION 8 – In Force/Replacement Information

1. Will any life insurance or annuity in this or any other company be replaced or changed as a result of this application? *(If **YES**, please list the policy or contract below & complete a Replacement Form.)* ☐ Yes ☐ No
2. Does the Proposed Insured(s) or any Proposed Additional Insured(s):
   a) Have any other life insurance or annuity in force? ☐ Yes ☐ No
   b) Have any application (including reinstatement) for life insurance or annuity now pending? ☐ Yes ☐ No
3. Has the Proposed Insured(s) or any Proposed Additional Insured(s) applied for any life insurance or annuity in the last ninety (90) days? ☐ Yes ☐ No
   *(If **YES**, please list the policy or contract below.)*

Proposed Insured/Additional Insured	Company	Policy #	Amount	Issue Date	Plan Type

SECTION 9 – Health and Medical Questions

	Proposed Insured	Proposed Additional Insured
1. Do you currently require oxygen therapy or kidney dialysis? Have you been told that you need an organ transplant?	☐ Yes ☐ No	☐ Yes ☐ No
2. Do you require assistance to perform any 2 of 6 Activities of Daily Living (ADL's)? (ADL's are: eating, toileting, transferring, bathing, dressing, and continence.) Are you currently in a nursing home?	☐ Yes ☐ No	☐ Yes ☐ No
3. Have you tested positive for Human Immunodeficiency Virus (HIV); or been medically diagnosed as having Acquired Immune Deficiency Syndrome (AIDS); or been medically diagnosed as having AIDS Related Complex (ARC)?	☐ Yes ☐ No	☐ Yes ☐ No
4. Have you ever been diagnosed as having or treated by a physician for:		
a) epilepsy, convulsions, headaches, emotional or mental conditions, or any other disease or disorder of the brain or nervous system?	☐ Yes ☐ No	☐ Yes ☐ No
b) ulcers, colitis, hepatitis, or any other disease or disorder of the liver, gallbladder, pancreas, stomach, rectum, or intestines?	☐ Yes ☐ No	☐ Yes ☐ No
c) diabetes, high or low blood sugar, thyroid, lymphatic system, or any other glandular disease or disorder?	☐ Yes ☐ No	☐ Yes ☐ No
d) high cholesterol, anemia, or any other disease or disorder of the blood?	☐ Yes ☐ No	☐ Yes ☐ No
e) asthma, emphysema, tuberculosis or any other disease or disorder of the lungs or respiratory system, or sleep apnea?	☐ Yes ☐ No	☐ Yes ☐ No
f) arthritis, gout, severe injury or other disease or disorder of the spine, bones, joints, or muscles?	☐ Yes ☐ No	☐ Yes ☐ No
g) allergies or any other disease or disorder of the eyes, ears, nose, throat, or skin?	☐ Yes ☐ No	☐ Yes ☐ No
h) sugar, albumin or blood in the urine, kidney stones, sexually transmitted disease, or any other disease or disorder of the kidneys, bladder, urinary, or reproductive system?	☐ Yes ☐ No	☐ Yes ☐ No
i) high blood pressure, chest pains, heart attack or failure, or any other disease or disorder of heart or blood vessels, or irregular heart beat?	☐ Yes ☐ No	☐ Yes ☐ No
j) memory loss, dementia or Alzheimer's disease?	☐ Yes ☐ No	☐ Yes ☐ No
k) cancer, tumor, leukemia, melanoma, or any other abnormal or malignant growth?	☐ Yes ☐ No	☐ Yes ☐ No
5. Have you experienced any unexplained weight loss or gain over the last year?	☐ Yes ☐ No	☐ Yes ☐ No
6. In the last **10 years**, have you received advice, treatment, or been convicted for the use of alcohol? In the last **10 years**, have you used, received advice for, been treated for, or been convicted of the use or possession of any narcotic, stimulant, sedative, or hallucinogenic drug?	☐ Yes ☐ No	☐ Yes ☐ No
7. Other than as previously stated on this application, have you consulted or been examined or treated by any physician or other medical professional, or had observation or treatment at a hospital?	☐ Yes ☐ No	☐ Yes ☐ No
8. Have you had a natural parent or sibling diagnosed with coronary artery disease, heart attack, stroke, diabetes, cancer, or chronic kidney disease before age 60?	☐ Yes ☐ No	☐ Yes ☐ No
9. Have you had any laboratory tests, treatments, or diagnostic procedures (including x-rays, EKG's, or scans)?	☐ Yes ☐ No	☐ Yes ☐ No
10. In the last **5 years**, have you received or applied for disability sickness or injury benefits or use a walker or wheelchair?	☐ Yes ☐ No	☐ Yes ☐ No
11. In the last **5 years**, have you been confined to any hospital or clinic, or been advised by a physician to have any diagnostic tests, treatments, or surgery that is not completed?	☐ Yes ☐ No	☐ Yes ☐ No
12. Are you presently taking any prescribed medication or on a prescribed diet?	☐ Yes ☐ No	☐ Yes ☐ No

If you answered **YES** to any of these questions, please explain in the provided following space.

Question #	Proposed Insured(s) Name	Doctor's Name, Address & Phone Number	Date & Explanation

Proposed Insured(s) Name	Medication	Reason for Medication

Use for Additional Explanation Details

SECTION 10 – Personal History and Lifestyle Related Questions

	Proposed Insured	Proposed Additional Insured
1. In the last **24 months**, have you participated in: sky diving, scuba or skin diving, vehicle or motorcycle racing, rodeo activities, hang gliding, bungee jumping, or ballooning? *(If you answered **YES**, please complete an Avocation Questionnaire.)*	☐ Yes ☐ No	☐ Yes ☐ No
2. In the last **10 years**, have you had a driver's license suspended or revoked, have you been convicted of reckless or negligent driving or driving under the influence of alcohol or drugs? *(If you answered **YES**, please complete a Drug & Alcohol Questionnaire.)*	☐ Yes ☐ No	☐ Yes ☐ No
3. Have you used any form of tobacco or nicotine products including cigarettes, cigars, pipes, chewing tobacco, snuff, nicotine patches or gum in the last ☐ 2 ☐ 3 ☐ 5 years?	☐ Yes ☐ No	☐ Yes ☐ No
4. In the last **5 years**, have you been convicted of, or are you awaiting trial for a felony?	☐ Yes ☐ No	☐ Yes ☐ No
5. Has any Proposed Insured ever flown or intend to fly as a pilot or crew member of any aircraft other than a commercial airline? *(If you answered **YES**, please complete an Aviation Questionnaire.)*	☐ Yes ☐ No	☐ Yes ☐ No
6. Have you ever had an application for insurance or reinstatement of insurance declined, postponed, rated, or modified?	☐ Yes ☐ No	☐ Yes ☐ No
7. In the next **2 years,** do you intend to travel outside of the United States? *(If you answered **YES**, please complete a Foreign Travel & Residence Questionnaire.)*	☐ Yes ☐ No	☐ Yes ☐ No

SECTION 11 – Additional Information/Special Request or Instructions

SECTION 12 – Fraud Warning

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.

SECTION 13 – Authorization and Acknowledgement

I understand that I am applying for life insurance coverage issued by Sagicor Life Insurance Company ("Sagicor"). I understand and consent that this application, and information obtained pursuant to this authorization may be used by Sagicor to evaluate my eligibility for life insurance.

I authorize the release to Sagicor of all information requested about me or any of my minor children proposed to be insured. This information may be released to Sagicor's authorized representatives. Authorized representatives include any consumer reporting agency acting on their behalf. Each of the following may be a source of information: the Medical Information Bureau, Inc. ("MIB"); my employer; physician, medical practitioner, hospital, clinic, or medically related facility; insurance or reinsuring company; consumer reporting agency; any other organization or insurance support organization; and a Pharmacy Benefit Manager.

Information means facts about me or any of my minor children that are proposed to be insured. Those facts include, but are not limited to; information about mental or physical health; other insurance coverage; use of drugs or alcohol; motor vehicle records; avocations; employment; prescription drug records; hazardous activities; character; general reputation; mode of living; finances; vocation; and other personal traits.

I understand and agree that Sagicor may disclose all or some of my information to its insurance administrators, its reinsurance companies, the producer who solicited my application and his or her principals, the MIB, and other persons or organizations performing business or legal services in connection with my application.

This authorization shall be valid for 30 months. I understand that I or my authorized representative may receive a copy of the authorization upon request. I agree that a photographic copy of this authorization shall be as valid as the original. I understand that I may revoke this authorization at any time by sending written notice to Sagicor's home office. I understand that my right to revoke this authorization is limited to the extent that Sagicor has not already taken action in reliance on the authorization.

To the best of my knowledge and belief, the statements and answers given on this form are true, complete, and correctly recorded. I understand that a policy does not go into effect and no liability exists for Sagicor until the policy is delivered and accepted by the Owner(s), the first full premium is paid, and there has been no change in the health of the Proposed Insured(s) that would change any of the answers in this application. I understand and agree that no producer may accept risks or pass upon insurability, make or modify contracts, or waive any of Sagicor's rights or requirements. I have received a copy of the "Disclosure Notice to Proposed Insured", and when applicable, the "Accelerated Benefit Insurance Rider Disclosure Statement".

For your protection, the law requires that a warning against insurance fraud appear on this application. Please see the previous page for the warning applicable to your state of residence before signing this form.

To help the government fight the funding for terrorism and money laundering activities, federal law requires all financial institutions obtain, verify, and record information that identifies each person who opens an account. What this means for you: when you apply for life insurance, we will ask for your name, address, date of birth, and other information that will allow us to identify you. We will also ask to see your driver's license or other government issued photo identification. If you wish to have more detailed explanation of our information practices, please write to: Sagicor Life Insurance Company; Attention: Compliance Department; PO Box 52121; Phoenix, AZ 85072-2121.

Under the penalties of perjury, by my signature on this application, I certify that: (1) the Social Security number shown on this application is my correct taxpayer identification number and, (2) I am not subject to back-up withholding either because I have not been notified by the IRS that I am subject to back-up withholding as a result of a failure to report all interest or dividends, or the IRS has notified me that I am no longer subject to back-up withholding.

Signed: _____ Date Signed: _____

City State

_____
Proposed Insured Signature
(If a minor, signature of parent or guardian)

_____
Proposed Additional Insured Signature
(If a minor, signature of parent or guardian)

_____
Proposed Owner's Signature
(If other than the Proposed Insured or Trustee)

_____
Proposed Trustee Signature *(if, applicable)*

_____
Writing Producer's Name *(Please Print)*

_____
Writing Producer's Number

_____
Writing Producer's Signature

_____
Countersigned
(Licensed resident producer if state required)

SECTION 14 – This section should be completed by the Producer.
For questions about this application or requirements, contact our Underwriting Department.

Producer Name (Please Print)	Producer ID Number	% Split

Each licensed Producer will share equally unless otherwise indicated.

1. Have you delivered the consumer protection notices to the Proposed Owner(s) and Proposed Insured(s)? ☐ Yes ☐ No
2. Did you personally meet with the Proposed Owner(s) and Proposed Insured(s), obtain their Social Security Number(s) and view for each a Government issued photo ID? *(If **YES**, specify the type of ID and ID number. If **NO**, please explain why.)* _____ ☐ Yes ☐ No
3. If premium was accepted, was the Conditional Receipt completed and delivered to the Proposed Owner? ☐ Yes ☐ No
4. Does the Proposed Insured(s) have any other life insurance or annuities currently in force or pending reinstatement? ☐ Yes ☐ No
5. Will any annuity or life insurance presently in force be replaced or changed by this policy that is being applied for? *(If **YES**, and if required by state regulation, any Replacement Comparison, Notice, or Statement must accompany this application.)* ☐ Yes ☐ No
6. Is this a 1035 Exchange? *(If **YES**, attach all required forms.)* ☐ Internal ☐ External ☐ Yes ☐ No
7. Is this a premium finance case? ☐ Yes ☐ No
8. How long have you known the Proposed Owner(s)? _____ Proposed Insured(s)? _____
9. Are you related to the Proposed Owner(s)? ☐ Yes ☐ No Proposed Insured(s)? ☐ Yes ☐ No
   If **YES**, how are you related? _____
10. Are the Proposed Owner(s) U.S. Citizen(s)? ☐ Yes ☐ No Proposed Insured(s)? ☐ Yes ☐ No
    If **NO**, how long have they been in the U.S.? _____ What type of Visa? _____
11. Does the Proposed Owner(s) understand and speak English? ☐ Yes ☐ No Proposed Insured(s)? ☐ Yes ☐ No
    If **NO**, please explain: _____
12. Was any other person present to answer questions? ☐ Yes ☐ No
    If **YES**, who was present and why? _____
13. What is the purpose of this insurance purchase? _____
14. Do you know of anything not disclosed in this application that may affect the risk of this life insurance purchase?
    ☐ Yes ☐ No If **YES**, please explain: _____
15. Sagicor is responsible for ordering all medical requirements. If the requirements are ordered by the producer, please indicate the requirements ordered and the company. Paramed Company: _____
    Date Ordered: _____ ☐ Blood Profile/HOS ☐ MD Exam ☐ Treadmill EKG ☐ EKG ☐ Paramedical Exam
16. Remarks: _____

Producer's Certification

I certify that I saw and know the Proposed Owner(s) and Proposed Insured(s) to be the person(s) described in this application, and have reviewed the appropriate documentation, and have truly and accurately recorded the information supplied by the Proposed Owner(s) and Proposed Insured(s), that I know of no condition affecting the insurability of the applicant not fully set forth in the application, and that I have made no declaration, representation, or waiver regarding coverage or the provisions or terms of the application or policy. I further certify that I am licensed in the state in which this application was completed and have delivered all required notices and disclosures and fully complied with all privacy and replacement regulations. I also assume full responsibility for the delivery of the policy and the submission of the first premium.

Signed (Writing Producer): _____ Date Signed: _____

Phone Number: _____ Fax Number: _____ E-mail Address: _____

Sagicor

LIFE INSURANCE COMPANY

Conditional Receipt ("Receipt")

Detach and leave this page with the Proposed Owner if money is submitted with the application. No payment may be accepted with the application, if, within the past three (3) years, any Proposed Insured(s) has been treated for or consulted a physician concerning heart disease, stroke, or cancer.

Make all checks payable to: **Sagicor Life Insurance Company**.
Do not make checks payable to the producer or leave the payee blank.

Received from _____ as the Proposed Owner, the sum of $ _____, for the insurance application

dated _____, with _____ as the Proposed Insured.

The policy you applied for will not become effective unless and until a policy is delivered to you, and all other conditions of coverage are met. Conditional insurance under the terms of the policy applied for may become effective as of the later of: (1) the date of application; (2) the date of the last medical examination, test and/or other screening required by Sagicor, if any (the "Effective Date"). Such conditional insurance is subject to the conditions and limitations of this Receipt. Such conditional insurance will take effect as of the Effective Date, so long as all of the following requirements are met:

1. Each Proposed Insured is found to have been insurable as of the Effective Date, exactly as applied for in accordance with Sagicor's underwriting rules and standards, without any modifications as to plan, amount, or premium rate;
2. As of the Effective Date, all statements and answers given in the application are true;
3. The payment with the application must not be less than the full initial premium for the mode of payment chosen in the application and must be received at Sagicor's Home Office within the lifetime of the Proposed Insured(s);
4. All medical examinations, tests, and other screenings required of the Proposed Insured(s) by Sagicor are completed and the results received at Sagicor's Home Office within ninety (90) days of the date the application was completed; and
5. The following items must be signed and received at Sagicor's Home Office: all parts of the application; any supplemental application; questionnaires; addendum; and/or amendment to the application.

The aggregate amount of conditional coverage provided under this Receipt, if any, and any other conditional receipt issued by Sagicor shall be limited to the lesser of the amount(s) applied for or $500,000 of life insurance. There is no conditional coverage for riders or any additional benefits, if any, for which you have applied.

There will be no conditional insurance coverage and the Company's liability will be limited to returning any premium submitted to the Company with this Receipt if any of the following occurs: (a) one or more of the Receipt's conditions have not been met exactly; (b) a Proposed Insured(s) dies by suicide; or (c) the Company does not approve and accept the application for insurance within ninety (90) days of the date the Proposed Insured(s) and/or Proposed Owner(s) signed the application, thus deeming the application rejected by the Company.

Any conditional coverage provided by this Receipt will terminate on the earliest of: (a) ninety (90) days from the date the application was signed; (b) the date Sagicor either mails a notice to the Proposed Owner(s) rejecting the application and/or mails a refund of any amount paid with the application; (c) when the insurance applied for goes into effect under the terms of the policy applied for; or (d) the date Sagicor offers to provide insurance on terms that differ from the insurance for which you have applied.

This Receipt is not valid unless all blanks are completed above and this Receipt is signed by the producer. This Receipt does not provide any conditional insurance until all of the conditions and requirements are met as outlined above.

Dated at _____ on _____ _____
City *State* *Date* *Producer's Signature*

Sagicor

LIFE INSURANCE COMPANY

Disclosure Notice to Proposed Insured

Leave with the Proposed Insured

Investigative Consumer Report Notice

You are our most important source of information, but personal information may also be collected from other sources. Such information may, in certain circumstances, be disclosed to third parties without your authorization.

An investigative consumer report may be prepared in which information is obtained from public records and through personal interviews with: your neighbors, friends, employers, business associates, financial sources, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics, and mode of living. You may request to be interviewed as part of the report. Upon written request to Sagicor, further information on the nature and scope of the report will be provided.

Information Practices

Personal information we obtain during the underwriting process is private and confidential. We will not disclose such information to other persons or organizations without your written authorization, except to the extent necessary to conduct our business, as permitted by law, or as required by law. You have the right to be told about and obtain access to certain items or personal information in our files. You also have the right to request correction of information you believe to be inaccurate. If you would like to receive a more detailed explanation of our information practices, please write to:

Sagicor Life Insurance Company
Attention: Compliance Department
P.O. Box 52121
Phoenix, AZ 85072-2121

Medical Information Bureau (MIB) Notice

Information regarding your insurability will be treated as confidential. Sagicor or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau (MIB). The MIB is a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. If you apply to another MIB member company for life insurance or health insurance coverage, or a claim for benefit is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734. MIB's toll free number is 866-692-6901 or TTY 866-346-3642. Website www.mib.com.

Sagicor Life Insurance Company or its reinsurers may also release information in its file to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted.