Sagicor

LIFE INSURANCE COMPANY

www.SagicorLifeUsa.com

INSTRUCTIONS: FOR SIMPLIFIED ISSUE LIFE INSURANCE APPLICATION (ICC115042/5042)

This application is for **Gold Series Whole Life and Platinum Series No Lapse Universal Life**
Issue Ages 18-65 with Face Amounts of $25,000 to $249,999
(except North Carolina, where the minimum face amount is $25,001)

PLEASE OBSERVE THE FOLLOWING TO ENSURE SUBMITTING AN APPLICATION IN GOOD ORDER:

- Complete in black/blue ink only – use of correction fluid/tape is not permitted.
- All corrections (cross-outs) must be initialed by the Owner.
- All sections of the application must be complete and legible (print information). Incomplete/illegible applications will delay the New Business process.
- Submit all pages of the Accelerated Benefit Insurance Rider Disclosure Statement using the appropriate state version.
- Check or Money Order must be made payable to Sagicor Life Insurance Company and are the only acceptable forms of payment, except for electronic fund transfers (EFT).

IMPORTANT REMINDERS:

Part 1 of Application:

SECTION 2 – Proposed Owner Information (if not Proposed Insured) **– A Proposed Owner is eligible to own the Policy only if they are able to answer "Yes" to one of the three relationship questions.**

SECTION 4 – Payor Information (if not Proposed Insured or Owner) – A person may be both the Payor and a beneficiary only if they are able to answer "Yes" to one of the three relationship questions.

SECTION 5 – Coverage Selection – **We will not issue any policy** for which the premium will be financed.

SECTION 7 – Have the applicant read the questions in Section 7 carefully and answer them as accurately as possible. **If an applicant's answer to any question in this Section is "Yes", the applicant does not qualify** for the coverage available through the Simplified Issue underwriting process.

SECTIONS 9 & 10 – Review these sections with your client, prior to completing the signature box in Section 10.

SECTION 11 – Complete in its entirety, sign, and submit with application.

DISCLOSURE NOTICE – Review and leave with your client. Do not return it with the application.

CONDITIONAL RECEIPT – If money will be submitted with the application, complete this page and leave it with your client. Checks must be made payable to Sagicor Life Insurance Company.

EFT AUTHORIZATION FORM – This form must be completed, dated and signed by the individual/entity (Payor) who will be paying the premium. A void check is not required if the financial institution information is accurately completed on the form. The information **must** be for the account from where the premiums are to be withdrawn. When EFT is selected as the method of payment, the initial premium will also be drafted from the designated account.

Debit card numbers are not always the checking account number and premiums **cannot** be drafted using a debit card number.

For premiums to be drafted from a savings account, the Payor must contact their financial institution for the appropriate routing number. A deposit slip does not provide the information required to setup the EFT. The routing number and savings account number **must** be added to the EFT form.

For all Life Policies, the draft date must be equal to the effective date of the policy. The Payor may change the draft date once the policy is in force.

Part 2 of Application:

Do not complete Part 2 of the Application. Part 2 will be completed by a tele-interviewer during the tele-interview process. **At time of policy delivery**, **review** with your client the answers in Part 2, and also review SECTIONS 13 & 14. **Complete the signature box in Section 14** and return to Sagicor an original executed copy of Part 2 of the application.

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LIFE INSURANCE COMPANY

INDIVIDUAL LIFE INSURANCE
SIMPLIFIED ISSUE APPLICATION

LIFE INSURANCE APPLICATION - PART 1

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

Date of Birth: _____ Place of Birth: _____ Marital Status: _____

Social Security Number: _____ E-Mail Address: _____

Telephone No: Home: _____ Other: _____

Government Issued Picture ID Type/State: _____ Number: _____

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

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

Secondary Addressee Name: _____
(First) (MI) (Last)

Secondary Address: _____
City State ZIP Code

SECTION 2 – Proposed Owner Information *(Complete if Owner different than Proposed Insured)*

Name: _____ Date of Birth: _____
(First) (MI) (Last)

Street Address: _____
City State Zip Code

Social Security Number: _____ E-Mail Address: _____

Telephone No: Home: _____ Other: _____

Government Issued Picture ID Type/State: _____ Number: _____

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

1. Does the Proposed Owner have one of the following relationships with the Proposed Insured: Spouse, Child, Parent, Grandchild, Grandparent, Brother, or Sister? ☐ Yes ☐ No If "Yes", Relationship: _____
2. If "No" to the above question, is the Proposed Insured a legal dependent, under Federal tax law, of the Proposed Owner or is the Proposed Owner the legal guardian of the Proposed Insured? ☐ Yes ☐ No
3. If "No" to the above questions, does the Proposed Owner have a lawful and material economic interest in having the life of the Proposed Insured continue? ☐ Yes ☐ No

BC120016 S4100512

SECTION 3 – 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: _____ Date of Birth: _____

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

Contingent Beneficiary Name: _____ Relationship: _____

Street Address: _____

City *State* *Zip Code*

Social Security Number: _____ Date of Birth: _____

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

SECTION 4 – Payor Information *(Complete if Payor different than Proposed Insured or Owner)*

Name: _____ Date of Birth: _____

(First) *(MI)* *(Last)*

Street Address: _____

City *State* *Zip Code*

Social Security Number: _____ E-Mail Address: _____

Telephone No: Home: _____ Other: _____

Government Issued Picture ID Type/State: _____ Number: _____

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

If the Payor will also be a beneficiary on the Policy, the following questions must be answered:

1. Does the Proposed Payor have one of the following relationships with the Proposed Insured: Spouse, Child, Parent,: Grandchild, Grandparent, Brother, or Sister? ☐ Yes ☐ No If "Yes", Relationship _____
2. If "No" to the above question, is the Proposed Insured a legal dependent, under Federal tax law, of the Proposed Payor or is the Proposed Payor the legal guardian of the Proposed Insured? ☐ Yes ☐ No
3. If "No" to the above questions, does the Proposed Payor have a lawful and material economic interest in having the life of the Proposed Insured continue? ☐ Yes ☐ No

SECTION 5 – Coverage Selection

Plan: _____ Face Amount Applied For: $ _____

☐ Tobacco Rates ☐ Non-Tobacco Rates

☐ Accidental Death Benefit ☐ Waiver of Premium

☐ Waiver of Monthly Deductions (Universal Life)

Universal Life Elections (select one for each)

Guideline Premium Test ☐ **OR** Cash Value Accumulation Test ☐

Death Benefit Option ☐ A **OR** ☐ B

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

Do you intend to finance the premium for this policy? ☐ Yes ☐ No *(If yes, Company will not issue policy)*

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: $ _____

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

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

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 6 – In Force/Replacement Information (if *Yes* to any question, list information below)

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**, complete a Replacement Form.)* ☐ Yes ☐ No
2. Does the Proposed Insured:
   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 applied for any life insurance or annuity in the last ninety (90) days? ☐ Yes ☐ No

Proposed Insured	Company	Policy #	Amount	Issue Date	Plan Type

SECTION 7 – Initial Medical and Personal History Questions

Proposed Insured

1. Is the Proposed Insured currently receiving health care at home, or requires assistance with activities of daily living such as bathing, dressing, feeding, taking medications or use of toilet, etc? ☐ Yes ☐ No
2. Is the Proposed Insured currently in a Hospital, Psychiatric, Extended or Assisted Care, Nursing, Prison or Correctional facility? ☐ Yes ☐ No
3. 'Have you 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. Has the Proposed Insured ever tested positive for or been diagnosed by a member of the medical profession as having Alzheimer's or Dementia, Cirrhosis, Emphysema or Chronic Obstructive Pulmonary Disease (COPD)? ☐ Yes ☐ No
5. **Has the Proposed Insured:**
   a) In the past 12 months been advised by a physician to be hospitalized or to have Diagnostic Tests, Surgery, or any medical procedure that has not yet been completed or for which the results are not yet available? ☐ Yes ☐ No
   b) In the past 24 months been treated for or diagnosed by a licensed member of the medical profession as having any cancer (other than Basel Cell Carcinoma), had a Heart Attack, Stroke or TIA (Transient Ischemic Attack), Alcohol or Drug Abuse? ☐ Yes ☐ No
   c) In the past 24 months had a Driver's License revoked or suspended, or been convicted of 2 or more moving violations, or been convicted of a violation for driving while intoxicated or under the influence, or for driving while ability impaired because of the use of alcohol and/or drugs? ☐ Yes ☐ No

SECTION 8 – Additional Information/Special Request or Instructions

SECTION 9 – Fraud Warning

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.

SECTION 10 – 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. 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. 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 any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information. 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 application 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, the first full premium is paid, there has been no change in the health of the Proposed Insured that would change any of the answers in this application, and Sagicor has received an executed copy of both Part 1 and Part 2 of 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".

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: Client Service 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 Owner's Signature
(if other than Proposed Insured)

_____ _____

Writing Producer's Signature

Writing Producer's Name *(Please Print)*

_____ _____

Writing Producer's Number

Florida License Number

SECTION 11 – 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 and Proposed Insured? ☐ Yes ☐ No
2. Did you personally meet with the Proposed Owner and Proposed Insured, 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 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? *(If yes, Company will not issue policy)* ☐ Yes ☐ No
8. How long have you known the Proposed Owner? _____ Proposed Insured? _____
9. Are you related to the Proposed Owner? ☐ Yes ☐ No Proposed Insured? ☐ Yes ☐ No
   If **YES**, how are you related? _____
10. Does the Proposed Owner understand and speak English? ☐ Yes ☐ No Proposed Insured? ☐ Yes ☐ No
    If **NO**, please explain: _____
11. Was any other person present to answer questions? ☐ Yes ☐ No
    If **YES**, who was present and why? _____
12. What is the purpose of this insurance purchase? _____
13. 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: _____
14. Remarks: _____

Producer's Certification

I certify that I saw and know the Proposed Owner and Proposed Insured 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 and Proposed Insured, 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: _____

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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: Client Service 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.

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LIFE INSURANCE COMPANY

Conditional Receipt ("Receipt")

Detach and leave this page with the Proposed Owner if premium is submitted with the application. No payment may be accepted with the application, if, within the past three (3) years, any Proposed Insured has been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession concerning heart disease, stroke, cancer, HIV or AIDS.

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

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 date the Proposed Insured completes in its entirety the tele-interview process to answer the questions in Part 2 of the application (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. The 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 of the Proposed Insured's statements and answers given in Part 1 of the application and during the tele-interview process for Part 2 of the application are true;
3. The payment accompanying the application is not less than the full initial premium for the mode of payment chosen in the application and is received at Sagicor's Home Office within the lifetime of the Proposed Insured; and
4. The following items have been signed and received at Sagicor's Home Office: Part 1 of the application; and any required supplemental application, questionnaire(s), addendum, and/or amendment to the application.

The aggregate amount of conditional coverage provided under this Receipt, if any, and any other conditional receipt(s) issued by Sagicor shall be limited to the lesser of the amount(s) applied for or $250,000 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) the Proposed Insured does not complete in its entirety the tele-interview process; (b) one or more of the Receipt's conditions have not been met exactly; (c) the Proposed Insured dies by suicide; or (d) the Company does not approve and accept the application for insurance within ninety (90) days of the date the Proposed Insured completes in its entirety the tele-interview process, 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 Proposed Insured completes in its entirety the tele-interview process; (b) the date Sagicor either mails a notice to the Proposed Owner rejecting the application and/or mails a refund of any amount paid with the application; (c) the date 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*