AMERICAN-AMICABLE LIFE INSURANCE COMPANY OF TEXAS
P.O. BOX 2549, WACO, TX 76702-2549 • (254) 297-2777

LIFE INSURANCE APPLICATION (Please print in black ink)

SecureLife Plus

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

_____ Phone _____ Best time to call ☐ am ☐ pm
E-mail Address_____@_____

Sex	Date of Birth	Age	State of Birth	SS# — —	Height: ____ft____in	Occupation:
☐ Male ☐ Female	Mo. Day Yr / /			DL#	Weight: lbs	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
Have you used tobacco or nicotine products in the past 12 months? ☐ Yes ☐ No.....or during the past 36 months? ☐ Yes ☐ No
Universal Life (select option): ☐ Option 1 (Face Amount Only) ☐ Option 2 (Face Amount Plus Cash Value)

Riders: ☐ Waiver of Specified Premium $_____ ☐ Term 10 or ☐ Term 20 $_____
☐ Waiver of Monthly Deduction ☐ Additional Insured Rider: ☐ Term 10 ☐ Term 20 $_____
☐ ADB $ ☐ Child Rider (Units):

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: / /

Do you have any existing life or disability insurance or annuity contract? ☐ Yes ☐ No Company
Will you replace an existing life or disability insurance policy or an annuity? ☐ Yes ☐ No Policy # Coverage Amount $

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

SECTION A: Answer Questions 1 through 3 for all Proposed Insureds. ***(circle all conditions that apply)***

1. **Within the past 10 years,** has any Proposed Insured taken medication or been treated for, or been diagnosed by a medical professional with:
   a. high blood pressure, heart attack, angina, arrhythmia, stroke, aneurysm, or any heart or circulatory disease or disorder? ☐ Yes ☐ No
   b. diabetes, cirrhosis, hepatitis, pancreatitis, Crohn's disease, ulcerative colitis, or any digestive or liver disease or disorder? ☐ Yes ☐ No
   c. asthma, emphysema, chronic obstructive pulmonary disease (COPD), sleep apnea or any respiratory disease or disorder? ☐ Yes ☐ No
   d. cancer in any form, migrane headaches, anemia, seizure, bi-polar disorder, schizophrenia, or mental or nervous disorder? ☐ Yes ☐ No
   e. any disease or disorder of the kidneys, urinary bladder, prostate, breast, reproductive organs, or sexually transmitted disease? ☐ Yes ☐ No
   f. connective tissue disease, systemic lupus (SLE), arthritis, or any disorder of the back, joints, muscles, or nervous system? ☐ Yes ☐ No
   g. any other disease or disorder, injury, surgery, birth defect, or deformity? ☐ Yes ☐ No
   h. Acquired Immunodeficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive for Human Immunodeficiency Virus (HIV)? ☐ Yes ☐ No
2. **Within the past 5 years,** has any Proposed Insured:
   a. been convicted of any misdemeanor or felony charge (including DUI or DWI), had a driver's license suspended or revoked or is currently suspended or revoked, or any motor vehicle violations or is currently on probation or parole? ☐ Yes ☐ No
   b. used illegal drugs, 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
   c. participated in motorized racing, hang gliding, rock or mountain climbing, rodeo events, sky diving, or skin or scuba diving? ☐ Yes ☐ No
   d. made or contemplated making any flights as a pilot, student pilot, or crew member of any aircraft? ☐ Yes ☐ No
   e. had application (including a reinstatement application) for life or health insurance declined, rated, modified, or postponed? ☐ Yes ☐ No
3. **Within the past 12 months,** has any Proposed Insured:
   a. consulted a medical professional, had surgery, been hospitalized, or had diagnostic tests such as EKG, Xray, MRI, CAT scan? ☐ Yes ☐ No
   b. had any diagnostic testing, 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).

Proposed Insured Name, Condition	Dates	Treatment	Name/Address/Phone No. of Physician/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, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application containing a false or deceptive statement may be guilty of insurance fraud.

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 Medical Information Bureau 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 Medical Information Bureau, 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 Medical Information Bureau; (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 two years from this date. 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 Pre-Notice. I acknowledge receiving the Accelerated Benefit Endorsement Disclosure Form.

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 ACKNOWLEDGEMENT

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 Benefit Endorsement Disclosure Form has been presented to the applicant.

Are you aware of any existing life insurance or annuity contract on the life of the Proposed Insured, except as noted in this application? ..... ☐ Yes ☐ No

Are you aware of this policy replacing any existing life insurance policies or annuity contracts with this or any other company? ..... ☐ 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)_____

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_____

Form No. AA9883

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 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 non-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. Please contact MIB at 866-692-6901 (TTY 866-346-3642). 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.

American-Amicable Life
Insurance Company of Texas
P.O. Box 2549 / Waco, Texas 76702-2549 / 254-297-2777

ACCELERATED BENEFIT DISCLOSURE

This is a summary of the benefits and requirements of the Accelerated Benefit Endorsement to be attached to and made a part of your policy. Please refer to the Endorsement for full details.

NOTICE

Death benefit, face amount and policy value will be reduced upon payment of an accelerated benefit. The accelerated benefits offered under this policy 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 benefits qualifies for favorable tax treatment, the benefits will be excluded from your income and not subject to federal taxation. However, accelerated benefit payments may be taxable by your state. Tax laws relating to accelerated benefits are complex. You should consult a qualified tax advisor for specific information. Receipt of an accelerated benefit payment may adversely affect your, your spouse's or your family's eligibility for medical assistance (Medicaid), Aid to Families with Dependent Children (AFDC), supplemental Social Security Income (SSI), and drug assistance or other public assistance programs. You should consult with a qualified advisor and with social services agencies regarding how receipt of such payment may affect eligibility for such persons.

SUMMARY OF ACCELERATED BENEFIT PROVISIONS

- If the insured is diagnosed as being terminally ill, (having a disease or illness that is expected to result in the insured's death within twelve months), the owner of the policy may request an acceleration of the death benefit.

- No accelerated benefit will be paid if the terminal illness is caused or contributed to, directly or indirectly, by an injury or sickness that is intentionally self-inflicted, while sane or insane, results from participation in insurrection, war or a criminal act.

- We reserve the right to require an independent medical examination, at our expense, by a physician of our choice to verify the Insured's terminal illness. If the opinion of the insured's physician and our physician differs, a mutually acceptable physician will be chosen to determine the insured's condition.

- The sum of all accelerated benefit payments paid may not exceed $100,000 or 75% of the death benefit then payable, whichever is less. The remaining death benefit can be no less than $10,000.

- The sum of any policy loans and interest due will be deducted from the accelerated benefit before it is paid.

- After an accelerated benefit is paid, the remaining death benefit will be reduced by the amount of the accelerated benefit, and the face amount and policy value will be reduced in the same proportion as the death benefit. Upon the death of the Insured, the Death Benefit payable will also be reduced by the accrued interest on the payment of the Accelerated Benefit.

- A statement of the adjusted values will be sent to the owner of the policy before the payment of any accelerated benefit.

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:_____

AA9526(11/07)

- ☐ American-Amicable Life Insurance Company of Texas
- ☐ IA American Life Insurance Company
- ☐ Occidental Life Insurance Company of North Carolina
- ☐ Pioneer American Insurance Company
- ☐ Pioneer Security Life Insurance Company

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 and routing number may be verified.

Bank Name _____

Bank Address _____

Transit/ABA Number _____ **Account Type:** Checking Savings (Circle One)

Account Number _____ **Amount $** _____

Requested Draft Date, If Any (1st-28th) _____ **OR Circle One of the Following:** 1st 2nd 3rd 4th Wednesday of Every Month

_____ _____

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

Bank Account Verification
COMPLETE ONLY IN ABSENCE OF VOID CHECK, DEPOSIT SLIP OR BANK STATEMENT

Telephone No: _____ **Person you spoke to at Bank/Credit Union:** _____ **Ext:** _____

I certify that I have contacted the applicant's bank or credit union and have verified that the above account is an active account and can be drafted for insurance premiums. I understand that if the information is incorrect or invalid that I will not be advanced on additional new business without a void check, deposit slip, or a copy of the proposed insured's bank statement. I also understand that if the information provided is found to be falsified my agent contract will be terminated immediately.

_____ _____ _____

DATE **AGENT NUMBER** **AGENT SIGNATURE**

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 account number and routing number may be verified.

_____ _____

SIGNATURE (AS ON FINANCIAL INSTITUION RECORDS) **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**

American-Amicable Life Insurance Company of Texas
P.O. Box 2549, Waco, TX 76702-2549
Ph: 800-736-7311 • Fax: 254-297-2102 • E-mail: underwriting@aatx.com

JUVENILE QUESTIONNAIRE

PROPOSED INSURED NAME: _____Ht/WT_____

APPLICATION NUMBER: _____ DATE OF BIRTH: _____

DOES THE CHILD RESIDE WITH THEIR FATHER AND MOTHER WHO ARE LISTED ON THE APPLICATION: _____yes _____no
If not, name and address and relationship with whom the child resides:
NAME_____ ADDRESS_____

CITY/STATE/ZIP _____ RELATIONSHIP _____

List any and all brothers and sisters by name and age:

NAME	AGE

Has insurance been requested on brothers and sisters also or do they have coverage in-force?
_____ yes _____ no
If yes, indicate the amount of coverage for each sibling child:

NAME	AMOUNT OF LIFE COVERAGE

Do the parents have coverage in-force? _____ yes _____no
If yes, indicate the amount of coverage for each parent:
Father's amount of life coverage in-force and company name: _____
_____
Mother's amount of life coverage in-force and company name: _____
_____

Provide the annual income for the household for which the juvenile resides: _____

Medical information for child:

List child's current physician's name and address: _____
_____
Date last seen and reason: _____
_____
List any current treatment or medications: _____

_____ _____
Parent (Owner) Signature Date

American-Amicable Life Insurance Company of Texas
IA American Life Insurance Company
Occidental Life Insurance Company of North Carolina
Pioneer American Insurance Company
Pioneer Security Life Insurance Company

SecureLife Plus Application Checklist

Required Forms:

_____ SecureLife Plus Application – *Form No. 9883 (AA, OL, PA, PS);*
Form No. UL201 (IAA) with state exceptions

_____ HIPAA Compliant Authorization for the Release of Medical Records – *Form No. 9526*

_____ Life Illustration Acknowledgement – *Form No. 9113*

Forms That Must Be Left With The Client:

_____ Accelerated Benefit Disclosure – *Form No. 9888 (AA, OL, PA, PS);*
Form No. AB501 (IAA) not approved for IAA in CA

Optional Forms That Could Be Used:

_____ Additional Insured Application – *Form No. 9901 (AA, OL, PA, PS);*
Form No. GL204 (IAA)

_____ Replacement Form – *Form No. 9396*
If they have existing insurance in force regardless of replacement!
(Only applies to following states: AL, AK, AZ, AR, CO, HI, IA, ID, KY, LA, MD, MO, MS, MT, NC, NE, NH, NJ, NM, OH, OR, RI, SC, TX, UT, VA, VI, VT, WV, WI)

_____ Sales Material Statement – *Form No. 9397 - Only use if a replacement is involved!*

_____ Multi Bank Draft Form – *Form No. 9903*

_____ Bank Account Verification (Used in absence of void check or deposit slip) – *Form No. 9724*

_____ Juvenile Questionnaire – *Form No. 9825 (required on all applications with issue ages 0-17)*

See Reverse side for Underwriting Requirements.

Not all riders available in all states.

Underwriting Requirements

Categories

Type	Face Amount Required	Issue Ages
Male or Female, Preferred, Non-Tobacco	$100,000	18-80
Male or Female, Standard, Non-Tobacco	$10,000	0-80
Male or Female, Tobacco	$10,000	18-80

Requirements

General Instructions to Determine the Amount of Risk:

The amount of risk equals:

1) the amount applied for, PLUS:
2) the total amount issued on a non-medical basis in the past two years.

Age	Up to $99,999	$100,000 - $250,000	$250,001 - $500,000	$500,001 - $1,000,000	$1,000,001 - $1,999,999
18-40	NM	P#	P#	P#	PE#
41-50	NM	P#	P#	PE#	PE#
51-60	P	P#	PE#	PE#	P#
61-65	P	PE#	PE#	P#	P#
66+	APS	APS	APS	P# APS	P# APS

Contact the home office for risk of $2,000,000 or above.

- Ages 0-17 – Face Amount less than $100,000.00 = Non-Medical with a Juvenile Questionnaire
- Ages 0-17 – Face Amount equal to or greater than $100,000.00 = Juvenile Questionnaire and requirements at underwriter's discretion

Acronyms:

NM = Non-Medical / Oral fluid test[1] in CA, CT, FL and ME
P = Paramedical examination with urine specimen
E = Electrocardiogram
# = Full Blood Profile
APS = Attending Physician's Statement

- APS requirements will be ordered by Home Office.
- Telephone inspection reports are required on all cases of $1,000,000 or more will be ordered by Home Office.
- A motor vehicle report (MVR) required on all cases $1,000,000 or more, all preferred cases, and when applying for ADB will be ordered by Home Office.
- A check with MIB and pharmaceutical related facility will be ordered on all applications.
- An HIV consent form must be signed by all clients that require blood testing and oral fluid testing. The Company reserves the right to request additional requirements or other evidence.

[1]An oral fluid test, administered by the agent, is required in the states of California, Connecticut, Florida and Maine. To obtain kits, please contact the home office at 1-800-736-7311, option 1,1,1. Agents must complete oral fluid collection training prior to use of the kits. Training is available at www.examone.com.

Height and Weight Table
(This table applies to both men and women)

Height	Preferred	Standard	Height	Preferred	Standard	Height	Preferred	Standard
4'8"	144	161	5'4"	188	210	6"	238	265
4'9"	149	166	5'5"	194	216	6'1"	245	273
4'10"	154	172	5'6"	200	223	6'2"	251	280
4'11"	160	178	5'7"	206	230	6'3"	258	288
5'	165	184	5'8"	212	237	6'4"	265	296
5'1"	171	191	5'9"	219	244	6'5"	272	304
5'2"	177	197	5'10"	225	251	6'6"	279	312
5'3"	182	203	5'11"	231	258	6'7"	287	320