American Continental Insurance Company
An Aetna Company
101 Continental Place
Brentwood, TN 37027

Application for Whole Life Insurance from American Continental Insurance Company

- Please print clearly and use blue or black ink.
- Use Section 4 for additional remarks, requests, or explanations.
- If completing electronically, fill in all blue highlighted areas. When complete, print form, sign, and send to us.

1. Proposed insured information

If insured's mailing address is different than residential address, use remarks (Section 4).

If billing address is different than residential address, use remarks (Section 4).

Write the date of birth that is on the birth certificate.

Full name of proposed insured *First, M.I., Last*

Residential address (No P.O. Boxes) | Phone

City | State | Zip

E-mail | Social Security Number

Birth date *mm/dd/yyyy* | Age

Height *Feet and inches* | Weight *Pounds* | ○ Male ○ Female

Are you a legal resident of the United States? ○ Yes ○ No

Have you used any form of tobacco in the past 12 months? ○ Yes ○ No

2. Benefits, beneficiary and replacement information

To determine which Plan the applicant qualifies for, complete the health questions in Section 3.

Unless otherwise requested, the effective date is the application date as long as the application is received at the Home Office within 15 days.

If a nonforfeiture option is not selected, extended term insurance is the default.

You have a choice of four payment modes for paying your premium. The Company does not charge you more based on the premium mode you select. There may be reasons, such as the time value of money, you would want to consider in making a decision on which premium mode to choose. Your agent can explain the differences in modes and help you decide which is best for you.

Initial amount of insurance applied for:
$

Plan requested: ○ Modified benefit plan ○ Graded benefit plan ○ Level benefit plan

Riders requested (if available):

Requested effective date:

Nonforfeiture options: (select only one)
○ Automatic premium loan
○ Paid-up insurance
○ Extended term insurance

Initial premium amount:
$

Initial premium method: ○ EFT ○ Check or money order

Payment mode: ○ Annually ○ Quarterly ○ Semi-Annually ○ Monthly EFT (Electronic Funds Transfer)

Full name of primary beneficiary *First, M.I., Last* | Relationship to insured

Contingent beneficiary *First, M.I., Last* | Relationship to insured

Does the proposed insured currently have any life insurance or annuity in force? ○ Yes ○ No

Will insurance applied for in this application replace, reduce or modify premiums paid for any existing life insurance or an annuity in force? ○ Yes ○ No

If the answer to either question is "yes", please provide the information below:

Company name | Face amount | Policy number

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3. Health questions

Section A

If you answered "yes" to any questions in this section, you are not eligible for insurance coverage.

If you answered "no" to ALL questions in this section, continue to Section B.

1. Do any of the following apply to you?
   - A. currently hospitalized, in a nursing facility, confined to a bed, receiving hospice care ○ Y ○ N
   - B. currently prescribed to use oxygen for any lung or respiratory disorder ○ Y ○ N
   - C. have been diagnosed by a medical professional as having an aneurysm that has not been surgically repaired ○ Y ○ N

2. At any time have you been diagnosed or treated by a medical professional or had surgery for any of the following?
   - A. any condition requiring bone marrow, stem cell, or organ transplant ○ Y ○ N
   - B. kidney disease requiring dialysis ○ Y ○ N
   - C. Alzheimer's Disease, dementia, mental incapacity ○ Y ○ N
   - D. Lou Gehrig's Disease (ALS) ○ Y ○ N
   - E. have been diagnosed as having a life expectancy of 12 months or less ○ Y ○ N
   - F. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), tested positive for the Human Immunodeficiency Virus (HIV) ○ Y ○ N

Section B

If you answered "yes" to any questions in this section, you qualify for the **Modified** benefit plan.

If you answered "no" to ALL questions in this section, continue to Section C.

3. Do you have:
   - A. diabetes diagnosed by a medical professional before age 40 ○ Y ○ N
   - B. diabetes in combination with any heart or circulatory disorder diagnosed by a medical professional (excluding high blood pressure) ○ Y ○ N
   - C. diabetes requiring 40 or more units of insulin daily ○ Y ○ N

4. Within the past 12 months, have you been diagnosed or treated by a medical professional or had surgery for any of the following?
   - A. heart attack, heart valve disorder, heart blockage, stroke or transient ischemic attack (TIA) ○ Y ○ N
   - B. any lung or respiratory disorder requiring the use of a nebulizer ○ Y ○ N
   - C. any lung or respiratory disorder and currently use tobacco ○ Y ○ N
   - D. internal cancer, melanoma, lymphoma, multiple myeloma, leukemia, systemic lupus (SLE) ○ Y ○ N
   - E. chronic pancreatitis, chronic hepatitis, cirrhosis ○ Y ○ N

5. Within the past 12 months, have you been recommended by a medical professional to have any of the following?
   - A. treatment or counseling for alcohol or drug abuse ○ Y ○ N
   - B. test, surgery, treatment or further evaluation that has not been performed or are there any test results pending ○ Y ○ N

Section C

If you answered "yes" to any questions in this section, you qualify for the **Graded** benefit plan.

If you answered "no" to ALL questions in this section, you qualify for the **Level** benefit plan.

6. Within the past 24 months, have you been diagnosed or treated by a medical professional or had surgery for any of the following?
   - A. aneurysm, heart attack, any circulatory disorder, stroke or transient ischemic attack (TIA) ○ Y ○ N
   - B. emphysema, chronic obstructive pulmonary disease (COPD) ○ Y ○ N
   - C. internal cancer, melanoma, leukemia ○ Y ○ N
   - D. neuromuscular disorder including, but not limited to, cerebral palsy, multiple sclerosis, muscular dystrophy ○ Y ○ N
   - E. any connective tissue disorder, ulcerative colitis, Crohn's disease ○ Y ○ N

7. At any time, have you been diagnosed or treated by a medical professional or had surgery for any of the following?
   - A. congestive heart failure, cardiomyopathy, Parkinson's disease ○ Y ○ N
   - B. any permanent paralysis, amputation caused by disease ○ Y ○ N

8. Are you dependent on a wheelchair or motorized mobility device? ○ Y ○ N

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Applicant Initials _____

4. Remarks

5. Privacy notice

Your application and telephone interview are American Continental Insurance Company's primary sources of information in determining whether to provide coverage to you. The Company, its affiliates, or its reinsurer(s) may also in certain circumstances release information collected by us to third parties without authorization from you. Upon written request, we will provide you with the information contained in your file. Should you wish to request correction, amendment or deletion of any information in your file, which you believe inaccurate, please contact us and we will advise you of the necessary procedures.

6. Producer compensation

When you purchase insurance from us, we pay compensation to the licensed agent, who represents us for such limited purposes as taking your insurance application, collecting your initial premiums and delivering your policy, and to any intermediaries through which the licensed agent works. This compensation may include commissions when a policy is purchased or renewed, and fees for marketing and administrative services and educational opportunities. The compensation may vary by the type of insurance purchased, or the particular features included with your policy. Additionally, some licensed agents and/or their intermediaries may also receive discounts on their own policy premiums and bonuses, and incentive trips or prizes associated with sales contests based on sales criteria, such as the overall sales volume of an agent or intermediary with our companies, or for the percentage of completed sales. (Generally, this will not be the case for registered variable insurance products or for fixed products sold through banks or broker-dealers.) Intermediaries may also pay compensation directly to the licensed agent. If the licensed insurance agent can sell insurance policies from other insurance carriers, those carriers may pay compensation that differs from ours.

7. Applicant agreement

I hereby apply to American Continental Insurance Company for a policy to be issued in reliance on my answers to the questions in this application. The applicant and agent represent that the applicant has read, or had read to applicant, the completed application, and the applicant understands that any false statements or misrepresentations made in the application may result in loss of coverage under the policy to which this application is a part.

I, the applicant, represent that the statements and answers given in the application are true, complete and correctly recorded to the best of my knowledge and belief. I agree that no insurance shall be in effect until the application has been accepted and approved by the Company and the first full modal premium has been paid. I understand that no insurance agent is authorized to waive any part of any answer on the application, to approve insurability, make or modify any contract or waive any of the Company's rights or requirements.

I understand and agree that, if I choose to pay my premium by electronic funds transfer (EFT) from my checking or savings account, I am accepting the terms and conditions of the EFT authorization attached to this application.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information on an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Applicant signature

X .....

Date signed

.....

Owner signature (if not proposed insured)

X .....

Owner Social Security Number

.....

If owner is different than insured, indicate name, address and relationship to insured in remarks (Section 4).

Signed in *City and State*

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SAMPLE

Applicant Initials _____

8. Account information

Complete this section if you are requesting electronic funds transfer (EFT) for premium payment.

Include a voided check with the application.

Proposed insured's name

.

Account owner name, if different than proposed insured's

.

Account owner relationship to proposed insured:

○ Business owned by proposed insured
○ Family member
○ Living trust
○ Power of Attorney
○ Other, specify: .
○ Employer
○ Conservator/guardian

Financial institution name

.

○ Checking ○ Savings

Routing number

.

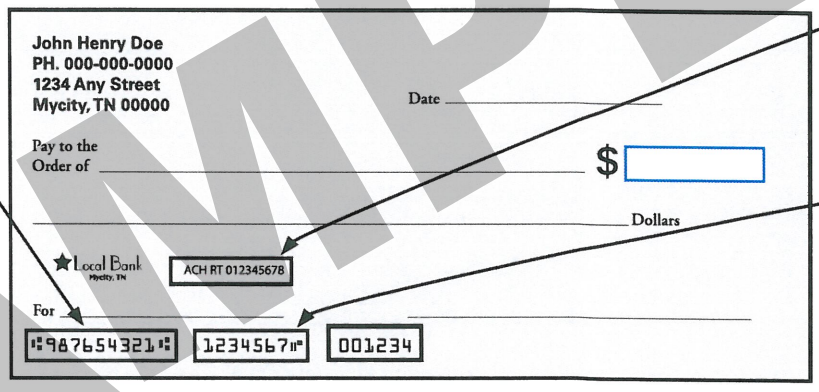
Account number

.

⚠ Initial premium will be drafted when the policy is approved and issued, unless "yes" is checked.

Do you prefer to have the initial premium drafted on the Effective Date? ○ Yes ○ No

This is an example of a personal check. A business check may be different.



For all other checks, use the nine-character bank **routing number**, which appears between the ⑆ symbols, usually at the bottom left corner of the check.

For checks with an **ACH RT (Automated Clearing House Routing) number**, please use this number.

The **account number** is up to 17 characters long and appears next to the ⑈ symbol at the bottom of the check and usually to the right of the bank routing number.

9. Electronic funds transfer (EFT) authorization

I understand and accept these terms and conditions:

- We are authorized to withdraw funds periodically from your account to pay insurance premiums for the insured.
- If your financial institution does not honor an EFT request, we will NOT consider your premium paid.
- If your financial institution does not honor an EFT request, we may make a second attempt within five business days.
- We have the right to end EFT payments at any time and bill you directly either quarterly or less frequently for premiums due.
- Information as to each EFT charge will be provided by entry on your account statement or by any other means provided by your financial institution. You will not receive premium notices from us.
- If you want to cancel or change this authorization, you must contact us at least three business days before a scheduled withdrawal.
- Any refund of unearned premium will be made to the policy owner or the policy owner's estate.

Signature only required if the account owner is different than the proposed insured.

Signature of account owner

X .

Date

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Applicant Initials _____

10. Agent Statement

I represent the following:

1. That the insurance being applied for is suitable for the owner's insurance needs.
2. I have explained to the applicant the premium mode options.
3. I have provided all required forms on or before the date the application was taken.
4. I have accurately recorded the information supplied by the applicant.

Number 4 is applicable only if agent has personally recorded the information on the application.

Does the proposed insured have any existing life insurance or annuity contracts? ○ Yes ○ No

Will the policy applied for be a replacement or change existing life insurance or an annuity? ○ Yes ○ No

If the answer to either question is "yes", have you complied with the requirements of the Company and your state regarding this replacement? ○ Yes ○ No

The writing number reflects where commissions will be paid.

Agent name *Printed*

Writing number (agent or company)

Agent signature

X

Phone

E-mail

11. Policy delivery requirements

Unless otherwise indicated policy will be mailed to agent.

Mail policy to: ○ Agent ○ Policyholder

12. Agent request to split commissions

This section must be completed with this application in order to split commissions.

If this application results in an issued policy through American Continental Insurance Company (ACI), the agents listed below have agreed to split the commissions earned on the policy.

- Both agents must be properly licensed and appointed with ACI in the policy's state of issue.
- Split commissions are calculated as a percentage of commissionable premium and will apply while the policy remains inforce.
- The percentage of the premium split can be for any amount but must be stated in whole numbers and total 100%. (For example, the percentage for the premium split can be from 1% to 99% but cannot be 0% or 100%.)
- Calculation of each agent's commissions are based on their respective ACI commission schedule.

Writing agent *Printed*

Percentage %

Secondary agent *Printed*

Writing number

Percentage %

By signing this form, the writing agent agrees to split his/her commission with the secondary agent as indicated above.

Writing agent signature

X

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