

SERFF Tracking Number: AMFD-127806356 State: Arkansas  
Filing Company: Sagicor Life Insurance Company State Tracking Number: 50221  
Company Tracking Number: 5044  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: Individual Life Insurance Juvenile Application  
Project Name/Number: 5044/5044

## Filing at a Glance

Company: Sagicor Life Insurance Company

Product Name: Individual Life Insurance

Juvenile Application

TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Filing Type: Form

SERFF Tr Num: AMFD-127806356 State: Arkansas

SERFF Status: Closed-Approved-  
Closed State Tr Num: 50221

Co Tr Num: 5044

Author: Francine Cardon

Date Submitted: 11/08/2011

State Status: Approved-Closed

Reviewer(s): Linda Bird

Disposition Date: 11/10/2011

Disposition Status: Approved-  
Closed

Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

## General Information

Project Name: 5044

Project Number: 5044

Requested Filing Mode:

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Deemer Date:

Submitted By: Francine Cardon

Filing Description:

RE: Sagicor Life Insurance Company

NAIC No.: 60445; FEIN: 74-1915841

Form Nos.: 5044 Individual Life Insurance Juvenile Application

Status of Filing in Domicile: Authorized

Date Approved in Domicile: 11/04/2011

Domicile Status Comments:

Market Type: Individual

Individual Market Type:

Filing Status Changed: 11/10/2011

State Status Changed: 11/10/2011

Created By: Francine Cardon

Corresponding Filing Tracking Number:

The above referenced form is being submitted for your review and approval. No part of this filing contains any unusual or possibly controversial items from normal company or industry standards. These documents are final printed versions. Form 5044 will be used for juvenile issued term life; whole life, and universal life policies.

5044 will be in paper and electronic format. Electronic format means the application may be in an electronic format for the producer's use instead of paper. All required signatures will be "wet" signatures.

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Please note that we may change the appearance and pagination but not the text of these forms to comply with future changes in print systems. No font will be less than 10 point size. The color and/or weight of the paper may change. No changes to the text other than corrections of typographical errors will be made to the form without re-filing the form with you.

Should you have any questions, please contact me toll-free at 800-531-5067 ext. 5652, or via electronic mail at francine\_cardon@sagicor.com.

Thank you for your consideration.

Sincerely,

Francine Cardon

## Company and Contact

### Filing Contact Information

Francine Cardon, Compliance Analyst Francine\_Cardon@sagicor.com  
4343 N. Scottsdale Road 480-425-5100 [Phone]  
Suite 300 480-425-5150 [FAX]  
Scottsdale, AZ 85251

### Filing Company Information

Sagicor Life Insurance Company CoCode: 60445 State of Domicile: Texas  
4343 N. Scottsdale Road Group Code: 3766 Company Type:  
Suite 300 Group Name: State ID Number:  
Scottsdale, AZ 85251 FEIN Number: 74-1915841  
(800) 531-5067 ext. 5653[Phone]

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## Filing Fees

Fee Required? Yes  
Fee Amount: \$100.00  
Retaliatory? Yes  
Fee Explanation: Domicile state filing fee is \$100 per filing.

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Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Sagicor Life Insurance Company	\$100.00	11/08/2011	53595300

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	11/10/2011	11/10/2011

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## Disposition

Disposition Date: 11/10/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

*SERFF Tracking Number:* AMFD-127806356      *State:* Arkansas  
*Filing Company:* Sagicor Life Insurance Company      *State Tracking Number:* 50221  
*Company Tracking Number:* 5044  
*TOI:* L08 Life - Other      *Sub-TOI:* L08.000 Life - Other  
*Product Name:* Individual Life Insurance Juvenile Application  
*Project Name/Number:* 5044/5044

<b>Schedule</b>	<b>Schedule Item</b>	<b>Schedule Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Flesch Certification		Yes
<b>Supporting Document</b>	Application		No
<b>Supporting Document</b>	Statement of Variability		Yes
<b>Form</b>	Individual Life Insurance Juvenile Application		Yes

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## Form Schedule

**Lead Form Number: 5044**

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	5044	Application/ Individual Life Enrollment Insurance Juvenile Form Application	Initial		50.100	5044 JUVIE APP file copy 11.8.11.pdf



LIFE INSURANCE COMPANY

# INDIVIDUAL LIFE INSURANCE JUVENILE APPLICATION

## SECTION 1 – Proposed Insured Information

Name: \_\_\_\_\_ Sex:  Male  Female  
*(First) (MI) (Last)*

Street Address: \_\_\_\_\_  
*City State ZIP Code*

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

Telephone No. : Home \_\_\_\_\_ Work \_\_\_\_\_ Other \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Driver's License Number/State: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Has the Proposed Insured used any form of tobacco in the past 24 months?  Yes  No

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

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

## SECTION 2 – Proposed Owner Information *(Complete if different from the Proposed Insured)*

Check if Proposed Owner is not an Individual *(If this is a Trust, please provide a copy of the Title & Signature page)*

Name: \_\_\_\_\_ Date of Birth/Trust Date: \_\_\_\_\_  
*(First) (MI) (Last)*

Street Address: \_\_\_\_\_ SSN/Tax ID #: \_\_\_\_\_  
*City State ZIP Code*

Telephone No. : Home \_\_\_\_\_ Work \_\_\_\_\_ Other \_\_\_\_\_

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

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

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

- Does the Proposed Owner have one of the following relationships with the Proposed Insured: Spouse, Child, Parent, Grandchild, Brother, or Sister?  Yes  No If "Yes", Relationship: \_\_\_\_\_
- 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
- 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

**SECTION 3 – Beneficiary Information** *(Continued)* **Check if the Beneficiary is not an Individual**

Primary Beneficiary Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Street Address: \_\_\_\_\_  
City State ZIP Code

Social Security Number/Tax ID: \_\_\_\_\_ Date of Birth/Trust Date: \_\_\_\_\_

Is the Primary Beneficiary a U.S. Citizen?  Yes  No Alien Registration Number: \_\_\_\_\_(If **NO**, please complete a Foreign Travel & Residence Questionnaire & provide an Alien Registration Number.) **Check if the Contingent Beneficiary is not an Individual**

Contingent Beneficiary Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Street Address: \_\_\_\_\_  
City State ZIP Code

Social Security Number/Tax ID: \_\_\_\_\_ Date of Birth/Trust Date: \_\_\_\_\_

Is the Contingent Beneficiary a U.S. Citizen?  Yes  No Alien Registration Number: \_\_\_\_\_(If **NO**, please complete a Foreign Travel & Residence Questionnaire & provide an Alien Registration Number.)**SECTION 4 – Payor Information** *(Complete if different from Proposed Owner)* **Check if Payor is not an individual** *(If this is a Trust, please provide a copy of the Title and Signature page.)*Name: \_\_\_\_\_ Date of Birth/Trust Date: \_\_\_\_\_  
(First) (MI) (Last)Street Address: \_\_\_\_\_ SSN/Tax ID #: \_\_\_\_\_  
City State ZIP Code

Telephone No. : Home \_\_\_\_\_ Work \_\_\_\_\_ Other \_\_\_\_\_

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

Is the Payor a U.S. Citizen?  Yes  No Alien Registration Number: \_\_\_\_\_(If **NO**, please complete a Foreign Travel & Residence Questionnaire & provide an Alien Registration Number.)**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, 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**

Face Amount being Applied For: \$ \_\_\_\_\_

**Gold Series Products** Whole Life] Other Gold or Platinum Series Plan Not Listed] \_\_\_\_\_**Platinum Series Products** No Lapse Universal Life]**Universal Life Elections (select one)**Guideline Premium Test Cash Value Accumulation Test **Death Benefit Option (select one)** A]  B]**Automatic Premium Loan Option (select one)**  Yes  No [(Whole Life Only)]**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 – Premium Information**

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)

**SECTION 7 – 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, please list the policy or contract below & 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  
*(If YES, please list the policy or contract below.)*

Name of Proposed Insured	Company	Policy #	Amount	Issue Date	Plan Type

**SECTION 8 – Simplified Issue Questions****Proposed Insured**

1. Do you currently require oxygen therapy or kidney dialysis? Have you been told that you need an organ transplant? Have you been diagnosed with diabetes, hepatitis, or paralysis?  Yes  No
2. Are you a resident in a nursing home or assisted living facility? In the past twelve (12) months, have you been disabled for more than thirty (30) days or received disability benefits of any kind?  Yes  No
3. Have you tested positive for Human Immunodeficiency Virus (HIV); or been medically diagnosed as having Acquired Immune Deficiency Syndrome(AIDS); or been medically diagnosed as having AIDS Related Complex (ARC)?  Yes  No
4. In the past twenty-four (24) months, have you been hospitalized two (2) or more times? (Do not include: stays of less than three (3) days/72 hours, pregnancy or childbirth related stays, or cosmetic surgery.)  Yes  No
5. In the past thirty-six (36) months, have you been treated for or diagnosed with any cancer (other than Basal Cell skin cancer), leukemia, hypertension, had a heart attack, stroke, heart failure, or heart surgery (including angioplasty)?  Yes  No
6. In the past thirty-six (36) months, have you used any illegal drugs, or been treated for or advised to have treatment for drug or alcohol abuse, or mental or emotional problems or neurological disorders or epilepsy?  Yes  No
7. In the past twenty-four (24) months, have you had a Driver's License revoked or suspended, or been issued 2 or more moving violations, or been issued 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
8. In the last five (5) years, have you been convicted of, or are you awaiting trial for a felony?  Yes  No
9. Have you ever had an application for insurance or reinstatement of insurance declined, rated, or postponed or have you been removed from a children's rider on a parent/guardian policy?  Yes  No

**SECTION 9 – Additional Information/Special Request or Instructions**


**SECTION 10 – Fraud Warning**

**Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.**

**SECTION 11 – Authorization and Acknowledgement**

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

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

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

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

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

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

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

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

Date Signed: \_\_\_\_\_

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

\_\_\_\_\_  
Proposed Owner’s Signature  
(If other than the Proposed Insured or Trustee)

\_\_\_\_\_  
Proposed Trustee Signature (if, applicable)

\_\_\_\_\_  
Writing Producer’s Name (Please Print)

\_\_\_\_\_  
Writing Producer’s Number

\_\_\_\_\_  
Writing Producer’s Signature

\_\_\_\_\_  
Countersigned  
(Licensed resident producer if state required)

**SECTION 12 – This section should be completed by the Producer.**

**For questions about this application or requirements, contact our Underwriting Department.**

<b>Producer Name (Please Print)</b>	<b>Producer ID Number</b>	<b>% Split</b>

Each licensed Producer will share equally unless otherwise indicated.

1. Have you delivered the consumer protection notices to the Proposed Owner(s) and Proposed Insured(s)?  Yes  No
2. Did you personally meet with the Proposed Owner(s) and Proposed Insured(s), obtain their Social Security Number(s) and view for each a Government issued photo ID? (If **YES**, specify the type of ID and ID number.  Yes  No  
If **NO**, please explain why.) \_\_\_\_\_
3. If premium was accepted, was the Conditional Receipt completed and delivered to the Proposed Owner?  Yes  No
4. Does the Proposed Insured(s) have any other life insurance or annuities currently in force or pending reinstatement?  Yes  No
5. Will any annuity or life insurance presently in force be replaced or changed by this policy that is being applied for? (If **YES**, and if required by state regulation, any Replacement Comparison, Notice, or Statement must accompany this application.)  Yes  No
6. Is this a 1035 Exchange? (If **YES**, attach all required forms.)  Internal  External  Yes  No
7. Is this a premium finance case? (If yes, Company will not issue policy)  Yes  No
8. How long have you known the Proposed Owner(s)? \_\_\_\_\_ Proposed Insured(s)? \_\_\_\_\_
9. Are you related to the Proposed Owner(s)?  Yes  No Proposed Insured(s)?  Yes  No  
If **YES**, how are you related? \_\_\_\_\_
10. Does the Proposed Owner(s) understand and speak English?  Yes  No Proposed Insured(s)?  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(s) and Proposed Insured(s) to be the person(s) described in this application, and have reviewed the appropriate documentation, and have truly and accurately recorded the information supplied by the Proposed Owner(s) and Proposed Insured(s), that I know of no condition affecting the insurability of the applicant not fully set forth in the application, and that I have made no declaration, representation, or waiver regarding coverage or the provisions or terms of the application or policy. I further certify that I am licensed in the state in which this application was completed and have delivered all required notices and disclosures and fully complied with all privacy and replacement regulations. I also assume full responsibility for the delivery of the policy and the submission of the first premium.

Signed (Writing Producer): \_\_\_\_\_ Date Signed: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_ E-mail Address: \_\_\_\_\_



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 Services  
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](http://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.



LIFE INSURANCE COMPANY

**Conditional Receipt ("Receipt")**

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

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

Received from \_\_\_\_\_ as the Proposed Owner, the sum of \$ \_\_\_\_\_, for the insurance application dated \_\_\_\_\_, with \_\_\_\_\_ as the Proposed Insured.

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

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

The aggregate amount of conditional coverage provided under this Receipt, if any, and any other conditional receipt issued by Sagicor shall be limited to the lesser of the amount(s) applied for, or [\$100,000] of life insurance. There is no conditional coverage for riders or any additional benefits, if any, for which you have applied.

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

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

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

Dated at \_\_\_\_\_ on \_\_\_\_\_  
City State Date Producer's Signature

SERFF Tracking Number: AMFD-127806356 State: Arkansas  
 Filing Company: Sagicor Life Insurance Company State Tracking Number: 50221  
 Company Tracking Number: 5044  
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
 Product Name: Individual Life Insurance Juvenile Application  
 Project Name/Number: 5044/5044

## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Flesch Certification <b>Comments:</b> <b>Attachment:</b> 5044 Read Cert.pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b> Application <b>Bypass Reason:</b> Please refer to the attached application under the Form Schedule tab. <b>Comments:</b>		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Statement of Variability <b>Comments:</b> <b>Attachment:</b> 5044 Read Cert.pdf		

# READABILITY CERTIFICATION

To Whom It May Concern:

This is to certify that the attached forms achieved a Flesch Reading Ease Score and are in compliance with applicable laws and regulations as follows:

<u>Form #Title</u>	<u>Flesch Score</u>
5044 Individual Life Insurance Application	50.1

Sagicor Life Insurance Company



\_\_\_\_\_  
Name: James Golembiewski  
Title: VP Compliance & Associate General Counsel

November 8, 2011  
Date

# READABILITY CERTIFICATION

To Whom It May Concern:

This is to certify that the attached forms achieved a Flesch Reading Ease Score and are in compliance with applicable laws and regulations as follows:

<u>Form #Title</u>	<u>Flesch Score</u>
5044 Individual Life Insurance Application	50.1

Sagicor Life Insurance Company



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Name: James Golembiewski  
Title: VP Compliance & Associate General Counsel

November 8, 2011  
Date