RF&G LIFE INSURANCE COMPANY LIMITED

Application for the LEEP PLAN

Proposed Insured

First Name _____

Middle Name _____

Last Name _____

Address _____

Mailing Address _____

E-mail Address _____

Date of Birth _____ (dd/mm/yy) Age Last Birthday _____

Gender _____ Telephone numbers (O) _____ (H) _____ (M)_____

Are you a resident of Belize? Yes ☐ No ☐ Are you a citizen of Belize? Yes ☐ No ☐

Are you a citizen of any other country other than Belize? Yes ☐ No ☐

If yes, please state which country: _____

Insurance Applied For

Please Check One.

Sum Insured $6,000 ☐; $10,000 ☐ (Applicable to age range 25 to 70 only)

Special Option $15,000 (Applicable to age range 25 to 65 only)

Premiums Payable: Annually ☐; Semi Annually ☐; Quarterly ☐; Monthly ☐

How Paid: Cash ☐ Post dated cheque ☐ Salary deduction ☐ Credit Card ☐

Beneficiary

Name if Full _____

Date of Birth _____ (dd/mm/yy)

Relationship to Insured _____

Health Declaration

If the answer to any of the following question is “yes”, the proposed insured is ineligible for coverage.

a. Have you ever been treated for AIDS, ARC (Aids Related Complex) or any immunological disorder or have been diagnosed as HIV Positive?

Yes ☐ No ☐

b. Within the last two years, have you been diagnosed or treated for a heart attack or other heart disease, stroke, cancer, cirrhosis of the liver, chronic renal failure, insulin dependent diabetes, senile dementia or Alzheimer’s disease?

Yes ☐ No ☐

Declaration

In the event of my death as a result of or directly or indirectly related to Human Immune Deficiency or Acquired Immunological Deficiency or complications arising there from and my death occurs within seven years after the issue date or the date of the last reinstatement, if any, the benefit will be limited to a payment equal to the premiums paid to date.

Agreement: I warrant that the above answers are full and true and agree that this declaration shall be part of the basis of the policy, should one be granted; that, if the application is accepted, I will pay the first premium on the policy, and that the said policy shall have no effect until the first premium has been paid during my life and while my health and other conditions remain as described in this application.

Medical Authorization: For Underwriting and claim purposed, I hereby authorize any physician, hospital, clinic, insurance company, or other organization, institution or Government office that has medical information for me to provide the RF & G Life Insurance Company Limited with any such information. A photocopy of this authorization shall be as valid as the original.

Date at _____ the _____Day of _____ in the year of _____.

_____ _____

Witness Signature of the Proposed Insured