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- Information is only entered once. If the same information is required on multiple forms the data is pre-filled.
- The application can be completed "side by side" or via email.
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- Electronic signature
- No need to print any forms.
- Electronic submission, no need to mail or fax the application.

Sagicor

LIFE INSURANCE COMPANY

www.SagicorLifeUsa.com

For additional assistance please contact the Producer Resouce Center (PRC) by calling toll-free 888-724-4267 Opt. 2, or by email at PRC@SagicorLifeUSA.com

Sagicor
LIFE INSURANCE COMPANY

INDIVIDUAL LIFE INSURANCE APPLICATION

SECTION 1 – Fraud Warning and Acknowledgement

***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.**

I understand and acknowledge that:

- *This is an application for life insurance coverage on the Proposed Insured, to be issued by Sagicor Life Insurance Company ("Sagicor").*
- *To the best of my knowledge and belief, the statements and answers given on this application are true, complete, and correctly recorded.*
- *Sagicor will rely on the truthfulness, completeness and corrections of the statements and answers on this application to make its decision as to whether to provide life insurance coverage on the Proposed Insured.*

Signed: _____ Date Signed: 07/26/2018
City State

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

Proposed Owner's Signature
(If other than Proposed Insured)

SECTION 2 – Proposed Insured Information

Name: ISSPWL App Sex: ☒ Male ☐ Female
First MI Last Suffix (Jr. Sr.)

_____ TX _____
Residence Street Address City State Zip Code

☐ Check box if the mailing address is the same as the Residence Street Address.

_____
Mailing Address City State Zip Code

Date of Birth: 07/26/1973 Social Security Number: _____

Driver's License #/State of Issue: *(If none, please provide an explanation in Section 10 and provide a Government Issued Picture ID.)* State _____ # _____

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

Telephone No: Home: _____ Other: _____ E-Mail Address: _____

Is the Proposed Insured a U.S. Citizen, or does the Proposed Insured have permanent resident (green card) status? ☐ Yes ☐ No
*(If **No**, please complete a Foreign Travel and Residence Questionnaire.)*

State of Birth if born in the U.S.: _____ Country of Birth if born outside the U.S. _____ Date of Entry into the U.S.: _____

Does the Proposed Insured plan to travel or reside outside of the U.S. in the next two years? ☐ Yes ☐ No

If **Yes**, please provide the city(s) and country(s), date(s), length(s) of stay and purpose(s) of travel: _____

Employer's Name and Address: _____

Occupation _____ Duties: _____

Annual Earned Income: _____ Total Household Income: _____

1. Has the Proposed Insured received or been promised any incentive to participate in this transaction? ☐ Yes ☐ No
2. If the Proposed Insured is also the Proposed Owner of the policy, does the Proposed Insured currently have any intention to transfer to a third party any portion of ownership of the policy if issued? ☐ Yes ☐ No

SECTION 3 – Initial Medical and Personal History Questions

*(If any question in Section 3 is answered **YES**, Proposed Insured is not eligible for insurance through this application.)*

1. Does the Proposed Insured currently receive health care at home, or require assistance with bathing, dressing, feeding, taking medications or use of toilet? ☐ Yes ☐ No
2. Is the Proposed Insured currently in a Hospital, Psychiatric, Extended or assisted Care Nursing Facility? ☐ Yes ☐ No
3. Is the Proposed Insured currently incarcerated due to a misdemeanor or felony conviction? ☐ Yes ☐ No
4. Has the Proposed Insured ever tested positive for the HIV virus or been diagnosed by a member of the medical profession as having AIDS or the AIDS Related Complex (ARC)? ☐ Yes ☐ No
5. 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
6. In the past 10 years has the proposed insured had 2 or more of the following impairments: Cancer, Diabetes, coronary artery disease (including Heart Attack), Stroke or TIA (Transient Ischemic Attack), carotid artery disease, heart valve replacement, Peripheral Vascular Disease (PVD), Peripheral Artery Disease (PAD) or had multiple strokes or transient ischemic attacks (TIA)? ☐ Yes ☐ No
7. 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, except those tests related to the Human Immunodeficiency Virus (AIDS)? ☐ Yes ☐ No
   b) In the past 24 months been diagnosed as having or advised by a physician to have treatment for Cancer (other than Basal Cell Carcinoma), 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 4 – Proposed Owner Information *(Complete if not Proposed Insured.)*

☐ Check box if the Proposed Owner is a company or trust.

Name: _____ Date of Birth: _____

First *MI* *Last* *Suffix (Jr. Sr.)*

☐ Check box if the Proposed Owner's address is the same as the Proposed Insured.

_____

Residence Street Address *City* *State* *Zip Code*

☐ Check box if the mailing address is the same as the Residence Street Address.

_____

Mailing Address *City* *State* *Zip Code*

Telephone No: Home: _____ Other: _____ E-Mail Address: _____

Social Security/ Tax Identification Number: _____

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

Is the Proposed Owner a U.S. Citizen, or does the Proposed Owner have permanent resident (green card) status? *(If **No**, please complete a Foreign Travel and Residence Questionnaire.)* ☐ Yes ☐ No

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**, please state relationship: _____
2. Has the Proposed Owner received or been promised any incentive to participate in this transaction? ☐ Yes ☐ No
3. Does the Proposed Owner currently have any intention, if a policy is issued, to transfer ownership of any portion of the policy to a third party who would not be able to answer Yes to question 1 above? *(If **Yes**, please provide details in Section 10.)* ☐ Yes ☐ No

SECTION 5 – Proposed Payor Information *(Complete if not Proposed Owner.)*

☐ Check box if the Proposed Payor is a company or trust. ☐ List Bill ☐ Government Allotment

Group or Franchise #: ______________________

Name: ______________________________________ Relationship: ______________

First *MI* *Last* *Suffix (Jr. Sr.)*

☐ Check box if the Proposed Payor's address is the same as the Proposed Insured.

____

Residence Street Address *City* *State* *Zip Code*

☐ Check box if the mailing address is the same as the Residence Street Address.

____

Mailing Address *City* *State* *Zip Code*

Social Security/Tax Identification Number: ______________________

Telephone No: Home: ____________ Other: ____________ E-Mail Address: ______________________

Government Issued Picture ID: Type: ____________ State: ________ Number: ______________________

1. Is the Proposed Payor a U.S. Citizen, or does the Proposed Payor have permanent resident (green card) status? *(If **No**, please complete a Foreign Travel and Residence Questionnaire.)* ☐ Yes ☐ No

2. Will the Proposed Payor be a beneficiary on the policy? *(If **Yes**, please answer the question below.)* ☐ Yes ☐ No

   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**, please state relationship: ______________________________________

SECTION 6 – Beneficiary Information *(If there are Additional Beneficiaries, attach information on a separate sheet of paper.)*

☐ Check box if company or trust. ☒ Primary ☐ Contingent

Name: ______________________________________ Relationship: ______________

First *MI* *Last* *Suffix (Jr. Sr.)*

Percentage: _____ Social Security/Tax ID #: ____________ City/State ____________ Date of Birth: ____________

☐ Check box if company or trust. ☐ Primary ☐ Contingent

Name: ______________________________________ Relationship: ______________

First *MI* *Last* *Suffix (Jr. Sr.)*

Percentage: _____ Social Security/Tax ID #: ____________ City/State ____________ Date of Birth: ____________

☐ Check box if company or trust. ☐ Primary ☐ Contingent

Name: ______________________________________ Relationship: ______________

First *MI* *Last* *Suffix (Jr. Sr.)*

Percentage: _____ Social Security/Tax ID #: ____________ City/State ____________ Date of Birth: ____________

☐ Check box if company or trust. ☐ Primary ☐ Contingent

Name: ______________________________________ Relationship: ______________

First *MI* *Last* *Suffix (Jr. Sr.)*

Percentage: _____ Social Security/Tax ID #: ____________ City/State ____________ Date of Birth: ____________

☐ Check box if company or trust. ☐ Primary ☐ Contingent

Name: ______________________________________ Relationship: ______________

First *MI* *Last* *Suffix (Jr. Sr.)*

Percentage: _____ Social Security/Tax ID #: ____________ City/State ____________ Date of Birth: ____________

SECTION 7 A – Coverage Selection

Plan: Gold ISSPWL Face Amount Applied For: $ 431354

Premium Class: Standard Tobacco: ☐ Yes ☒ No

UL Elections:

Guideline Premium Test ☐ OR Cash Value Accumulation Test ☐ Death Benefit Option ☒ A OR ☐ B

Whole Life Election: Automatic Premium Loan: ☐ Yes ☐ No

SECTION 7 B – Rider Selection

☐ Waiver of Premium/Monthly Deductions Rider

☐ Accidental Death Benefit Rider Amount: $ _____

☐ Guaranteed Insurability Option Rider *(NLUL, FIUL only)*

☐ Over Loan Protection Rider *(FIUL only)*

☐ Children's Term Rider *(Term, NLUL, FIUL only.)* Amount $

Eligible Children: include Children Born to or Legally Adopted by the Proposed Insured

Name of Proposed Insured Child First Middle Last	Relationship	Sex	Social Security Number

Medical and Personal History Information of the Proposed Insured Children *(Record Yes answers in Section 10.)*

1. Are any minor children of the proposed insured excluded from this application? ☐ Yes ☐ No
2. Are any children proposed for coverage not living with the Proposed Insured? ☐ Yes ☐ No
3. Has a licensed member of the medical profession diagnosed any child as having Attention Deficit Hyperactivity Disorder, Dyslexia, Autism, mental retardation, or any psychiatric disorder? ☐ Yes ☐ No
4. Has a licensed member of the medical profession diagnosed or treated any child for:
   a) Congenital Heart Abnormalities, Heart Disorder, Seizures, Cancer, Malignancy, Leukemia, Diabetes, Cystic Fibrosis, Brain or Neurological Disorder? ☐ Yes ☐ No
   b) Asthma, lung or respiratory disease, or illness requiring hospitalization? ☐ Yes ☐ No

SECTION 7 C - Premium Selection

Premium Collected with Application: $ _____ Planned Modal Premium: $ 150000.00

☐ Transfer/1035 Exchange Amount: $ _____

☐ Draft Initial Premium

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

Do you intend to finance the premium for this policy? ☐ Yes ☐ No *(If **Yes**, please provide details in Section 10.)*

SECTION 8 – In Force/Replacement Information

1. Does the Proposed Insured have any other life insurance or annuity in force? ☐ Yes ☐ No
   *(If **YES**, a replacement form may have to be completed. Please visit www.sagicorlifeUSA.com and check your state's requirements.)*
2. Will any life insurance or annuity of this or any other company be replaced or changed as a result of this application? *(If **YES**, please complete a Replacement Form and list information below.)* ☐ Yes ☐ No
3. Does the Proposed Insured have any application (including reinstatement) for life insurance now pending, or has he/she applied for any life insurance in the last ninety (90) days? *(If **YES**, please list information below.)* ☐ Yes ☐ No

Company	Policy #	Amount	Issue Date	Plan Type	Applied For (A), Existing (E), or Replacing (R)

SECTION 9 A – Additional Medical and Personal History Questions
*(Record details to **Yes** answers in Section 9 C.)*

1. Name and Address of Proposed Insured's primary care physician (if none check this box ☐)

First *Middle* *Last* *Suffix (Jr. Sr.)* *Phone*

Mailing Address *City* *State* *Zip Code*

2. Date and reason last consulted? Date: _____ Reason: _____

3. Your Current: Height _____ (feet and inches) Weight _____ (pounds)

4. Have you had any weight loss in the past 12 months? ☐ Yes ☐ No

5. In the past 24 Months have you used any form of tobacco or nicotine products including cigarettes, e-cigarettes, cigars, pipes, chewing tobacco, snuff, nicotine patches or gums? ☐ Yes ☒ No

6. In the past 5 years, have you requested or received Worker's Compensation, Social Security, or disability income payment? ☐ Yes ☐ No

7. Are you currently disabled and/or receiving disability benefits other than above? ☐ Yes ☐ No

8. Have you ever had an application for life or health insurance declined, postponed, modified, rated or offered with a reduced face amount? ☐ Yes ☐ No

9. In the past 10 years, have you consulted or been given medical advice by a member of the medical profession for:
   a) Internal Cancer, Malignant Tumor, Lymphoma or Leukemia, Melanoma, or received chemotherapy, radiation or had surgery for any cancer (other than Basal Cell or Squamous Cell skin cancer)? ☐ Yes ☐ No
   b) Other than Basal Cell or Squamous Cell cancer of the skin, have you ever had more than one occurrence of any cancer or are you currently being treated for cancer? ☐ Yes ☐ No
   c) Heart Disease including Coronary Artery Disease, Heart Attack, Heart Failure and Irregular Heartbeat, or Vascular Disease involving the Arteries? ☐ Yes ☐ No
   d) Stroke, Transient Ischemic Attack (TIA), or aneurysm? ☐ Yes ☐ No

10. In the past 5 years, have you consulted or been given medical advice by a member of the medical profession for:
   a) Parkinson's Disease, Cerebral Palsy, Seizures, Paralysis, Multiple Sclerosis, loss of memory or mental capacity? ☐ Yes ☐ No
   b) Blood, protein, albumin, or sugar in the urine, disease or disorder of the prostate, bladder, or genitourinary organs? ☐ Yes ☐ No
   c) Kidney Disease or disorder? ☐ Yes ☐ No
   d) Any Lung or Breathing Disorder including Asthma, Chronic Obstructive Pulmonary Disease (COPD), Chronic Bronchitis, Emphysema, and Sleep Apnea? ☐ Yes ☐ No
   e) Major or Minor Depression, Bipolar Disorder, Anxiety or any other mental or nervous disease or disorder? ☐ Yes ☐ No
   f) Rheumatoid Arthritis (not Osteoarthritis), Systemic Lupus (SLE), Progressive Systemic Sclerosis (PSS or Scleroderma) or Polymyositis? ☐ Yes ☐ No
   g) Hepatitis or other Liver Disorder, Crohn's Disease, Ulcerative Colitis, or a Disorder of the Gallbladder? ☐ Yes ☐ No
   h) High Blood Pressure (Hypertension) or High Cholesterol (Hyperlipidemia)? ☐ Yes ☐ No
   i) Immune system disorder (other than related to HIV) or blood disorder? ☐ Yes ☐ No
   j) Diabetes, high blood sugars or disorder or a disease of the thyroid, pituitary, pancreas or endocrine system? ☐ Yes ☐ No
   k) Any other disorders or diseases not listed above? ☐ Yes ☐ No

11. In the past 5 years, have you used illegal drugs, consulted a member of the medical profession or been treated, hospitalized, or taken medication for abuse of alcohol or drugs (including prescription drugs)? ☐ Yes ☐ No

SECTION 9 A – Additional Medical and Personal History Questions (Continued)
*(Record details to **Yes** answers in Section 9 C.)*

12. Does your occupation involve oil or gas exploration, military special forces, police or fire specialty units? ☐ Yes ☐ No
13. Have you ever used or are you currently using amphetamines, barbiturates, cocaine, heroin, crack, marijuana, LSD, PCP, or other illegal, restricted or controlled substance, including prescribed by a member of the medical profession? ☐ Yes ☐ No
14. In the past 10 years have you consumed alcoholic beverages? ☐ Yes ☐ No
15. In the past 24 months have you flown, or in the next 24 months do you intend to fly as a pilot, student pilot, or crew member on any aircraft, (other than scheduled commercial flights)? ☐ Yes ☐ No
16. Have you ever been convicted of a felony or do you currently have any pending felony charges? ☐ Yes ☐ No
17. In the past 2 years have you engaged in or within the next 2 years do you intend to engage in, certain activities such as hang gliding, ultra-light flying, heli-skiing, mountain, ice, or rock climbing, cliff or base jumping, motor vehicle racing, motorcycle or any other motorized land or water vehicle racing, or scuba or sky diving? ☐ Yes ☐ No

Please respond to the following questions if you are purchasing a single premium whole life insurance policy.

18. Within the past 12 months have you:
    a) Been unable to perform or do you require supervision or assistance in dressing, eating, continence, toileting, transferring or bathing? ☐ Yes ☐ No
    b) Been advised by a member of the medical profession to be hospitalized, confined to a nursing home, hospice, convalescent, long-term care facility, or diagnosed with a terminal illness with a life expectancy of 12 months or less? ☐ Yes ☐ No
    c) Been advised to have or scheduled a surgical operation, diagnostic test, or evaluation that has not yet been completed? ☐ Yes ☐ No
19. Within the past 10 years have you been diagnosed with, consulted with a member of the medical profession, or been treated for:
    a) Organ transplant, unexplained weight loss over 10 pounds, kidney failure or insufficiency, or digestive system disorder including ulcers and bleeding? ☐ Yes ☐ No
    b) Alzheimer's disease, dementia, memory loss, cognitive impairment, or tremors? ☐ Yes ☐ No
    c) Anemia, sepsis or any other disease or disorder of the blood or immune system? ☐ Yes ☐ No
    d) Sought advice from medical professional or treatment for loss of appetite, falling, fainting, unstable gait, bladder control, dizziness, or deterioration of vision? ☐ Yes ☐ No
    e) Do you use any medical appliance such as, but not limited to respiratory equipment (oxygen or ventilator) or dialysis equipment or are you dependent on the use of a walker, a wheelchair, or motorized ambulatory device? ☐ Yes ☐ No
    f) Been physically limited in any way, or used any equipment such as crutches to aid in mobility? ☐ Yes ☐ No
    g) Any disease or disorder of the muscles, bones or joints? ☐ Yes ☐ No
    h) Any other disease or disorder not listed above? ☐ Yes ☐ No

SECTION 9 B – Family History
*(Record details to **Yes** answers in Section 9 C.)*

Family Member	Living	Cause of Death	Age of Death
Mother	☐ Yes ☐ No ☐ N/A		
Father	☐ Yes ☐ No ☐ N/A		
Sister (s)	☐ Yes ☐ No ☐ N/A		
Brother(s)	☐ Yes ☐ No ☐ N/A		

SECTION 9 C - Details To All *Yes* Answers for 9 A and 9 B

SECTION 10 – Additional Information/Special Request or Instructions

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 11 – Authorization and Acknowledgement

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

I, the undersigned, **AUTHORIZE** any health plan, physician, healthcare professional, hospital, pharmacy, Pharmacy Benefit Managers, clinic, laboratory, the Medical Information Bureau Inc. (MIB), other medical or medically related facility, Veterans Administration, or U.S. Military facility, insurance or reinsuring company, employer, person, or organization having records or information available as to diagnosis, treatment, and prognosis with respect to any physical, mental, and/or behavioral condition, to give to Sagicor Life Insurance Company (Sagicor), or its authorized representative, any and all information relating to my: health/medical history; character; general reputation; personal characteristics; prescription drug records; use of drugs or alcohol; sexually transmitted diseases, if any; insurance coverage; and my health status with regard to Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) and/or treatment thereof. Authorized representatives include any consumer reporting agency acting on their behalf.

I **AUTHORIZE** any law enforcement agency, any federal, state, or local tax agency, other government agencies such as the Workers' Compensation Board and the Social Security Administration, other insurers, certified public accountants and tax preparers, banks and financial institutions, consumer reporting agencies, employers, and educational institutions to disclose non-medical information about me. The non-medical information that I authorize to be used or disclosed includes, but is not limited to: vocation, character, general reputation, mode of living, avocations, driving and aviation records, avocations and habits, hazardous activities, other insurance coverage, employment, education, finances, including income tax records, law enforcement, court, and military records, any business records associated with me, 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. I authorize Sagicor Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB.

This authorization shall be valid for 30 months which complies with the time limit, if any, permitted by applicable law in the state where the policy is delivered or issued for delivery. I agree that a photographic copy of this authorization shall be as valid as the original. I understand that: (1) I or my authorized representative may receive a copy of the authorization upon request; (2) I may revoke this authorization at any time by sending written notice to Sagicor's home office;(3) 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; and 4) 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 and agree that: (1) 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 this application; (2) I must/will notify Sagicor if I become aware that there has been a change in the health of the Proposed Insured that would change any of the answers in this application; (3) no producer may accept risks or pass upon insurability, make or modify contracts, or waive any of Sagicor's rights or requirements; and (4) 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: prior to your signing of this life insurance application, 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 penalties of perjury, I certify that: (1) The tax identification number shown on this form is correct, and (2) I am not subject to backup withholding either because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and (3) I am a U.S. citizen or other U.S. person (defined in the W-9 instructions), and (4) I am exempt from FATCA reporting. The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Signed: _____ Date Signed: 07/26/2018

City *State*

_____ _____

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

Proposed Owner's Signature
(If other than Proposed Insured)

SECTION 12 – 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
Sagicor Test Web User	TESTPRODUCER	100

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. If premium was accepted, was the Conditional Receipt completed and delivered to the Proposed Owner? ☐ Yes ☒ No
3. 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
4. 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
5. Is this a 1035 Exchange? *(If **YES**, attach all required forms.)* ☐ Yes ☒ No
   If **YES**, is the 1035 Exchange ☐ Internal or ☐ External?
6. Are there any other Sagicor Life Insurance Company applications associated with this application? ☐ Yes ☐ No
7. Has the Proposed Insured applied for any life insurance or annuity in the last ninety (90) days? ☐ Yes ☐ No
8. What is the purpose of this insurance purchase? _____
9. Do you know the Proposed Insured? ☐ Yes ☐ No Proposed Owner? ☐ Yes ☐ No
10. Are you related to the Proposed Insured? ☐ Yes ☐ No Proposed Owner? ☐ Yes ☐ No
    If **YES**, how are you related? _____
11. 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 & number. If **NO**, please explain why.)* ☐ Yes ☐ No _____
12. Does the Proposed Insured understand and speak English? ☐ Yes ☐ No Proposed Owner? ☐ Yes ☐ No
    If **NO**, please explain: _____
13. Was any other person present to answer questions? ☐ Yes ☐ No
    If **YES**, who was present and why? _____
14. Do you know of anything not disclosed on this application that may affect the risk of this life insurance purchase? ☐ Yes ☐ No
    If **YES**, please explain: _____
15. Is this a premium finance case? *(If **Yes**, please provide details.)* _____ ☐ Yes ☒ No

Producer's Certification

I certify the above answers to be true and accurate and that the Proposed Owner and Proposed Insured are the person(s) described in this application, I have truly and accurately recorded the information supplied by the Proposed Owner and Proposed Insured, 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: 07/26/2018

Phone Number: _____ Fax Number: _____ E-mail Address: TOM_GERMROTH@SAGICOR.COM

Sagicor

LIFE INSURANCE COMPANY

Disclosure Notice to Proposed Insured

Leave with the Proposed Insured, or, if the Insured is a Minor, Parent or Guardian

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.

Sagicor

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 the application in its entirety (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 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: 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 the application in its entirety; (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 the application in its entirety, 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 the application in its entirety; (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*

Sagicor

LIFE INSURANCE COMPANY

4343 N. Scottsdale Rd., Suite 300
Scottsdale, Arizona 85251/800-531-5067
www.SagicorLifeUsa.com

ACCELERATED BENEFIT INSURANCE RIDER
DISCLOSURE STATEMENT

The Accelerated Benefit offered under this rider may or may not qualify for favorable tax treatment under the Internal Revenue Code of 1986. Whether such benefit qualifies depends on factors such as your life expectancy at the time benefits are accelerated or whether you use the benefits to pay for necessary long-term care expenses, such as nursing home care. If the accelerated benefit qualifies for favorable tax treatment, the benefits will be excluded from your income and not subject to federal taxation. Tax laws relating to acceleration benefits are complex. You are advised to consult with a tax advisor about circumstances under which you could receive accelerated benefits excludable from income under federal law.

Receipt of an accelerated benefit may affect Your, Your spouse or Your family's eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependant Children (AFDC), supplementary social security income (SSI), and drug assistance programs. You are advised to consult with a qualified tax advisor and with social service agencies concerning how receipt of such a payment will affect You, Your spouse and Your family's eligibility for public assistance.

DESCRIPTION OF BENEFITS

An **Accelerated Benefit** is an advance of a portion of the Death Benefit prior to the Insured's death due to a Terminal Condition or certification by a Licensed Physician that the Insured is diagnosed with a Chronic Illness.

Terminal Condition, as used in this Rider, means that an imminent death is expected as a result of a non-correctable medical condition that with reasonable medical certainty will result in a drastically limited life span of 12 months or less of the Insured.

Chronic Illness, as used in this Rider, means that the Insured has been certified by a Licensed Physician within the last 30 days as being unable to perform, without substantial assistance from another individual, at least two Activities Of Daily Living for a period that is expected to last at least 90 days due to a loss of functional capacity.

Activities Of Daily Living, as used in this Rider, are the following; eating, toileting, transferring, bathing, dressing, or continence, as defined in the rider.

Accelerated Benefit Amount, as used in this Rider, means the lesser of an amount equal to the Death Benefit less $25,000, or $250,000.

Administrative Fee, as used in this Rider, means a one time charge of $150 or the maximum allowed by law in the state in which this Policy was issued.

ACCELERATED BENEFIT AMOUNT DUE TO A TERMINAL CONDITION

Upon certification by a Licensed Physician that the Insured has been diagnosed with a Terminal Condition, as defined in this Rider, You may elect to accelerate any portion of the Accelerated Benefit Amount. The Administrative Fee will be deducted from the amount elected and the remainder will be paid in a lump sum.

BC070187 S410507

ACCELERATED BENEFIT AMOUNT DUE TO A CHRONIC ILLNESS
Upon certification by a Licensed Physician that the Insured has been diagnosed with a Chronic Illness, as defined in this Rider, You may elect to accelerate any portion of the Accelerated Benefit Amount. The amount elected will be paid in 33 equal monthly installments. The Administrative Fee will be deducted from the first installment.

EFFECT ON YOUR POLICY
Upon payment of the Accelerated Benefit, Your coverage will remain In Force. The Accelerated Benefit acts as an interest free lien against the Death Benefit. Therefore, the Death Benefit will be reduced by the portion of the Accelerated Benefit Amount paid. The Face Amount, Accumulation Value, Minimum Accumulation Value, Guaranteed Tabular Cash Value, Single Premium and any Indebtedness of this Policy will be reduced proportionately based on the ratio of the portion of the Accelerated Benefit Amount paid to the Death Benefit prior to the reduction.

Upon payment of an acceleration benefit, or if periodic payments are being made at least annually, We will send you a statement specifying the amount of benefit paid, adjusted Death Benefit, Accumulation Value, Cash Surrender Value, and applicable charges, and any amount remaining for acceleration.

I ACKNOWLEDGE RECEIPT OF THIS DISCLOSURE

	07/26/2018		07/26/2018
Signature of Agent	Date	Signature of Owner	Date
Sagicor Test Web User	TESTPRODUCt	ISSPWL App	
Print Name of Agent	Agent Number	Print Name of Owner	

Customer Electronic Consent and Disclosure

IMPORTANT NOTICE – PLEASE READ CAREFULLY AND KEEP FOR FUTURE REFERENCE

What is the purpose of this Electronic Consent and Disclosure?

You are applying for a life insurance policy from Sagicor Life Insurance Company ("Sagicor") and have expressed your desire to conduct business electronically with regard to this life insurance policy ("Policy") and communications related to the Policy. To conduct business electronically, you must provide Sagicor and its authorized designees and producers with your consent. If you check the "I Consent" box and electronically sign this form, you will be providing Sagicor and its authorized designees and producers, with your consent:

a) to have the information described in this Customer Electronic Consent and Disclosure ("Consent") delivered to you electronically;
b) to execute via electronic means the documents that are described in this Consent; and
c) to all of the terms and conditions set forth below in this Consent.

If you do ***not:***

- want to have the information described in this Consent delivered to you electronically;
- want to execute via electronic means the documents that are described in this Consent; or
- agree with all of the terms and conditions of this Consent,

you may not conduct business electronically with Sagicor, and you must check the "I Do Not Consent" box below.

What does this Consent cover once I sign it?

Sagicor
LIFE INSURANCE COMPANY
www.SagicorLifeUsa.com

This Consent covers your agreement to all of the terms and conditions herein, including your agreement to:

1. **receive via electronic means the documents that Sagicor is required by law to provide or make available to you in writing ("Required Documents"), as well as other information and documents (collectively, "Other Documents");**
2. **execute via electronic means Required Documents and Other Documents; and**
3. **be bound with the same force and effect as if you had affixed your signature on paper by hand when you check the "I Consent" box or otherwise apply your electronic signature to Required Documents or Other Documents.**

While not a complete listing, the types of Required Documents that may be sent to you or otherwise made available to you electronically include:

- the Life Insurance application and related documents
- your Life Insurance policy
- your Life Insurance policy statements
- required disclosure statements
- privacy notices

While not a complete listing, the types of Other Documents that may be sent to you or otherwise made available to you electronically include:

- information about your Life Insurance policy
- service forms
- general communications

Even though you have provided Sagicor with this consent, Sagicor may, at its option:

a) deliver Required Documents and Other Documents to you on paper, and
b) require that certain communications from you be delivered to Sagicor on paper.

Can I get paper copies of the Required Documents and Other Documents?

Yes. You may obtain paper copies of any of the Required Documents or Other Documents at any time and without charge by contacting Sagicor at the address provided below (or such other Insurer address as may be provided to you in the future).

Should I maintain copies of the Required Documents and Other Documents?

Yes. You agree to print or save this Consent and all Required Documents and Other Documents, and to keep printed or electronic copies of them for your records. If you have any trouble with printing or saving, you should contact Sagicor.

How long will this Consent remain in effect?

This Consent shall become effective once you check the "I Consent" box and sign this form and will remain in effect for as long as your Policy remains in effect, or until you withdraw your consent (as described in the next section), whichever occurs first.

What if I change my mind?

If at any time you would like to cease doing business electronically with Sagicor with respect to your Policy, you will need to provide Sagicor with written notice of your withdrawal of your consent to do business electronically, which will then terminate this Consent. You may withdraw consent at any time and without charge by contacting Sagicor. Your withdrawal of consent to do business electronically and the termination of this Consent will become effective two (2) business days after Sagicor's receipt of your withdrawal. Thereafter, *all* Required Documents and Other Documents will be provided to you on paper.

What if my contact information changes?

You must keep Sagicor informed of any changes to your e-mail address and all other contact information. You may inform Sagicor of any such changes by contacting Sagicor at the address provided below (or such other Insurer address as may be provided to you in the future).

How can I contact Sagicor?

You can contact Sagicor as follows:

Mail: Sagicor Insurance Company
P.O. Box 52121
Phoenix, AZ 85072-2121

Telephone: 1-888-SAGICOR (724-4267)
Website: www.SagicorLifeUSA.com

Are there any hardware or software requirements to do business electronically with Sagicor?

Yes. To access and retain the Required Documents and Other Documents sent or made available to you electronically by Sagicor you must have access to a computer with an Internet connection. You must be able to send and receive e-mails, and be able to save the Required Documents and Other Documents to a storage device for later reference or have a computer connected to a printer so you can print out such documents. The minimum hardware and software requirement are:

- Minimum Screen Resolution 1024 X 768
- Windows: Intel® Pentium® III 450MHz or faster processor (or equivalent)
- Operating System: Windows 7, Windows Vista; Windows XP Service Pack 2
- Macintosh: Apple Mac OS X 10.4.8 or above, Intel Core™ Duo 1.83GHz or faster processor
- Microsoft Silverlight plug-in 3.0 +
- Web browser: Internet Explorer 6+, Firefox 2+, Safari 3+, Google Chrome.
- Misc: 128MB of RAM, Cookies Enabled.

PLEASE PRINT OR SAVE A COPY OF THIS CONSENT NOW FOR FUTURE REFERENCE

I have CAREFULLY read this Consent and accept it voluntarily and with full knowledge and understanding of its terms and conditions. I have read this Consent using computer hardware and software that meets the minimum hardware and software requirements described above. I have successfully printed or saved a copy of the Consent.

☐ I Consent

☐ I Do Not Consent

		07/26/2018
Proposed Insured	Email Address	Date Signed
Owner if other than Proposed Insured	Email Address	Date Signed

Sagicor
LIFE INSURANCE COMPANY

4343 N. Scottsdale Rd., Suite 300
Scottsdale, Arizona 85251
(888) 724-4267

ILLUSTRATION ACKNOWLEDGEMENT FORM

IMPORTANT NOTICE

Applicant(s), please do not sign this form unless you have first reviewed both the illustration and its numeric summary page that are immediately preceding this page. Your signature on this page functions as your signature on the numeric summary page.

Applicant Acknowledgement

I have reviewed and received a copy of this illustration and understand that any non-guaranteed elements illustrated are subject to change and could be either higher or lower. The Producer has told me that they are not guaranteed. I understand that any values shown, other than guaranteed minimum values, are not guarantees, promises, or warranties.

	07/26/2018
Signature of Applicant (Policy Owner)	Date
Signature of Joint Applicant (if applicable)	Date

Producer Acknowledgement

I certify that this illustration has been presented to the Applicant(s) and that I have explained that any non-guaranteed elements illustrated are subject to change. I have made no statements that are inconsistent with the illustration. I have not made statements which differ in any significant manner from this material. I have not made any promises or guarantees about the future value of any current values.

	07/26/2018
Signature of Producer	Date
Sagicor Test Web User	TESTPRODUCER
Print Name of Producer	Producer Number

Sagicor
LIFE INSURANCE COMPANY

4343 N. Scottsdale Rd., Suite 300
Scottsdale, Arizona 85251
(888) 724-4267

DOCUMENT RECEIPT VERIFICATION

IMPORTANT NOTICE

You may have reviewed (and signed if required) all or some of the following documents during the application process. You must receive a copy of the documents you have reviewed.

- **Disclosure Notice to Proposed Insured**
- **Accelerated Benefit Disclosure Form**
- **Illustration for Proposed Policy**
- **Replacement Form**
- **Conditional Receipt (premium)**

Applicant Statement

I acknowledge that with respect to the life insurance application accompanying this form, I have reviewed the applicable documents above, and (check applicable statement):

☐ *I received a printed copy of the documents. (or)*
☐ *I accept delivery of the documents through electronic access.*

	07/26/2018
Signature of the Applicant/Owner	Date
ISSPWL App	
Printed name of the Applicant/Owner	Printed name of the Proposed Insured if different than Applicant/Owner

Producer Statement

This is to certify that with respect to the life insurance application accompanying this form, I have reviewed with the Applicant the applicable documents above and provided to the Applicant (check applicable statement):

☐ *A printed copy of the documents. (or)*
☐ *Instructions for electronically accessing the documents.*

	07/26/2018
Signature of the Producer	Date
Sagicor Test Web User	TESTPRODUCER
Printed name of the Producer	Producer Number