

SERFF Tracking Number: AMFD-127893509 State: Arkansas  
Filing Company: Sagicor Life Insurance Company State Tracking Number: 50466  
Company Tracking Number: 5042  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: Individual Life Insurance Simplified Issue Application  
Project Name/Number: 5042/5042

## Filing at a Glance

Company: Sagicor Life Insurance Company

Product Name: Individual Life Insurance

Simplified Issue Application

TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Filing Type: Form

SERFF Tr Num: AMFD-127893509 State: Arkansas

SERFF Status: Closed-Approved-  
Closed State Tr Num: 50466

Co Tr Num: 5042

Author: Francine Cardon

Date Submitted: 12/13/2011

State Status: Approved-Closed

Reviewer(s): Linda Bird

Disposition Date: 12/16/2011

Disposition Status: Approved-  
Closed

Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

## General Information

Project Name: 5042

Project Number: 5042

Requested Filing Mode:

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Deemer Date:

Submitted By: Francine Cardon

Filing Description:

Status of Filing in Domicile: Authorized

Date Approved in Domicile: 12/05/2011

Domicile Status Comments:

Market Type: Individual

Individual Market Type:

Filing Status Changed: 12/16/2011

State Status Changed: 12/16/2011

Created By: Francine Cardon

Corresponding Filing Tracking Number:

RE: Sagicor Life Insurance Company

NAIC No.: 60445; FEIN: 74-1915841

Form Nos.: 5042 Individual Life Insurance Simplified Issue Application

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. The Application will be used for Term Life; Whole Life, and Universal Life products with a death benefit or face amount

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Project Name/Number: 5042/5042  
of \$250,000 or less.

5042 will be in paper, electronic and telephonic format. The application authorization, replacement and required notices, will be signed or given to the proposed insured prior to any telephonic application. If the application is completed telephonically, additional questions that would be asked if the proposed insured answers questions in a certain way, such as a "yes" response are attached under the Supplemental Documentation tab. If the application is taken telephonically the application will be signed at the time of delivery and attached to the policy. The free look period for the policies that will use 5042 gives the policyowner 30 days from the date of delivery to return the policy for a full refund of premium.

If the electronic format is utilized, all required signatures will be verified by assigning a code to the proposed insured/policyowner. If the agent is present, the agent must verify that the person signing is whom they claim to be, by asking for a government issued identification form, such as a passport or a driver's license. If the agent is not present, the signer must insert the code prior to viewing and signing the application.

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 forms without re-filing them with you.

Should you have any questions, please contact me toll-free at 480.425.5100 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  
4343 N. Scottsdale Road  
Suite 300  
Scottsdale, AZ 85251

Francine\_Cardon@sagicor.com  
480-425-5100 [Phone]  
480-425-5150 [FAX]

### Filing Company Information

Sagicor Life Insurance Company  
4343 N. Scottsdale Road

CoCode: 60445  
Group Code: 3766

State of Domicile: Texas  
Company Type:

SERFF Tracking Number: AMFD-127893509 State: Arkansas  
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Company Tracking Number: 5042  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: Individual Life Insurance Simplified Issue Application  
Project Name/Number: 5042/5042  
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.  
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Sagicor Life Insurance Company	\$100.00	12/13/2011	54497692

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	12/16/2011	12/16/2011

### Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Supporting Document	Additional Questions	Francine Cardon	12/14/2011	12/14/2011

*SERFF Tracking Number:* AMFD-127893509      *State:* Arkansas  
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## **Disposition**

Disposition Date: 12/16/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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<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>Supporting Document</b>	Additional Questions		Yes
<b>Form</b>	Individual Life Insurance Simplified Issue Application		Yes

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**Amendment Letter**

Submitted Date: 12/14/2011

**Comments:**

In reviewing the submission, inadvertently the additional questions that may be asked during the tele-interview were not attached. I have placed them under the Supporting Documentation tab.

Thank you,

Francine Cardon

**Changed Items:**

**Supporting Document Schedule Item Changes:**

**User Added -Name: Additional Questions**

Comment:

5042 Add Questions 12.2.11.pdf

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## Form Schedule

**Lead Form Number: 5042**

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	5042	Application/ Individual Life Enrollment Insurance Simplified Form Issue Application	Initial		50.900	5042 Simp Iss App file copy 12.12.11.pdf



LIFE INSURANCE COMPANY

# INDIVIDUAL LIFE INSURANCE SIMPLIFIED ISSUE APPLICATION

## LIFE INSURANCE APPLICATION - PART 1

### SECTION 1 – Proposed Insured Information

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

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

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

Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Telephone No: Home: \_\_\_\_\_ Other: \_\_\_\_\_

Government Issued Picture ID: Type/State: \_\_\_\_\_ Number: \_\_\_\_\_

Employer's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_ Annual Earned Income: \$ \_\_\_\_\_

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

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

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

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

Social Security Number: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Telephone No: Home: \_\_\_\_\_ Other: \_\_\_\_\_

Government Issued Picture ID: Type/State: \_\_\_\_\_ Number: \_\_\_\_\_

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

- Does the Proposed Owner have one of the following relationships with the Proposed Insured: Spouse, Child, Parent, Grandchild, Grandparent, Brother, or Sister?  Yes  No If "Yes", Relationship: \_\_\_\_\_
- 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 *(If there are Additional Beneficiaries, attach information on a separate sheet of paper.)*

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

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

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

**SECTION 3 – Beneficiary Information** *(continued)*

Contingent Beneficiary Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City State Zip Code  
Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Is the Contingent Beneficiary a U.S. Citizen?  Yes  No Alien Registration Number: \_\_\_\_\_

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

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(First) (MI) (Last)  
Street Address: \_\_\_\_\_  
City State Zip Code  
Social Security Number: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_  
Telephone No: Home: \_\_\_\_\_ Other: \_\_\_\_\_  
Government Issued Picture ID: Type/State: \_\_\_\_\_ Number: \_\_\_\_\_  
Is the Payor a U.S. Citizen?  Yes  No Alien Registration Number: \_\_\_\_\_

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

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

**SECTION 5 – Coverage Selection**

**Plan:** \_\_\_\_\_ Face Amount Applied For: \$ \_\_\_\_\_  
 Tobacco Rates  Non-Tobacco Rates  
 Accidental Death Benefit  Waiver of Premium  
 Waiver of Monthly Deductions (Universal Life)  
**Universal Life Elections (select one for each)**  
Guideline Premium Test  **OR** Cash Value Accumulation Test   
Death Benefit Option  A **OR**  B  
**Automatic Premium Loan Option (select one)** [ Yes  No] [(Whole Life Only)]  
Do you intend to finance the premium for this policy?  Yes  No *(If yes, Company will not issue policy)*  
Premium Class Quoted: \_\_\_\_\_ (Policy will be issued in the premium class quoted unless advised otherwise.)  
Premium Collected with Application: \$ \_\_\_\_\_ Transfer/1035 Exchange:  Yes  No Amount: \$ \_\_\_\_\_  
Planned Modal Premium: \$ \_\_\_\_\_ Draft Initial Premium:  Yes  No  
Mode:  Annual  Semi-Annual  Quarterly  Monthly EFT *(Complete an Electronic Funds Transfer (EFT) Authorization)*

**NOTICE:** State insurance law may prohibit the owner of a life insurance policy from entering into an agreement to sell, transfer, or assign a life insurance policy prior to the date the policy was issued, or within a period of time specified by state law after the date the policy was issued. You should consult with legal advisors if you have any questions about these matters.

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

- 1. Will any life insurance or annuity in this or any other company be replaced or changed as a result of this application? *(If YES, complete a Replacement Form.)*  Yes  No
- 2. Does the Proposed Insured:
  - a) Have any other life insurance or annuity in force?  Yes  No
  - b) Have any application (including reinstatement) for life insurance or annuity now pending?  Yes  No
- 3. Has the Proposed Insured applied for any life insurance or annuity in the last ninety (90) days?  Yes  No

Proposed Insured	Company	Policy #	Amount	Issue Date	Plan Type

**SECTION 7 – Initial Medical and Personal History Questions** **Proposed Insured**

- 1. Is the Proposed Insured currently receiving health care at home, or requires assistance with activities of daily living such as bathing, dressing, feeding, taking medications or use of toilet, etc?  Yes  No
- 2. Is the Proposed Insured currently in a Hospital, Psychiatric, Extended or Assisted Care, Nursing, Prison or Correctional facility?  Yes  No
- 3. 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
- 4. Has the Proposed Insured ever tested positive for or been diagnosed by a member of the medical profession as having Alzheimer's or Dementia, Cirrhosis, Emphysema or Chronic Obstructive Pulmonary Disease (COPD)?  Yes  No
- 5. **Has the Proposed Insured:**
  - a) In the past 12 months been advised by a physician to be hospitalized or to have Diagnostic Tests, Surgery, or any medical procedure that has not yet been completed or for which the results are not yet available?  Yes  No
  - b) In the past 24 months been 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 8 – Additional Information/Special Request or Instructions**


**SECTION 9 – 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 10 – Authorization and Acknowledgement**

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

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

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

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

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

To the best of my knowledge and belief, the statements and answers given on this application are true, complete, and correctly recorded. I understand that a policy does not go into effect and no liability exists for Sagicor until the policy is delivered and accepted by the Owner, the first full premium is paid, there has been no change in the health of the Proposed Insured that would change any of the answers in this application, and Sagicor has received an executed copy of both Part 1 and Part 2 of this application. I understand and agree that no producer may accept risks or pass upon insurability, make or modify contracts, or waive any of Sagicor's rights or requirements. I have received a copy of the “Disclosure Notice to Proposed Insured”, and when applicable, the “Accelerated Benefit Insurance Rider Disclosure Statement”.

To help the government fight the funding for terrorism and money laundering activities, federal law requires all financial institutions obtain, verify, and record information that identifies each person who opens an account. What this means for you: when you apply for life insurance, we will ask for your name, address, date of birth, and other information that will allow us to identify you. We will also ask to see your driver's license or other government issued photo identification. If you wish to have more detailed explanation of our information practices, please write to: Sagicor Life Insurance Company; Attention: Client Service Department; PO Box 52121; Phoenix, AZ 85072-2121.

**Under the penalties of perjury, by my signature on this application, I certify that: (1) the Social Security number shown on this application is my correct taxpayer identification number and, (2) I am not subject to back-up withholding either because I have not been notified by the IRS that I am subject to back-up withholding as a result of a failure to report all interest or dividends, or the IRS has notified me that I am no longer subject to back-up withholding.**

Signed: \_\_\_\_\_  
City State

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

\_\_\_\_\_  
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/Number (Please Print)

**SECTION 11 – This section should be completed by the Producer.**

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

Producer Name (Please Print)	Producer ID Number	% Split

Each licensed Producer will share equally unless otherwise indicated.

1. Have you delivered the consumer protection notices to the Proposed Owner and Proposed Insured?  Yes  No
2. Did you personally meet with the Proposed Owner and Proposed Insured, obtain their Social Security Number(s) and view for each a Government issued photo ID? (If **YES**, specify the type of ID and ID number. If **NO**, please explain why.)  Yes  No  
\_\_\_\_\_
3. If premium was accepted, was the Conditional Receipt completed and delivered to the Proposed Owner?  Yes  No
4. Does the Proposed Insured have any other life insurance or annuities currently in force or pending reinstatement?  Yes  No
5. Will any annuity or life insurance presently in force be replaced or changed by this policy that is being applied for? (If **YES**, and if required by state regulation, any Replacement Comparison, Notice, or Statement must accompany this application.)  Yes  No
6. Is this a 1035 Exchange? (If **YES**, attach all required forms.)  Internal  External  Yes  No
7. Is this a premium finance case? (If yes, Company will not issue policy)  Yes  No
8. How long have you known the Proposed Owner? \_\_\_\_\_ Proposed Insured? \_\_\_\_\_
9. Are you related to the Proposed Owner?  Yes  No Proposed Insured?  Yes  No  
If **YES**, how are you related? \_\_\_\_\_
10. Does the Proposed Owner understand and speak English?  Yes  No Proposed Insured?  Yes  No  
If **NO**, please explain: \_\_\_\_\_
11. Was any other person present to answer questions?  Yes  No  
If **YES**, who was present and why? \_\_\_\_\_
12. What is the purpose of this insurance purchase? \_\_\_\_\_
13. Do you know of anything not disclosed in this application that may affect the risk of this life insurance purchase?  
 Yes  No If **YES**, please explain: \_\_\_\_\_
14. Remarks: \_\_\_\_\_

**Producer's Certification**

I certify that I saw and know the Proposed Owner and Proposed Insured to be the person(s) described in this application, and have reviewed the appropriate documentation, and have truly and accurately recorded the information supplied by the Proposed Owner and Proposed Insured, that I know of no condition affecting the insurability of the applicant not fully set forth in the application, and that I have made no declaration, representation, or waiver regarding coverage or the provisions or terms of the application or policy. I further certify that I am licensed in the state in which this application was completed and have delivered all required notices and disclosures and fully complied with all privacy and replacement regulations. I also assume full responsibility for the delivery of the policy and the submission of the first premium.

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

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



LIFE INSURANCE COMPANY

## Disclosure Notice to Proposed Insured

**Leave with the Proposed Insured**

### Investigative Consumer Report Notice

You are our most important source of information, but personal information may also be collected from other sources. Such information may, in certain circumstances, be disclosed to third parties without your authorization.

An investigative consumer report may be prepared in which information is obtained from public records and through personal interviews with: your neighbors, friends, employers, business associates, financial sources, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics, and mode of living. You may request to be interviewed as part of the report. Upon written request to Sagicor, further information on the nature and scope of the report will be provided.

### Information Practices

Personal information we obtain during the underwriting process is private and confidential. We will not disclose such information to other persons or organizations without your written authorization, except to the extent necessary to conduct our business, as permitted by law, or as required by law. You have the right to be told about and obtain access to certain items or personal information in our files. You also have the right to request correction of information you believe to be inaccurate. If you would like to receive a more detailed explanation of our information practices, please write to:

Sagicor Life Insurance Company  
Attention: Client Service Department  
P.O. Box 52121  
Phoenix, AZ 85072-2121

### Medical Information Bureau (MIB) Notice

Information regarding your insurability will be treated as confidential. Sagicor or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau (MIB). The MIB is a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. If you apply to another MIB member company for life insurance or health insurance coverage, or a claim for benefit is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734. MIB's toll free number is 866-692-6901 or TTY 866-346-3642. Website [www.mib.com](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.

4343 N. Scottsdale Rd. #300, Scottsdale, AZ 85251 / T (888) 724-4267 / F (480) 425-5150



LIFE INSURANCE COMPANY

**Conditional Receipt ("Receipt")**

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

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

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

The policy you applied for will not become effective unless and until a policy is delivered to you, and all other conditions of coverage are met. Conditional insurance under the terms of the policy applied for may become effective as of the date the Proposed Insured completes in its entirety the tele-interview process to answer the questions in Part 2 of the application (the "Effective Date"). Such conditional insurance is subject to the conditions and limitations of this Receipt. Such conditional insurance will take effect as of the Effective Date, so long as all of the following requirements are met:

1. The Proposed Insured is found to have been insurable as of the Effective Date, exactly as applied for in accordance with Sagicor's underwriting rules and standards, without any modifications as to plan, amount, or premium rate;
2. As of the Effective Date, all of the Proposed Insured's statements and answers given in Part 1 of the application and during the tele-interview process for Part 2 of the application are true;
3. The payment accompanying the application is not less than the full initial premium for the mode of payment chosen in the application and is received at Sagicor's Home Office within the lifetime of the Proposed Insured; and
4. The following items have been signed and received at Sagicor's Home Office: Part 1 of the application; and any required supplemental application, questionnaire(s), addendum, and/or amendment to the application.

The aggregate amount of conditional coverage provided under this Receipt, if any, and any other conditional receipt(s) issued by Sagicor shall be limited to the lesser of the amount(s) applied for or \$250,000 of life insurance. There is no conditional coverage for riders or any additional benefits, if any, for which you have applied.

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

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

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

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

## 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.

<b>SECTION 12 A — Additional Medical and Personal History Questions</b> <i>(Record details to "Yes" answer in Section 12C below)</i>	<b>Proposed Insured</b>
---	-------------------------

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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Are you presently taking any medications prescribed by a doctor, hospital or other medical practitioner?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. <b>Your Current    Height                      Weight                      lbs.</b> Have you lost more than 20 lbs. in the past 12 months (other than diet or following pregnancy)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Are you currently disabled and/or receiving disability benefits?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. <b>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:</b>	
a) Cancer (other than Basal Cell Carcinoma)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) Heart or coronary artery disease or disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c) Stroke, transient ischemic attack (TIA), or other blood vessel disease or disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
d) Parkinson or Cerebral Palsy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
e) Kidney or Liver disease or disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
f) Epilepsy or seizure disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
g) Multiple Sclerosis (MS)?	<input type="checkbox"/> Yes <input type="checkbox"/> No

<b>SECTION 12 B — Additional Medical and Personal History Questions</b> <i>(Record details to "Yes" answer in Section 12C below)</i>	<b>Proposed Insured</b>
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6. <b>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:</b>	
h) Asthma, Chronic lung or pulmonary disease?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
j) Depression, Anxiety or other mental or emotional disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
k) Diabetes?	<input type="checkbox"/> Yes <input type="checkbox"/> No
l) Hepatitis B or C?	<input type="checkbox"/> Yes <input type="checkbox"/> No
m) High blood pressure (Hypertension)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
n) Pancreas disease or disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No

<b>SECTION 12 C – Details To All "Yes" Answers Above:</b>
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<b>SECTION 12 D – Preferred Classification Information</b>
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7. Family Member	Living?	Cause of Death?	Age of Death?
Mother	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Father	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Sister(s)	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Brother(s)	<input type="checkbox"/> Yes <input type="checkbox"/> No		



SERFF Tracking Number: AMFD-127893509 State: Arkansas  
Filing Company: Sagicor Life Insurance Company State Tracking Number: 50466  
Company Tracking Number: 5042  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: Individual Life Insurance Simplified Issue Application  
Project Name/Number: 5042/5042

## Supporting Document Schedules

	Item Status:	Status Date:
<b>Satisfied - Item:</b> Flesch Certification <b>Comments:</b> <b>Attachment:</b> 5042 Read Cert.pdf		

	Item Status:	Status Date:
<b>Bypassed - Item:</b> Application <b>Bypass Reason:</b> The application was placed under the Forms Schedule tab. <b>Comments:</b>		

	Item Status:	Status Date:
<b>Satisfied - Item:</b> Statement of Variability <b>Comments:</b> <b>Attachment:</b> 5042 SOV 12.12.11.pdf		

	Item Status:	Status Date:
<b>Satisfied - Item:</b> Additional Questions <b>Comments:</b> <b>Attachment:</b> 5042 Add Questions 12.2.11.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 #</u>	<u>Title</u>	<u>Flesch Score</u>
5042	Individual Life Insurance Application	50.9

Sagicor Life Insurance Company



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

December 12, 2011

Date

## STATEMENT OF VARIABILITY

### INDIVIDUAL LIFE INSURANCE APPLICATION

FORM # 5042

Page 2 – Section 5 – Coverage Selection

Products names or availability may change

Automatic Premium Loan Option (select one)

Additional products may be listed if the of option is added to other types of insurance. No other types of insurance would be listed without review and approval of the product.

**Additional Questions that may be asked for the Individual Life Insurance Application, form 5042.**

**Application Section 12 A – Additional Medical and Personal History Questions**

**Questions:**

**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\_\_\_**

• *NO = Proceed to next question*

• *YES = Drill Down:*

1. *What form of tobacco or nicotine products have you used in the past 24 months?*

**2. Are you presently taking any medications prescribed by a doctor, hospital or other medical practitioner?**

**YES\_\_\_ NO\_\_\_**

• *NO = Proceed to next question.*

• *YES = Drill Down:*

1. *What Medications are you presently taking?*

**3. Height\_\_\_ Weight\_\_\_ Have you lost more than 20 lbs. in the past 12 months (other than diet or following pregnancy)? YES\_\_\_ NO\_\_\_**

• *NO = Proceed to next question.*

• *YES = Drill Down ONLY if current height and weight is acceptable according to Build Tables:*

1. *How many lbs. have you lost?.*

2. *What was the reason for the weight loss?*

**4. Are you currently disabled and/or receiving disability benefits? YES\_\_\_ NO\_\_\_**

• *NO = Proceed to next question.*

• *YES = Eliminate Waiver of Premium and proceed to next question.*

**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:**

**Sub-Questions:**

**a) Cancer (other than Basal Cell Carcinoma)? YES\_\_\_ NO\_\_\_**

• *NO = Proceed to next Sub-question.*

• *YES = Drill Down:*

1. *What type of Cancer or Tumor did you have?*

2. *When did you complete your Cancer treatment or surgery?*

3. *Have you had a recurrence of any Cancer or Tumors?*

**b) Heart or coronary artery disease or disorder? YES\_\_\_ NO\_\_\_**

• *NO = Proceed to next Sub-question.*

• *YES = Drill Down:*

1. *What type of heart or coronary disease or disorder do you have?*

**c) Stroke, transient ischemic attack (TIA), or other blood vessel disease or disorder? YES\_\_\_ NO\_\_\_**

• *NO = Proceed to next Sub-question.*

• *YES = Drill Down:*

1. *What Condition were you treated for?*

**d) Parkinson or Cerebral Palsy? YES\_\_\_ NO\_\_\_**

• *NO = Proceed to next Sub-question.*

• *YES = (Applies to either condition) Drill Down:*

1. *Do you require assistance with activities of daily living such as bathing, dressing, feeding, taking medications, use of toilet, etc?*

**e) Kidney or Liver disease or disorder? YES \_\_\_ NO \_\_\_**

- NO = Proceed to next Sub-question.
- YES = Drill Down:
  1. What condition were you treated for?

**f) Epilepsy or seizure disorder? YES \_\_\_ NO \_\_\_**

- NO = Proceed to next Sub-question.
- YES = Drill Down:
  1. How was your Epilepsy or Seizures diagnosed or described as?
  2. How many seizures did you experience in the last year?

**g) Multiple Sclerosis (MS)? YES \_\_\_ NO \_\_\_**

- NO = Proceed to next question.
- YES = Drill Down:
  1. Do you require assistance with activities of daily living such as bathing, dressing, feeding, taking medications, use of toilet, etc?

## **Section 12 B – Additional Medical and Personal History Information**

### **Questions:**

**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:**

#### **Sub-Questions:**

**h) Asthma, Chronic lung or pulmonary disease? YES \_\_\_ NO \_\_\_**

- NO = Proceed to next Question.
- YES = Drill Dow:

If Asthma:

  1. Is your Asthma Chronic or requiring on-going treatment and medications?
  2. Or Seasonal or Allergic requiring temporary medication and treatment?
    - If Chronic Lung or pulmonary disease:
  3. What type of lung or pulmonary disease have you been treated for?

**i) Alcohol or drug use? YES \_\_\_ NO \_\_\_**

- NO = Proceed to next Sub-question.
- YES = Drill Down:
  1. Have you been a member of Alcoholics Anonymous, Narcotics Anonymous or similar organizations?
  2. Do you presently use Alcohol and/or drugs other than as prescribed by a Doctor or Medical Practitioner?

**j) Depression, Anxiety or other mental or emotional disorder? YES \_\_\_ NO \_\_\_**

- NO = Proceed to next Sub-question.
- YES = Drill Down:
  1. Do you know the diagnosis for the condition that you have received treatment for?
  2. Do you require assistance with activities of daily living such as bathing, dressing, feeding, taking medications, use of toilet, etc?

**k) Diabetes? YES \_\_\_ NO \_\_\_**

- NO = Proceed to next Sub-question.
- YES = Drill Down:
  1. Do you currently take Insulin?

**l) Hepatitis B or C? YES \_\_\_ NO \_\_\_**

- NO = Proceed to next Sub-question.

- YES = Drill Down:
  1. Were you diagnosed with Hepatitis B or C?
- m) High blood pressure (Hypertension)? YES\_\_\_ NO\_\_\_**
  - NO = Proceed to next Sub-question.
  - YES = Drill Down:
    1. Do you currently take any other medications in addition to the medication to control your high blood pressure (Hypertension)? YES\_\_\_ NO\_\_\_  
If 1 is: NO = Proceed to the next Sub-question  
If 1 is: YES = Drill Down:
    2. What is the name of the other medications you are taking?
- n) Pancreas disease or disorder? YES\_\_\_ NO\_\_\_**
  - NO = Proceed to next question.
  - YES = Drill down:
    1. Was your condition diagnosed or described as Pancreatitis? YES\_\_\_NO\_\_\_  
If 1. is: No = Proceed to next question  
If 1. is: YES = additional Drill-down:
    2. When was your condition diagnosed?

## **Section 12 D – Preferred Classification Information**

### **Questions:**

- **Are both of your parents alive? YES\_\_\_ NO\_\_\_**
  - YES = Proceed to next question.
  - NO = Drill Down:
    1. Which Parent is deceased?
    2. What was the Cause of death?
    3. What was his/her age at death?
- **Are your siblings (Brothers and Sisters) alive? YES\_\_\_ NO\_\_\_**
  - YES = Proceed to next question
  - NO = Drill Down:
    1. Which Sibling is deceased?
    2. What was the Cause of death?
    3. What was his/her age at death?
- **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\_\_\_**
  - NO = Proceed to next question
  - YES = Drill Down:
    1. What sports, hobby or activity have you participated in the past 24 months or plan to participate in?
- **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\_\_\_**
  - NO = Interview is complete
  - YES = Drill Down:
    1. What type of aircraft have you piloted?
    2. Do you currently have a Pilot Certificate?
    3. How many hours have you flown as a pilot in the past 12 Months?