APPLICATION FOR INDIVIDUAL LIFE INSURANCE

Sagicor Life Insurance Company 4343 N. Scottsdale Road, Suite 300, Scottsdale, AZ 85251

PROPOSED INSURED

Name (First, MI, Last)

Email

Primary Phone

Residence Street Address

Date of Birth

Social Security Number

What is your gender?

Height and Weight

How often do you use cigarettes or nicotine-based products?

What is your country of birth?

Are you a U.S. Citizen or Legal Permanent Resident?

Do you have a government issued picture ID?

What type of ID do you have?

ID Number

What state issued your ID?

PROPOSED OWNER (If not the Proposed Insured)

Name (First, MI, Last)

Email

Primary Phone

Residence Street Address

Date of Birth

Social Security Number

What is your relationship to the Proposed Insured?

What is your country of birth?

Are you a U.S. Citizen or Legal Permanent Resident?

Do you have a government issued picture ID?

What type of ID do you have?

ID Number

What state issued your ID?

BC190006

COVERAGE

Policy Type

Class

Coverage Amount

Premium

Payment Frequency

Initial Payment Method

Do you plan to sell or transfer this life insurance policy?

Do you have another life insurance or annuity policy in-force?

Do you intend to replace or otherwise change any current policy with this new policy?

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.

HEALTH QUESTIONS

1 My living condition:

2 My daily needs:

3 I have used, or been advised by a member of the medical profession to use, oxygen equipment (not including use for sleep apnea):

4 I have received, or been advised by a member of the medical profession to receive, kidney dialysis:

5 I have been advised by a member of the medical profession to have surgery, hospitalization or diagnostic testing (not related to HIV) which has not yet been started, completed, or for which results are not known:

6 I have received, or been advised by a member ofthe medical profession to receive, an organ or bone marrow transplant or related medications:

7 I have received, or been advised by a member of the medical profession to receive, an amputation due to diabetes:

8 I have been diagnosed by a member of the medical profession with alcohol abuse:

9 I have been diagnosed by a memb er of the medical profession with drug abuse:

10 I have used illegal drugs (not including recreational marijuana):

11 I have received, or been advised by a member of the medical profession to receive, treatment or medication for alcohol or drug abuse:

12 I have been diagnosed with cancer, or received or been advised by a member of the medical profession to receive, chemotherapy or radiation for cancer (not including basal cell skin cancer):

13 I have been diagnosed by a member of the medical profession with more than one occurrence of the same or different type of cancer (not including basal cell skin cancer):

14 Within the past 5 years, I have been diagnosed with, or received or been advised by a member of the medical profession to receive, treatment or medication for:

15 Within the past 5 years, I have been diagnosed with, or received or been advised by a member of the medical profession to receive treatment for:

16 Within the past 2 years, I have been diagnosed with, or received or been advised by a member of the medical profession to receive treatment for, any of the following complications of diabetes:

17 Within the past 2 years, I have been diagnosed with, or received or been advised by a member of the medical profession to receive treatment for:

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BENEFICIARIES

Name (First, MI, Last)

Relationship To You | Allocation Percentage

Date of Birth | Social Security Number

Resident City and State

Beneficiary Type

Name (First, MI, Last)

Relationship To You | Allocation Percentage

Date of Birth | Social Security Number

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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

AUTHORIZATION AND ACKNOWLEDGEMENT (1 of 2)

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.

AUTHORIZATION AND ACKNOWLEDGEMENT (2 of 2)

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.

MY SIGNATURE

Your name will appear here as your e-signature.

Signed On

State Signed In