

## PERSONAL FACT SHEET

P.O. Box 1109 GT, Mary Street  
Grand Cayman, Cayman Islands, B.W.I.

Please print or type all Information

1. <b>Proposed Insured</b> (First, middle, last)	Sex	Birth date	Age	Birth place
	<input type="checkbox"/> Male <input type="checkbox"/> Female	(Month, day, year)		(City & country)
Driver's license number and country		Home phone	Business phone	

2. <b>Residence Address of Proposed Insured</b>						
City	State/County	Region	Locality	Country	Postal code	Email Address

3. <b>Payor of Required Premiums (if different from proposed insured)</b>				Relationship to Proposed Insured
Birth date (Month, day, year)	Age	Birth place (City and country)		Email Address

4. <b>Plan of Insurance</b>	Face/Specified amount in U.S. \$	Premium mode and method	Amount remitted with this Personal Fact Sheet in U.S. \$
	\$		\$
If Universal Life, Death benefit <input type="checkbox"/> Option 1 <input type="checkbox"/> Option 2 (If Universal Life) First premium (may not be less than minimum premium for the mode selected)			
Planned periodic premium in U.S. \$		Minimum premium in U.S. \$	
\$		\$	
Source of Premium Funding			
Rider Name/Amount in U.S. \$	Rider Name/Amount in U.S. \$	Rider Name/Amount in U.S. \$	

5. <b>Spouse Proposed for Insurance</b> (First, middle, last)	Sex	Birth date	Age	Birth place
	<input type="checkbox"/> Male <input type="checkbox"/> Female	(Month, day, year)		(State & country)
Height Mtrs/ Ft	Weight now Lbs/ Kilos	Weight one year ago Lbs/ Kilos	Cause of any lost weight	
Driver's license number and country		(Specified) Amount or \$	Units	

6. <b>Occupation of Proposed Insured(s) or Payor if Proposed Insured is under age 21.</b>		List duties.
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7. <b>Employer of Proposed Insured(s) name and address</b> (Applies to Payor if Proposed Insured is under age 21.)
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**8. List all life insurance amounts in force on all persons proposed for insurance** (if none, so state).

Name of Person and Insurance Company	Year Issued	Amount of Personal Insurance	Amount of Business Insurance	Amount of Accidental Death Benefit
		\$	\$	\$
		\$	\$	\$
		\$	\$	\$
		\$	\$	\$
		\$	\$	\$

**Will the policy applied for replace or change any insurance or annuity currently in force with this or any other company on the life of the persons proposed for insurance?**  No  Yes

Have you replaced a life insurance policy in the past three years?  No  Yes

Replaced two or more times in the last five years?  No  Yes If Yes, give name and reason.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Is any application for life or health insurance pending in this or any company?  No  Yes If Yes, give name, company and details.

Name	Company	Policy number	Issue year	Face amount U.S. \$	Acc. death benefit amt. U.S. \$
				\$	\$

**9. Send premium notice to:**  Proposed Insured Residence  Proposed Insured Business Address  Other

Name	Address	City	Country	Postal code

**10. Name of owner, if other than Proposed Insured, or Applicant** (Include contingent owner, if any.)

Name	Owner's Identification Number

**11. Beneficiary Designation** (Print full name(s) and relationship to Proposed Insured).

Name	%	Relationship	Identification Number

Contingent Beneficiary:

**12. Has the person(s) proposed for insurance:**

Yes No

- A.   In the last 3 years flown or plans to fly, as a pilot, student pilot or crew?
- B.   Traveled or resided or plans to travel or reside outside of the resident country?
- C.   Ever been convicted of a crime?
- D.   Had 2 or more automobile violations in the past 3 years, been convicted of driving while intoxicated, or ever had driver's license suspended or revoked?
- E.   In the last 3 years, engaged in, or intends to engage in, sky or scuba diving, hang-gliding, rock climbing, or any form of motorized racing?
- F.   Received advice or treatment from a member of the medical profession for the use of alcohol or drugs, or been convicted of using, selling, or possessing any narcotics, stimulant, sedative or hallucinogenic drug in the past 10 years?
- G.   Ever been advised by a physician to quit using tobacco for health reasons?
- H.   Ever been declined for insurance, had a policy rated, modified in any way or denied reissue, reinstatement or renewal of a policy?

**Details of Yes answers for question 12** (Include proposed insured, dates, duration, attending physicians, and questionnaire for A & E)

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**13. Special Features requested, such as policy date, risk classification, issue instructions**

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**14. Proposed Insured Tobacco Use?**  Never  Present  Former

Check type: \_\_\_\_\_ Month / Year quit \_\_\_\_\_ # Years as a smoker \_\_\_\_\_ # Packs per day \_\_\_\_\_  
 smokeless  cigar cigarette  pipe

**15. Proposed Insured**

Height \_\_\_\_\_ Weight: current \_\_\_\_\_ Weight one year ago \_\_\_\_\_ Cause of any weight loss \_\_\_\_\_  
Mtrs/ Ft \_\_\_\_\_ Lbs/ Kilos \_\_\_\_\_ Lbs/ Kilos \_\_\_\_\_

	Month / Year of Last Exam	Results
Sigmoidoscopy	_____	_____
Prostate Exam	_____	_____
Mammogram	_____	_____
Breast Exam	_____	_____

**Annual income** \_\_\_\_\_ Estimated net worth \_\_\_\_\_ Ever filed bankruptcy? \_\_\_\_\_  
\$ \_\_\_\_\_ \$ \_\_\_\_\_  Yes  No

**Exercise Activities—**aerobic / muscle strengthening / toning

Month / Year Started \_\_\_\_\_ Times/Week \_\_\_\_\_ Duration \_\_\_\_\_

**Regular Physician**

Name (First, middle, last) \_\_\_\_\_ Address \_\_\_\_\_ City \_\_\_\_\_ State/County \_\_\_\_\_  
Region \_\_\_\_\_ Locality \_\_\_\_\_ Country \_\_\_\_\_ Postal Code \_\_\_\_\_ E-mail address \_\_\_\_\_  
Telephone \_\_\_\_\_ Date of last visit \_\_\_\_\_ Reason for/result of last visit \_\_\_\_\_

**16. In the past 10 years, has any person proposed for insurance been treated for or had:**

Yes No (If Yes, circle each applicable item.)

- A.   Any disease or disorder of eyes, ears, nose or throat?
- B.   Dizziness, fainting, convulsions, head injury, headaches, speech defect, paralysis or stroke, tremor, muscle weakness, depression, other mental or nervous disorder?
- C.   Shortness of breath, persistent hoarseness or cough, blood spitting, bronchitis, pleurisy, asthma, emphysema, tuberculosis or chronic respiratory disorder?
- D.   Chest pain, palpitations, high blood pressure, rheumatic fever, heart murmur, varicose veins, phlebitis, or other heart or blood vessel disorder?
- E.   Hepatitis, ulcer, hernia, colitis, diverticulitis, recurrent indigestion, or other disorder of the stomach, intestines, liver, gall bladder, pancreas, or spleen?

- F.   Sugar, albumin, blood or pus in urine, sexually transmitted or venereal disease, stone or other kidney, bladder, prostate or reproductive organ disorder?
- G.   Allergies, anemia, bleeding tendency or other disorders of the blood?
- H.   Neuralgia, neuritis, sciatica, rheumatism, arthritis, gout, or disorder of the muscles or bones including the spine, back and joints?
- I.   Disorder of the skin or lymph glands, cyst, tumor or cancer?
- J.   Persistent fever, night sweats, chills, and/or diarrhea?
- K.   Diabetes, thyroid or other endocrine disorder?
- L.   Diagnosis or treatment for AIDS by a member of the medical profession?
- M.   Any mental or physical disorder not listed; had or been advised to have any checkup, consultation, illness, injury, hospitalization, treatment or surgery including an EKG, X-ray or other diagnostic test, not already listed?

17.   Is any person proposed for insurance receiving treatment or taking any medication?

**18. Family History**

	Age						
	if living	or	at death		Cancer History?		Heart Diseases/Circulatory Disorder?
Mother	_____		_____	<input type="checkbox"/> No <input type="checkbox"/> Yes, since age _____		<input type="checkbox"/> No <input type="checkbox"/> Yes, since age _____	_____
Father	_____		_____	<input type="checkbox"/> No <input type="checkbox"/> Yes, since age _____		<input type="checkbox"/> No <input type="checkbox"/> Yes, since age _____	_____
Siblings	_____		_____	<input type="checkbox"/> No <input type="checkbox"/> Yes, since age _____		<input type="checkbox"/> No <input type="checkbox"/> Yes, since age _____	_____
Siblings				<input type="checkbox"/> No <input type="checkbox"/> Yes, since age _____		<input type="checkbox"/> No <input type="checkbox"/> Yes, since age _____	_____

19.  Yes  No In the past 90 days, has any person proposed for insurance been admitted to a hospital or other medical facility, been advised to be admitted, contemplated surgery, or had surgery performed or recommended?

Yes  No In the past two years, has any person proposed for insurance been treated by a member of the medical profession for heart disease, stroke, cancer or AIDS, or had such treatment recommended?

**Details of Yes answers for questions 16,17, and 19** (include item #, proposed insured, dates, duration, medication, name and address of physicians)

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\_\_\_\_\_

\_\_\_\_\_

**Power of Attorney**

I hereby grant a limited and specific Power of Attorney to HSBC International Trustee Limited located in Grand Cayman as my attorney-in-fact ("Attorney"). Said Attorney accepts this appointment subject to its terms and is directed to do, undertake and perform the following acts on my behalf, without posting a bond:

- (i) Execute any and all necessary and convenient applications /documents to apply for life insurance coverages underwritten by the Direct Life Insurance Segregated Portfolio of CNA International Life Company, SPC, Ltd of Grand Cayman("Insurance Company"). In making such application for life insurance, my Attorney shall disclose all of the information contained in this Personal Fact Sheet plus any additional information that is reasonably requested by Insurance Company to enable Insurance Company to properly underwrite the risk.
- (ii) Deliver any funds that represent premiums for life insurance coverages to Insurance Company or its designee.
- (iii) Take physical delivery of the insurance policy issued by Insurance Company and to execute any document so requested by Insurance Company as evidence of receipt of the insurance policy.

The authority herein shall include such incidental acts as are reasonably required to carry out and perform the specific authorities granted herein.

The Attorney-in-fact shall be entitled to rely upon the facts as stated in this Personal Fact Sheet by the Proposed Insured and/or the Applicant as being true and accurate and shall not be liable or responsible for any mistake, misrepresentation, dishonest or fraudulent statements contained herein. The Attorney-in-fact or any of its Directors, Officers or employees shall not be liable for any damage, loss, costs or expenses whatsoever to the Proposed Insured, the Applicant or the Insurance Company at any time howsoever caused. The Proposed Insured and/or the Applicant shall be solely responsible and liable for any mistake, misstatement or misrepresentation, whether willful or fraudulent or otherwise, contained herein.

The Proposed Insured and the Applicant, if other than the Proposed Insured, agrees that: (1) all statements and answers in this Personal Fact Sheet are complete, true and correctly recorded; (2) the information contained in this Personal Fact Sheet will be used by my Attorney-in-Fact to execute an Application for Life Insurance with the Insurance Company, and that no such Application is submitted until executed by my Attorney-in-Fact; (3) if the Application submitted by my Attorney-in-Fact is accepted by the Insurance Company, the policy applied for and the Application submitted by my Attorney-in-fact will constitute the entire insurance policy, and the entire insurance policy will be delivered to my Attorney-in-Fact; (4) I understand and agree that the terms and conditions of any insurance policy issued in response to the Application executed and submitted by my Attorney-in-fact in the Cayman Islands shall be governed by and construed in accordance with the laws of the Cayman Islands, and I agree to submit to the jurisdiction of the courts of the Cayman Islands. Any legal suit, action or proceeding arising out of or relating to this Personal Fact Sheet and/or the policy to be issued is subject to the exclusive jurisdiction of the courts of the Cayman Islands. The Proposed Insured acknowledges having received and read the Notice to the Proposed Insured and the Medical Information Notice.

Executed as a Deed at (City) \_\_\_\_\_ (Country) \_\_\_\_\_ this \_\_\_\_ day of \_\_\_\_\_ (month,year).

X \_\_\_\_\_ X \_\_\_\_\_ | \_\_\_\_\_  
 Applicant (if other than Proposed Insured)      Signature of Proposed Insured      Identification number

X \_\_\_\_\_ X \_\_\_\_\_  
 Official capacity (if signed on behalf of a corporation, trust, etc.)      Witness

I certify to the best of my knowledge the answers to the questions in all parts of this Personal Fact Sheet are true and correct. I further certify to the best of my knowledge this policy  will  will not replace or change any existing life insurance or annuity policy now in force.

X \_\_\_\_\_  
 Broker (Witness)      Broker #

**Authorization To Obtain and Release Information**

I HEREBY AUTHORIZE any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsuring company, the Medical Information Bureau, Inc., or consumer reporting agency, having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment, including psychiatric conditions, drug or alcohol abuse, and any other medical or non-medical information about me or my health to give to CNA International Life Company its legal representatives, or its reinsurers any and all such information.

To facilitate rapid submission of such information, I authorize all said sources, except MIB, to give such records or knowledge to any agency employed by the Company to collect and transmit such information.

I UNDERSTAND the information obtained by use of this Authorization will be used by CNA International Life Company to determine eligibility for insurance. Any information obtained will not be released by CNA International Life Company to any person or organization EXCEPT to reinsuring companies, the Medical Information Bureau, Inc., or other persons or organizations performing business or legal services in connection with my Personal Fact Sheet, or as may be otherwise lawfully required or as I may further authorize.

I UNDERSTAND that I may request to receive a copy of this Authorization.

I AGREE that a photographic copy of this Authorization shall be as valid as the original.

I ACKNOWLEDGE having received and read the Notice to the Proposed Insured and the Medical Information Bureau Notice.

I AGREE that this Authorization shall remain valid for two years from its date.

X \_\_\_\_\_  
 Proposed Insured      Witness Broker  
 (if signing on behalf of Proposed Insured, specify relationship/authority)      Date (month, day, year)

**Requirements Ordered**

Date Submitted: \_\_\_\_\_

	Blood	HOS	MED	INSP	APS	EKG	QUEST	Other
Proposed Insured 1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Proposed Insured 2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Broker's Report**

**This report should always be completed and remain attached to the Personal Fact Sheet.**

**Purpose of Insurance**  Personal:  Estate Creation  Family Protection  Charitable  Other  
 Business:  Key Person  Buy-Sell  Creditor  Sole Proprietor  Corporation  Other  
 If business, are other business associates being insured?  Yes  No If "No" give explanation below.

\_\_\_\_\_  
 \_\_\_\_\_

**History of Proposed Insured(s)**

How long have you known the proposed insured(s)? \_\_\_\_\_  
 Friend  Acquaintance  Existing Client  Relative  Stranger

Prior Residence and Business Name and Address if current is less than 5 years:  
 \_\_\_\_\_  
 \_\_\_\_\_

**Amount of Insurance**

The death benefit amount was determined by (check all that apply):  
 Insured  Needs Analysis Software  Needs Analysis Manual  Multiple of Income  
 Cost of Final Expenses  Other \_\_\_\_\_

**Premiums:**

Annual U.S.\$ \_\_\_\_\_ Modal premium U.S.\$ \_\_\_\_\_ Rate class quote \_\_\_\_\_

Source of premium funding \_\_\_\_\_

**Cash with Personal Fact Sheet**

Check one:  No payment was accepted with Personal Fact Sheet.  
 Payment was received with the Personal Fact Sheet (Agent checks will not be accepted)

\_\_\_\_\_  
 Amount of payment U.S.\$ \_\_\_\_\_ Date received \_\_\_\_\_

**Explanations and Special requests**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Commission Credit**

Writing Broker \_\_\_\_\_ code \_\_\_\_\_ Split % \_\_\_\_\_  
 Regional Broker \_\_\_\_\_ code \_\_\_\_\_ Split % \_\_\_\_\_  
 Managing General Agent/Sales Office \_\_\_\_\_ code \_\_\_\_\_ Split % \_\_\_\_\_  
 Life Sales Rep \_\_\_\_\_ code \_\_\_\_\_ Split % \_\_\_\_\_

I represent that (1) I did personally see the proposed insured when the Personal Fact Sheet was taken; (2) I truly and accurately recorded in this Personal Fact Sheet the information as supplied by the owner and the proposed insured; (3) to the best knowledge and belief there is nothing adversely affecting the insurability of the proposed insured other than as indicated in this Personal Fact Sheet; and (4) the written disclosure statement as given on or before the date the Personal Fact Sheet was signed.

Writing Broker X \_\_\_\_\_ Date \_\_\_\_\_

Broker X \_\_\_\_\_ Date \_\_\_\_\_

Broker X \_\_\_\_\_ Date \_\_\_\_\_

## **Notice To Proposed Insured**

### **Detach—leave with applicant**

In order to properly underwrite and administer your insurance coverage we must collect certain necessary and helpful information concerning your insurability. You are our most important source of information, but we must also contact other sources, including medical professionals and institutions, employers, and other insurance companies.

We may obtain an investigative consumer report whereby information as to your character, general reputation and personal characteristics are secured through personal interviews with your friends, neighbors and others with whom you are acquainted.

In some situations, and in compliance with applicable law, we may disclose necessary items of information to third parties without your specific authorization.

## **Notice Regarding Medical Information Bureau**

### **Please Read Carefully**

Information regarding your insurability will be treated as confidential. CNA International Life Company or their reinsurer(s) may, however, make a brief report to the Medical Information Bureau, a nonprofit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file. CNA International Life Company or their reinsurer(s) may also make information in its file available to other life insurance companies to whom you may apply for life or health insurance, or to whom you submit a claim for benefits. It is our understanding that upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112 USA.