

AMERICAN-AMICABLE LIFE INSURANCE COMPANY OF TEXAS

P.O. BOX 2549, WACO, TX 76702-2549 • (254) 297-2777

INDIVIDUAL LIFE INSURANCE APPLICATION (Please print in black ink)

Telephone Case No: _____

Proposed Insured: _____ <small>(First) (Middle) (Last)</small> Address: (No. & Street) _____ City: _____ State: _____ Zip Code: _____	Telephone interview done (if applicable) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> am <input type="checkbox"/> pm Phone _____ Best time to call _____ E-mail Address _____ @ _____
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<input type="checkbox"/> Sex	Date of Birth	Age	State of Birth	SS#	DL#	Height	Weight
<input type="checkbox"/> Male	Mo. Day Yr			— —		ft in	lbs
<input type="checkbox"/> Female	/ /				State of Issue		

Occupation/Duties: _____ **Hire date (MM/YY):** _____ **Annual Salary: \$** _____

Owner: Name _____ SS# _____ Address: _____

Payor: Name _____ SS# _____ Address: _____

Primary Primary Beneficiary _____ SS# _____ Relationship _____

Insured: Contingent Beneficiary _____ SS# _____ Relationship _____

Plan: _____ **Face Amount \$** _____ Non-Tobacco Tobacco Preferred Non-Tobacco
 Have you used tobacco or nicotine products in any form in the past 12 months? Yes No.....or during the past 36 months? Yes No

Riders: Waiver of Premium Unemployment Rider Return of Premium Other: _____
 Critical Illness % Child Rider (complete Form No. 3215) Units ADB \$
 Disability Income \$ Spouse Level Term \$

Mode: Bank Draft Draft 1st Prem on Req. Date Other Modal Prem \$ **CWA:** E-Check Immediate 1st Prem Collected \$ **Mail Policy To:** Agent Insured Owner
Policy Date Request: / /

Physician: Name: _____ City/State _____ Phone: _____

List current prescribed medications: _____

SECTION A: Health Questions-Answer Questions 1 through 4 for Proposed Insured. (circle all conditions that apply)

1. **Within the past 10 years**, have you been treated for, or tested positive for, or been diagnosed by a medical professional with:
 - a. high blood pressure, high cholesterol, heart attack, angina (cardiac chest pain), angioplasty, bypass surgery or stent, pacemaker or defibrillator, cardiomyopathy, congestive heart failure (CHF), irregular heartbeat, peripheral vascular disease (PVD), carotid artery disease, or any heart or circulatory disease or disorder? Yes No
 - b. stroke, transient ischemic attack (TIA), amputation caused by disease, aneurysm, hemophilia, or anemia? Yes No
 - c. diabetes, cirrhosis, hepatitis, pancreas disorder, Crohn's disease, ulcerative colitis, or any digestive or liver disease or disorder?..... Yes No
 - d. asthma, emphysema, chronic obstructive pulmonary disease (COPD), sleep apnea, or any respiratory or lung disease or disorder? Yes No
 - e. cancer in any form, Hodgkin's disease, leukemia, lymphoma, multiple myeloma, or organ transplant? Yes No
 - f. migraine headaches, seizures, bi-polar disorder, schizophrenia, Alzheimer's, memory loss, dementia, anxiety or depression, mental retardation, mental incapacity, mental or nervous disorder, psychiatric disorder, or a suicide attempt? Yes No
 - g. any disease or disorder of the kidneys, urinary bladder, prostate, breast, reproductive organs, or sexually transmitted disease? Yes No
 - h. connective tissue disease, systemic lupus (SLE), multiple sclerosis, Parkinson's, cerebral palsy, muscular dystrophy, cystic fibrosis? Yes No
 - i. arthritis, paralysis of two or more extremities or any disorder of the back, joints, muscles, or nervous system?..... Yes No
 - j. any other disease or disorder, injury, surgery, birth defect, or deformity? Yes No
 - k. Acquired Immune Deficiency Syndrome (AIDS), or any immune deficiency related disorder or the Human Immunodeficiency Virus (HIV)? Yes No
2. Are you currently unemployed due to medical reasons or been prohibited from actively working full time (30 hours or more per week) at your regular occupation due to any illness, injury, or health related problem, or are you currently receiving benefits, compensation, or pension for disability?..... Yes No
3. Are you currently hospitalized, confined to a nursing facility, receiving Hospice Care or home health care, or do you require assistance (from anyone) with activities of daily living such as bathing, dressing, eating or toileting?..... Yes No
4. **Within the past 12 months**, have you:
 - a. consulted a medical professional, had surgery, or been hospitalized, or had diagnostic tests (excluding HIV/AIDS) such as EKG, Xray, MRI, CAT scan? Yes No
 - b. had any diagnostic testing (excluding HIV/AIDS), surgery, or hospitalization recommended by a medical professional which has not been completed or for which the results have not been received, or been referred to a medical professional? Yes No
 - c. been declined, postponed, rated, or modified for life or medical insurance? Yes No

SECTION B: Give details to all "Yes" answers in Section A and list current medications (use COMMENTS section on back for additional space).

Condition	Dates	Treatment	Name/Address/Phone No. of Physician/Hospital
	/ /		
	/ /		
	/ /		

SECTION C: Answer Questions 1 through 5 for Proposed Insured. (circle all conditions that apply)

1. Have you had a natural parent or sibling diagnosed or treated by a licensed medical professional for diabetes, kidney disease, require a major organ transplant, or been medically diagnosed with heart disease, cerebrovascular disease, internal cancer prior to age 60? (If yes, list in COMMENTS section: name, relationship, age at onset, medical condition, age if living or age at death.) Yes No
2. a. **Within the next 24 months**, do you intend to work, travel, or reside outside of the U.S. for more than 30 days? Yes No
If yes, where? _____
- b. **Within the past 24 months**, have you made or contemplated making any flights as a pilot, student pilot, or crew member of any aircraft? Yes No
3. a. **Within the past 5 years**, have you pled guilty to or been convicted of a felony or misdemeanor (including DUI or DWI) or do you have such charge currently pending against you or have you had a driver's license suspended or revoked or is currently suspended or revoked, have you plead guilty to or been convicted of any motor vehicle violations or **within the past 6 months**, have you been on probation or parole? Yes No
- b. **Within the past 5 years**, participated in motorized racing, hang gliding, rock or mountain climbing, rodeo events, sky diving, or skin or scuba diving? Yes No
4. **Within the past 10 years**, have you used illegal drugs, or abused alcohol or drugs, or had or been recommended by a medical professional or a licensed counselor to discontinue the use of alcohol or drugs or to have treatment or counseling for alcohol or drugs? Yes No

5. Do you have any existing life or disability insurance or annuity contract? <input type="checkbox"/> Yes <input type="checkbox"/> No		Company
Will you replace or change an existing life or disability insurance policy or an annuity? <input type="checkbox"/> Yes <input type="checkbox"/> No	Policy #	Coverage Amount \$

COMMENTS: _____

AGREEMENT—I agree with American-Amicable Life Insurance Company of Texas (the Company) as follows: (1) To the best of my knowledge and belief, and with the intent to induce the Company to issue the plan of insurance, all answers and statements contained in this application are true, complete, and correctly recorded; and (2) This application, supplemental applications, addendums, amendments, questionnaires, and any policy issued on the basis of such applications shall form the entire contract; and (3) No change in this contract shall be effected without my written consent with regard to: (a) the amount of insurance; (b) age at issue; (c) classification of risk; (d) plan of insurance; or (e) benefits. If this application is declined by the Company, I will accept the return of any premium paid. 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.

AUTHORIZATION—In order to properly classify my application for life insurance, I authorize any and all physicians, medical practitioners, hospitals, clinics, medical or medically-related facilities, health plans, pharmacy benefit managers, pharmacies or pharmacy-related facilities; insurance companies and their business associates and those persons or entities providing services to the insurer's business associates which are related in any way to their insurance plans; the [MIB, LLC (MIB)] or other organization that has knowledge or records of me and my health to give such information to: (a) American-Amicable Life Insurance Company of Texas; and (b) its reinsurers. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information. This medical or health information includes information on the diagnosis and treatment of mental illness, alcohol, and drug use. This also includes information on the diagnosis, treatment, and testing results related to HIV, AIDS, and sexually transmitted diseases, unless otherwise restricted by state law. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization or the insurance company exercises a legal right to contest a claim or the policy itself. I may revoke the authorization by sending a written revocation to the Company address of 425 Austin Ave., Waco TX 76701. I understand that if I refuse to sign this authorization to release my complete medical records, my application for insurance with the Company will be rejected.

All said sources, except the MIB, are authorized to give records or knowledge such as statements regarding hobbies, employment, criminal records or medical history that might be required to determine eligibility for insurance to any agency employed by the Company to collect and transmit data. I authorize American-Amicable Life Insurance Company of Texas to disclose any personal data gathered while processing this application. This data may be released to the following: (a) reinsuring companies; (b) the MIB; (c) other persons or groups performing services in connection with this application; or (d) any others to whom it may be lawfully required or authorized. This authorization shall remain valid for the time limit, if any, permitted by applicable law in the state where the policy is delivered or issued for delivery. A copy of this authorization shall be as valid as the original.

ACKNOWLEDGEMENT

I acknowledge receiving the Fair Credit Reporting Act Notice, the MIB Pre-Notice, the Terminal Illness Accelerated Benefit Rider and Confined Care Accelerated Benefit Rider Disclosure Forms, if applicable.

Signed at (City) _____ (State) _____ Date of Application (MM/DD/YY) _____

SIGNATURE OF PROPOSED INSURED

SIGNATURE OF OWNER (IF OTHER THAN PROPOSED INSURED)

SIGNATURE OF SPOUSE (IF APPLYING FOR COVERAGE)

AGENT'S REPORT

I certify that I have personally asked each question on this application to the proposed insured(s), I have truly and completely recorded on the application the information supplied by him/her, and I witnessed their signature. I certify that the Accelerated Living Benefit Rider Disclosure Form, the Terminal Illness Rider Disclosure Form, the Confined Care Accelerated Benefit Rider and Chronic Illness Accelerated Death Benefit Rider Disclosure Forms have been presented to the applicant, if applicable.

Agent's Remarks: _____

- Does the proposed insured have any existing life or disability insurance or annuity contract? Yes No
- Is the proposed insurance intended to replace or change any existing life or disability insurance or annuity? Yes No
- Has the proposed insured applied for any life insurance or annuity in the last ninety (90) days? Yes No

Agent Signature _____ Agent Printed Name _____ No: _____ %
 Agent Signature _____ Agent Printed Name _____ No: _____ %

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CONDITIONAL RECEIPT

NO COVERAGE WILL BECOME EFFECTIVE PRIOR TO POLICY DELIVERY UNLESS AND UNTIL ALL CONDITIONS OF THIS RECEIPT ARE MET. NO AGENT HAS THE AUTHORITY TO ALTER THE TERMS OR CONDITIONS OF THIS RECEIPT.

ALL PREMIUM CHECKS MUST BE PAYABLE TO THE COMPANY
DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE PAYEE BLANK

Received of _____ the sum of \$ _____ as first payment on this application.

Date _____ Agent _____

If (1) an amount equal to the first full premium is submitted; and if (2) all underwriting requirements, including any medical examinations required by the Company's rules, are completed; and (3) the proposed insured is, on the date of application, a risk acceptable for insurance exactly as applied for without modification of plan, premium rate, or amount under the Company's rules and practices, then insurance under the policy applied for shall become effective on the latest of (a) the date of application, or (b) the date of the latest medical exam required by the Company. THE AMOUNT OF LIFE INSURANCE, INCLUDING ANY AMOUNT IN FORCE OR BEING APPLIED FOR, WHICH MAY BECOME EFFECTIVE PRIOR TO THE DELIVERY OF THE POLICY SHALL IN NO EVENT EXCEED \$150,000 (INCLUDING LIFE INSURANCE AND ACCIDENTAL DEATH BENEFITS).

If any of the above conditions are not met, the liability of the Company shall be limited to the return of any amount paid.

NOTICE

Printed in compliance with Public Law 91-508

Thank you for considering American-Amicable Life Insurance Company of Texas for your insurance needs. This is to inform you that as part of our procedure for processing your insurance application, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation and personal characteristics. You have the right to make a written request within a reasonable period of time to receive additional detailed information about the nature and scope of this investigation.

MIB PRE-NOTICE

Information regarding your insurability will be treated as confidential. American-Amicable Life Insurance Company of Texas, or its reinsurers, may, however, make a brief report thereon to the MIB, formerly known as Medical Information Bureau, a not-for-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 or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information 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 procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is [50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.]

American-Amicable Life Insurance Company of Texas, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.