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 Number_____

Proposed Insured: _____ (First) (Middle) (Last)
Address: (No. & Street) _____
City: State: Zip Code:

Telephone interview done (if applicable) ☐ Yes ☐ No ☐ am ☐ pm
_____ _____
Phone Best time to call
E-mail Address

Sex	Date of Birth	Age	State of Birth	SS# — —	Height: ____ft___in	Occupation: _____
☐ Male ☐ Female	Mo. Day Yr / /			DL# SOI	Weight: lbs	Annual Salary: $

Owner: Name _____ SS#_____ Address:_____
Payor: Name SS# Address:

Primary Insured: Primary Beneficiary _____ SS#_____ Relationship _____
Contingent Beneficiary SS# Relationship

Plan: Decreasing Term Life Insurance
Monthly Income Death Benefit: $_____
Level Term Period: ☐ 15 ☐ 20 ☐ 25 ☐ 30 ☐ To Age 70

During the past 12 months have you used tobacco in any form (excluding occasional pipe and cigar use)? ☐ Yes ☐ No

Riders: ☐ Waiver of Premium ☐ Disability Income $_____ ☐ FIA_____Units
☐ ADB $_____ ☐ Accident Only DIR $_____ ☐ CIA_____Units
☐ Waiver of Premium for Unemployment ☐ Other

Policy Date Request: / /

Mail Policy: ☐ Agent ☐ Insured ☐ Owner

Mode: ☐ Bank Draft ☐ Draft 1st Prem on Req. Date ☐ Payroll Deduction
☐ Qtrly ☐ Other Modal Prem $

CWA: ☐ E-Check Immediate 1st Prem
☐ Collected $

Do you have any existing life or disability insurance or annuity contract? ☐ Yes ☐ No
Will you replace an existing life or disability insurance policy or an annuity? ☐ Yes ☐ No

Company
Policy # Amt Cov $

Other Proposed Insureds: Name	Rider	Amt.	Sex	Birthdate	St. of Birth	Height	Weight	Relationship

SECTION A: Answer Questions 1, 2, and 3 for all Proposed Insureds.

1. Has any Proposed Insured been diagnosed or treated by a medical professional for, taken medication for or currently under treatment for *(circle condition that applies):*
   a. high blood pressure, heart attack, angina, arrhythmia, aneurysm, stroke, TIA, heart or circulatory disease or disorder? ..... Yes ☐ No ☐
   b. diabetes, pancreas disorder, hepatitis, Crohn's Disease, ulcerative colitis, liver or digestive disease or disorder? ..... Yes ☐ No ☐
   c. cancer in any form, lung disease or disorder, seizures, mental or nervous disorder, bipolar disorder, paralysis, blindness? ..... Yes ☐ No ☐
   d. any disease or disorder of the kidneys, urinary bladder, prostate, reproductive organs, or sexually transmitted disease? ..... Yes ☐ No ☐
   e. connective tissue disease, systemic lupus (SLE), anemia, arthritis, or any disorder of the back, joints, muscles?..... Yes ☐ No ☐
   f. any other disease or disorder, injury, surgery **within the past 24 months**? ..... Yes ☐ No ☐
2. **Within the past 2 years** has any proposed insured participated in parachuting, hang gliding, rock or mountain climbing, rodeo events, sky diving, scuba diving, organized racing of any kind, any professional sport, or aviation? ..... Yes ☐ No ☐
3. Has any Proposed Insured:
   a. been medically treated or diagnosed by a medical professional as having Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC), or any immune deficiency related disorder or tested positive for the Human Immunodeficiency Virus (HIV)? ... Yes ☐ No ☐
   b. **within the past 5 years,** been convicted of any misdemeanor or felony charge, had their driver's license suspended or revoked, or convicted of driving under the influence of alcohol or drugs, or driver's license currently suspended or revoked?... Yes ☐ No ☐
   c. **within the past 5 years,** 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 ☐
   d. **within the past 6 months,** been prohibited from actively working full time (30 hours or more per week) at their regular occupation due to any illness, injury, or health related problem, or are you **currently** receiving benefits, compensation, or pension for disability?..... Yes ☐ No ☐
   e. **within the past 12 months,** consulted a physician, had surgery, been hospitalized, or had diagnostic tests (excluding AIDS/HIV tests) such as EKG, Xray, MRI, CAT scan?..... Yes ☐ No ☐
   f. **within the past 12 months,** had diagnostic testing (excluding AIDS/HIV tests), surgery, or hospitalization recommended by a medical professional which has not been completed or for which the results have not been received? ..... 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).

Illness, Injury, Disease, or Condition	Dates	Treatment	Name and Address of Physician and/or Hospital
	/ /		
	/ /		
	/ /		
	/ /		

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, all answers and statements contained in this application are true, complete and correctly recorded; and (2) This application and any policy issued on the basis of such application 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 licensed 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, Inc. 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. 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, Inc., 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, Inc.; (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.

CERTIFICATION—I hereby certify, under penalties of perjury, that (1) the social security number indicated above is my correct taxpayer identification number and (2) that I am not subject to backup withholding under Section 3406 (a) (1) (c) of the Internal Revenue Code. The Internal Revenue Service does not require your consent to any provision of this document other than the certification required to avoid backup withholding.

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

Signed at _____ Date of Application _____

CITY STATE MONTH DAY YEAR

_____ _____

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 Terminal Illness Accelerated Benefit Rider Disclosure Form has been presented to the applicant, if applicable.

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

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

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

PREAUTHORIZATION CHECK PLAN - AUTHORIZATION TO HONOR CHARGE DRAWN

Insured_____Account Holder_____

Financial Institution (name/address)_____

Transit / ABA Number_____ Account Number_____ ☐ Checking ☐ Savings Requested Draft Day (1st-28th)____

ATTACH VOIDED CHECK OR DEPOSIT SLIP

As a convenience to me, I hereby request and authorize you to pay and charge to my account amounts drawn on my account, whether by electronic or paper means, by and payable to the order of American-Amicable Life Insurance Company of Texas, for the purpose of paying premiums on life insurance policy, provided there are sufficient funds in said account to pay the same upon presentation. I agree that your rights with respect to each such charge shall be the same as if it were signed personally by me. This authorization is to remain in effect until revoked by me in writing and until you actually receive such notice. I agree that you shall be fully protected in honoring any such check. I further agree that if any such check be dishonored, whether with or without cause, and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

SIGNATURE (As on Financial Institution Records)_____ DATE_____

AMERICAN-AMICABLE LIFE INSURANCE COMPANY OF TEXAS

[P.O. BOX 2549, WACO, TX 76702-2549]

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. THIS RECEIPT SHALL BE INVALID AND MAY NOT BE ISSUED WITH RESPECT TO PROPOSED PAYMENT OF THE INITIAL PREMIUM TENDERED BY MEANS OF A POST-DATED CHECK.

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

Received from_____ the sum of $_____as first payment on this application for Proposed Insured _____Date_____Agent_____

If (1) an amount equal to the first full premium is submitted or a payroll deduction authorization,a government allotment authorization, or a bank draft authorization has been fully implemented in an amount sufficient to pay the first full monthly premium, (2) any check or bank draft authorization given in payment of the initial premium is honored when first presented, (3) all underwriting requirements, including any medical examinations required by the Company's rules, are completed, and (4) 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, (b) the date the payroll deduction authorization or government allotment authorization is submitted for processing, or (c) the requested draft date specified in the bank draft authorization, or (d) the date of the latest medical exam required by the Company. THE TOTAL 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 $150,000.00. (INCLUDING LIFE INSURANCE AND ACCIDENTAL DEATH BENEFITS).

If any of the above conditions are not met exactly, 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, INC. 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, Inc., 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, Inc. member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, Inc., upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information in your file. Please contact MIB, Inc. at 866-692-6901. If you question the accuracy of information in MIB, Inc.'s file, you may contact MIB, Inc. and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB, Inc.'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, Inc. may be obtained on its website at www.mib.com.

AMERICAN-AMICABLE LIFE INSURANCE COMPANY OF TEXAS
WACO, TEXAS

DISCLOSURE STATEMENT

TERMINAL ILLNESS ACCELERATED BENEFIT RIDER

TAX IMPLICATIONS. The acceleration-of-life-insurance benefits offered under this Rider may or may not qualify for favorable tax treatment under the Internal Revenue code of 1986. Whether such benefits qualify depends on factors such as your life expectancy at the time benefits are accelerated or whether you use the benefits to pay for necessary long-term care expenses, such as nursing home care. If the acceleration-of-life-insurance benefits qualify for favorable tax treatment, the benefits will be excludable from your income and not subject to federal taxation. Tax laws relating to acceleration-of-life-insurance benefits are complex. You are advised to consult with a qualified tax advisor about circumstances under which you could receive acceleration-of-life-insurance benefits excludable from income under federal law.

ANY MEDICAID OR OTHER GOVERNMENT ENTITLEMENT FOR WHICH YOU ARE ELIGIBLE MAY BE AFFECTED BY PAYMENTS RECEIVED UNDER THIS RIDER.

The Accelerated Benefit Rider attached to your Policy allows you to receive up to 100% of the Death Benefit proceeds of the Policy when the Insured has a medical condition that reasonably can be expected to result in death within 12 months. Upon receipt of proof satisfactory to the Company of the Insured's reduced life expectancy and written consent of any assignee or irrevocable beneficiary we will pay an accelerated benefit. It will be paid in a lump sum. It is payable only once.

The Benefit to be paid will be reduced by an Actuarial Adjustment Factor and an Administrative Charge of $150. We will deduct from the Benefit paid any outstanding indebtedness, but only in proportion to the percentage of Death Benefit paid. We will also return to you a proportionate amount of any premium paid beyond the date any Benefit under this Rider is paid. Payment of the Benefit will reduce the Death Benefit proceeds by the amount of the Benefit paid under the Rider. Any portion remaining after reduction of the death benefit due to payment of any acceleration-of-life-insurance benefit will be paid upon the death of the Insured. The Cash Value, the amount available for loans and the premium, excluding the Policy fee, for the Policy will decrease in proportion to the amount of Benefit paid. Continued payment of the reduced premium is necessary for the Policy to remain in force. If the entire Death Benefit is paid, then the Policy will terminate with no further value.

AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS
American-Amicable Life Insurance of Texas (here after referred to as the Company)

This Authorization complies with the HIPAA Privacy Rules

The Authorization must be fully completed as a condition of obtaining coverage. A refusal to sign this authorization will result in a rejection of your application for the insurance. A copy of this authorization will be considered as valid as the original.

1. I hereby authorize the following person(s) or group of persons to disclose information to the company: 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 insurers' business associates which are related in any way to their insurance plans.

2. This authorization specifically includes the release of **all medical records** including without limitation those containing information relating to diagnoses, treatments, consultation, care, advice, laboratory or diagnostic tests, physical examinations, recommendations for future care, prescription drug information, alcohol or drug abuse, mental illness or information regarding communicable or infectious conditions, such as HIV and/or AIDS.

3. Person(s) or group of persons authorized to receive and use the information: The Company and its business associates and those persons or entities providing services to the Company plans.

4. The information will be used to make enrollment/eligibility for benefit determinations, specifically including, but not limited to, underwriting and risk rating determinations. If coverage is issued, such determinations may include determinations as to whether coverage should be rescinded or reformed if I have made any material omission(s) or misrepresentation(s) in my application.

5. 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.

6. 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.

7. 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.

8. This authorization will expire 24 months after the date signed.

Signature of Proposed Insured who is Age 18 and over, Parent (on behalf of a minor) or Legal Representative:

Proposed Insured:_____ Date:_____

Spouse (if applicable):_____ Date:_____

Signature of minor's parent or legal guardian:_____ Date:_____

American-Amicable Life Insurance Company of Texas

Please note charge may appear on statement under American-Amicable Group of Companies

P.O. Box 2549 Waco TX 76702-2549

Bank Draft Authorization - Please Attach a Voided Check.

The Company indicated above is authorized to initiate debit entries to the account indicated below, and the Bank named below is authorized to debit the same to such account. This authority can be terminated by the undersigned at any time by written notification to the Company, provided only that the Company and the bank will have a reasonable opportunity to act on such notification. By signing below, I authorize the Company indicated above and/or their representative to receive information from the banking facility named so my account number and routing number may be verified.

Bank Name _____

Bank Address _____

Transit/ABA Number _____ **Account Type:** ☐ Checking ☐ Savings

Account Number _____ **Amount $** _____

Would you like your draft to coincide with your Social Security payment schedule? ☐ Yes ☐ No

Please choose one of the following as your requested draft date (applies to first and future drafts of this account):

☐ Requested Draft Date, If Any (1st-28th) _____ OR ☐ 2nd Wednesday ☐ 3rd Wednesday ☐ 4th Wednesday

_____ _____

SIGNATURE (AS ON FINANCIAL INSTITUTION RECORDS) **DATE**

Bank Account Verification - Complete ONLY in absence of void check.

I have verified that the above account is a valid account and can be drafted for insurance premiums. I understand that if the information provided is found to be falsified, I may be subject to disciplinary action up to and including termination of my agent contract. This information was verified by a verification call with a bank representative.

Please provide the phone number and name of the person you spoke to at the Bank:_____

_____ _____

AGENT SIGNATURE / AGENT NUMBER **DATE**

By signing below, I authorize the Company indicated above and/or one of their representatives to receive information from the banking facility named above so my banking information can be verified.

_____ _____

SIGNATURE (of bank account holder) **DATE**

E-Check Bank Draft Authorization
COMPLETE THIS SECTION TO IMMEDIATELY DRAFT PREMIUM

Immediately upon receipt of My Application, please draft $_____ from my account listed above and identified with a void check, deposit slip, bank statement or Bank Account Verification above.

_____ _____

SIGNATURE **DATE**