REMINDER, THE FOLLOWING SECTION, PART 2, SHOULD NOT BE COMPLETED AT THIS TIME.

Part 2 will be completed during the tele-interview.

LIFE INSURANCE APPLICATION - PART 2

NOTE: ***Do not complete these sections.*** *They will be completed by a tele-interviewer during the tele-interview process, and the Proposed Insured will sign at time of Policy delivery.*

SECTION 12 A –– Additional Medical and Personal History Questions

(Record details to "Yes" answer in Section 12C below)

Proposed Insured

1. In the past 24 months have you used any form of tobacco or nicotine products including cigarettes, cigar, pipes, chewing tobacco, snuff, nicotine patches or gum? ☐ Yes ☐ No
2. Are you presently taking any medications prescribed by a doctor, hospital or other medical practitioner? ☐ Yes ☐ No
3. **Your Current Height** _____ **Weight** _____ **lbs.**

   Have you lost more than 20 lbs. in the past 12 months (other than diet or following pregnancy)? ☐ Yes ☐ No
4. Are you currently disabled and/or receiving disability benefits? ☐ Yes ☐ No
5. **In the past 10 years, have you been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for:**

   a) Cancer (other than Basal Cell Carcinoma)? ☐ Yes ☐ No

   b) Heart or coronary artery disease or disorder? ☐ Yes ☐ No

   c) Stroke, transient ischemic attack (TIA), or other blood vessel disease or disorder? ☐ Yes ☐ No

   d) Parkinson or Cerebral Palsy? ☐ Yes ☐ No

   e) Kidney or Liver disease or disorder? ☐ Yes ☐ No

   f) Epilepsy or seizure disorder? ☐ Yes ☐ No

   g) Multiple Sclerosis (MS)? ☐ Yes ☐ No

SECTION 12 B –– Additional Medical and Personal History Questions

(Record details to "Yes" answer in Section 12C below)

Proposed Insured

6. **In the past 5 years, have you been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for:**

   h) Asthma, Chronic lung or pulmonary disease? ☐ Yes ☐ No

   i) The use of alcohol and drugs and have been advised to discontinue or decrease the use of alcohol and/or the use of prescribed or non-prescribed drugs or other medications? ☐ Yes ☐ No

   j) Depression, Anxiety or other mental or emotional disorder? ☐ Yes ☐ No

   k) Diabetes? ☐ Yes ☐ No

   l) Hepatitis B or C? ☐ Yes ☐ No

   m) High blood pressure (Hypertension)? ☐ Yes ☐ No

   n) Pancreas disease or disorder? ☐ Yes ☐ No

SECTION 12 C – Details To All "Yes" Answers Above:

SECTION 12 D – Preferred Classification Information

Please respond to the best of your knowledge and belief.

7.	Family Member	Living?	Cause of Death?	Age of Death?
	Mother	☐ Yes ☐ No		
	Father	☐ Yes ☐ No		
	Sister(s)	☐ Yes ☐ No		
	Brother(s)	☐ Yes ☐ No		

8. In the past 24 months have you participated in or in the next 24 months do you intend to participate in; aerial sport, auto racing, ballooning, hang gliding, motorcycle racing, motor sport, mountain climbing, rock climbing, rodeo, underwater diving? ☐ Yes ☐ No

9. In the past 24 months have you piloted, or in the next 24 months do you intend to pilot any aircraft other than a commercial airliner? ☐ Yes ☐ No

SECTION 13 – 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 14 – 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 previously received a copy of the "Disclosure Notice to Proposed Insured", and when applicable, the "Accelerated Benefit Insurance Rider Disclosure Statement".

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