RF&G LIFE INSURANCE

CREDITOR LIFE APPLICATION FORM

APPLICANT

Name: _____

Address: _____

Contact Numbers: Home: _____ Cell: _____ Work: _____

Date of Birth: _____ Height: _____ Weight: _____

Occupation: _____

Exact Duties: _____

Name of Employer: _____

Address of Employer: _____

JOINT APPLICANT

Name: _____

Address: _____

Contact Numbers: Home: _____ Cell: _____ Work: _____

Date of Birth: _____ Height: _____ Weight: _____

Occupation: _____

Exact Duties: _____

Name of Employer: _____

Address of Employer: _____

POLICY DETAILS

Assignee (Financial Institution):_____

Address: _____Telephone Number:_____

Loan Information: Amount: $_____ Period: _____ Annual Interest Rate: _____%

Coverage required: Single Life ☐ Joint Life ☐

Mode of Payment: Annual ☐ Single ☐ Modal Premium: $ _____

HEALTH INFORMATION

		Applicant		Joint Applicant	
		Yes	No	Yes	No
1	Have you been diagnosed as having or been treated for human immunodeficiency virus (HIV) infection or any other acquired immune deficiency syndrome (AIDS) or AIDS related complex (ARC), significant weight loss, chronic fatigue or diarrhea, night sweats or enlarged glands?	☐	☐	☐	☐
2	Are you or any dependent (whether applying for coverage or not) currently pregnant, anticipating surgery or is anyone applying for coverage disabled, restricted or unable to perform the normal activities of daily living and self-care?	☐	☐	☐	☐
3	Have you ever applied and/or have been declined for Life or Health Insurance coverage with any Company?	☐	☐	☐	☐

	Applicant		Joint Applicant	
	Yes	No	Yes	No
4 Are you currently taking medication?	☐	☐	☐	☐
5 Is there any existing medical condition or problem, including any undiagnosed symptoms that have not otherwise been indicated on this application?	☐	☐	☐	☐
6 During the last 5 years have you been incapacitated from work for more than one week, suffering from any serious illness or injury, consulted any medical advisor or attended hospital?	☐	☐	☐	☐

Details to "Yes" answers (include dates, duration, name and addresses of doctors as applicable)

Applicant or Joint Applicant (specify)	Question #	Details

	Applicant		Joint Applicant	
	Yes	No	Yes	No
7 Are you now in good health?	☐	☐	☐	☐

Medical Advisor Name: _____

Medical Advisor Address: _____

DECLARATIONS/AUTHORIZATIONS

I hereby apply for life insurance to be issued solely and entirely in reliance upon the written answers to the foregoing questions and I agree that the insurance provided only covers the applicant and who is accepted. I have read the answers to the questions before signing this application and the answers are correctly written as given by me to the best of my knowledge; true and complete. I understand and agree that no coverage shall be in force until the policy premium is paid and the policy issued, that coverage will be in force as of the effective date shown in the policy.

I understand that no Agent is authorized to make change or notify in any way any applicable coverage section of the policy or to suppress any of the Company's requirements. If the policy is not accepted, the applicant is responsible for payment to RF&G Life Insurance Company Limited for medical and administrative expenses incurred in the process of evaluating the application for life insurance.

I hereby authorized any licensed Physician, Medical Practitioner, Hospital, Clinic or any other medically related facility, Insurance Companies, Medical information Bureau or any other organization, institution or person that has any records or knowledge of my health, to give RF&G Life Insurance Company Limited.

I further declare that:
(i) The Sum Assured under the Policy does not exceed the amount of the Loan, and
(ii) The Policy will be used as Collateral Security on the Borrower's Loan.

_____ (Applicant's Signature)

_____ (Joint Applicant's Signature)

_____ (Date)

_____ (Date)