EASY UL or UL PERFORMER

OCCIDENTAL LIFE INSURANCE COMPANY OF NORTH CAROLINA

P.O. BOX 2595, WACO, TX 76702-2595 • (254) 297-2775

Telephone Case No:

Proposed Insured: _____ (First) (Middle) (Last)

Address: (No. & Street) _____

City: State: Zip Code:

Telephone interview done (if applicable) ☐ Yes ☐ No

_____ 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 Insured: Primary Beneficiary _____ SS#_____ Relationship _____

Contingent Beneficiary SS# Relationship

Plan: _____ **Face Amount $**_____ **Mail Policy To:** ☐ Agent ☐ Insured ☐ Owner **Policy Date Request:** / /

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

Riders: ☐ Waiver of Premium ☐ CIA_____Units ☐ ADB $_____

☐ Disability Income $ ☐ FIA Units ☐ Other

☐ Option 1 (Face Amount Only)

☐ Option 2 (Face Amount Plus Cash Value)

Mode: ☐ Bank Draft ☐ Draft 1st Prem on Req. Date ☐ Lump Sum Prem $_____

☐ Other Modal Prem $

CWA: ☐ E-Check Immediate 1st Prem

☐ Collected $

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 5 for all Proposed Insureds.

1. Has any Proposed Insured 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
2. Within the past 7 years, has any Proposed Insured been diagnosed with, treated for, or taken medication for: *(circle condition that applies)*
   a. high blood pressure, heart attack, angina, arrhythmia, stroke, aneursym, 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, anemia, seizure, bi-polar disorder, schizophrenia, Alzheimer's, dementia, or mental or nervous disorder? ☐ Yes ☐ No
   e. any disease or disorder of the kidneys, urinary bladder, prostate, 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
3. 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 on probation or parole, or driver's license is currently suspended or revoked? ☐ 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
4. Within the past 2 years has any Proposed Insured:
   a. participated in, or intend to participate in parachuting, hang gliding, rock or mountain climbing, rodeo events, sky diving, scuba diving, any professional sport, organized racing of any kind, or any other hazardous sport/activity? ☐ Yes ☐ No
   b. made or contemplated making any flights as a pilot, student pilot, or crew member of any aircraft? ☐ Yes ☐ No
5. 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).

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

COMMENTS:_____

_____

_____

_____

AGREEMENT—I agree with Occidental Life Insurance Company of North Carolina (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 or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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) Occidental Life Insurance Company of North Carolina; 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 Occidental Life Insurance Company of North Carolina 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 Terminal Illness Accelerated Benefit Rider Disclosure Form and the Accelerated Benefits Rider-Confined Care Disclosure Form, 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 Terminal Illness Accelerated Benefit Rider Disclosure Form and the Accelerated Benefits Rider-Confined Care Disclosure Form have 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 Occidental Life Insurance Company of North Carolina, 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_____

OCCIDENTAL LIFE INSURANCE COMPANY OF NORTH CAROLINA
P.O. BOX 2595, WACO, TX 76702-2595

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 Occidental Life Insurance Company of North Carolina 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. Occidental Life Insurance Company of North Carolina, 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, 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 (TTY 866-346-3642). 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.

Occidental Life Insurance Company of North Carolina, 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.

AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS
Occidental Life Insurance of North Carolina (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	1-800-736-7311
☐ IA AMERICAN LIFE INSURANCE COMPANY	1-800-736-7311
☐ PIONEER AMERICAN INSURANCE COMPANY	1-800-736-7311
☐ PIONEER SECURITY LIFE INSURANCE COMPANY	1-800-736-7311
☐ OCCIDENTAL LIFE INSURANCE COMPANY OF NORTH CAROLINA	1-800-736-7311

----------425 AUSTIN AVENUE, WACO, TEXAS 76701----------

LIFE ILLUSTRATION ACKNOWLEDGMENT

Check the applicable box below.

This form must be signed, dated and submitted with the application.

☐ I have applied for an illustratable life insurance policy, **but the Agent has not provided an illustration.** An illustration conforming to the policy as issued will be provided no later than at the time of policy delivery.

☐ I have been presented with an illustration for a life insurance policy, **but have applied for coverage other than as illustrated.** An illustration conforming to the policy as issued will be provided no later than at the time of policy delivery.

☐ I have been presented with a **computer displayed illustration** for a life insurance policy that complies with state requirements, **but the Agent has not provided a printed illustration.** The illustration was based on the following personal policy information:

1. Gender — Male_____ Female _____
2. Age — _____
3. Underwriting or Rating Class — _____
4. Type of Policy — _____
5. Type of Rider(s) — _____
6. Initial Death Benefit — $_____
7. Interest Rates — Guaranteed_____ Non-Guaranteed_____
8. Number of Years Illustrated — _____
9. Premium — Amount $ _____ No.of Years _____

The agent has displayed a computer screen illustration for the applicant that complies with state requirements and for which no printed illustration was provided to the applicant. The illustration was based on the above personal and policy information.

An illustration conforming to the policy as issued will be provided no later than at the time of policy delivery.

_____ _____ _____

Agent Signature — Applicant Signature

_____ _____ _____

Agent Name (typed or printed) — Applicant Name (typed or printed)

_____

Date

OCCIDENTAL LIFE INSURANCE COMPANY OF NORTH CAROLINA
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.

OCCIDENTAL LIFE INSURANCE COMPANY OF NORTH CAROLINA
WACO, TEXAS

DISCLOSURE STATEMENT

ACCELERATED BENEFITS RIDER - CONFINED CARE

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 THE OWNER IS ELIGIBLE MAY BE AFFECTED BY PAYMENTS RECEIVED UNDER THIS RIDER.

The Rider provides early (pre-death) payments of life insurance proceeds if the Insured is receiving Confined Care as defined in the Accelerated Benefits Rider - Confined Care. Benefits are only paid at the Owner's option and request. The terms and conditions are detailed in the Rider. **THE RIDER IS NOT INTENDED TO PROVIDE HEALTH INSURANCE, NURSING HOME INSURANCE OR LONG TERM CARE INSURANCE. IT MAY NOT COVER ALL NURSING HOME EXPENSES. IT DOES NOT COVER HOME CARE OR ADULT DAY CARE SERVICES.**

Cash Value, if any, and the Face Amount are reduced if Accelerated Benefits are paid.

- ☐ 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**

Occidental Life Insurance Company of North Carolina
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