FAMILY PLAN

OCCIDENTAL LIFE INSURANCE COMPANY OF NORTH CAROLINA
P.O. BOX 2595, WACO, TX 76702-2595 • (254) 297-2775

LIFE INSURANCE APPLICATION (**Please print in black ink**) **Telephone Case No:**_____

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

Phone interview completed (Age 40-49) ☐ Yes ☐ No
_____ Phone _____ Best time to call ☐ am ☐ pm
E-mail Address

Sex	Date of Birth	Age	State of Birth	SS# / DL#	Height	Weight	Occupation
☐ Male ☐ Female	Mo. Day Yr / /			SS# __ __ / DL#	ft in	lbs	

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

Primary Beneficiary	Relationship	Contingent Beneficiary	Relationship

Plan: ☐ Immediate Plan (Issue Age 0-49) ☐ Return of Premium (Issue Age 18-49) Automatic Prem. Loan Elected ☐ Yes ☐ No
During the past 12 months have you used tobacco in any form (excluding occasional pipe and cigar use)? ☐ Yes ☐ No **Face Amt $**

Rider: ☐ Children's Ins. Agreement $_____ ☐ ADB $ ☐ Other
☐ Spouse or Civil Union Partner Term Rider $ _____ Name:

Sex	Birthdate	Height	Weight

Mode: ☐ Bank Draft ☐ Quarterly ☐ Semi-Annual ☐ Annual ☐ Draft 1st premium on Requested Date Modal Premium $

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

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 # Amount of Coverage $

Physician: Name City/State Phone:

HEALTH INFORMATION - Answer Questions for all Proposed Insureds.

	PROPOSED INSURED		***PROPOSED SPOUSE OR CIVIL UNION PARTNER***	
	YES	NO	YES	NO
1. Have you 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?	☐	☐	☐	☐
2. **Within the past 24 months,** have you been convicted of any felony, or had your driver's license suspended or revoked, or been convicted of driving under the influence of alcohol or drugs, or used illegal drugs or abused alcohol or drugs, or had or been recommended to have treatment or counseling for alcohol or drug abuse?	☐	☐	☐	☐
3. **Within the past 12 months,** have you been on probation, parole, or been prohibited from actively working full time (30 hours or more per week) at your regular occupation due to any illness, injury, or health related problem, or **currently** disabled?	☐	☐	☐	☐
4. **Within the past 5 years** have you been medically diagnosed or treated, or taken medication for internal cancer, melanoma, Hodgkin's disease, or lymphoma?	☐	☐	☐	☐
5. Have you been medically diagnosed, treated, or taken medication for diabetes prior to age 21, or do you currently take insulin shots, or been medically diagnosed with diabetes combined with a medical history of any of the following: retinopathy, nephropathy, neuropathy, insulin shock, or diabetic coma?	☐	☐	☐	☐
6. Have you been medically diagnosed, treated, or taken medication for:				
a. heart or circulatory disease or disorder, stroke, congestive heart failure, cardiomyopathy, heart valve disease, sickle cell anemia, leukemia, hemophilia, Marfan's syndrome, cystic fibrosis, muscular dystrophy, Huntington's disease, motor neuron disease, systemic lupus (SLE), connective tissue disease?	☐	☐	☐	☐
b. mental retardation, bi-polar or schizophrenia, Down's syndrome, liver or kidney failure or renal insufficiency (including dialysis), had an amputation caused by disease or had or been advised to have an organ transplant?	☐	☐	☐	☐

If any answer to questions 1 through 6 is answered "Yes" the Proposed Insured is not eligible for any coverage.

7. Have you been medically diagnosed, treated, or taken medication for:				
a. high blood pressure prior to age 30, diabetes prior to age 39 or taking 3 or more medications for high blood pressure?	☐	☐	☐	☐
b. rheumatoid arthritis, paralysis of two or more extremities or any neuro-muscular disease (including, but not limited to cerebral palsy, multiple sclerosis, or Parkinson's disease), liver disease, Hepatitis C, chronic hepatitis or chronic pancreatitis, Crohn's disease or ulcerative colitis?	☐	☐	☐	☐
8. **Within the past 12 months** have you had surgical treatment for morbid obesity, or been declined for life insurance coverage or 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?	☐	☐	☐	☐
9. **Within the past 3 years** have you been medically diagnosed or treated, or taken medication for chronic bronchitis, emphysema, chronic obstructive pulmonary disease (COPD), irregular heart beat, seizures, blood clot, aneurysm?	☐	☐	☐	☐

If any answer to questions 7 through 9 is answered "Yes" the Proposed Insured is eligible for the Return of Premium Death Benefit Plan. If any answer to questions 1 through 9 is answered "Yes" the Spouse or Civil Union Partner is not eligible for any coverage.

If all questions 1 through 9 are answered "No" the Proposed Insured and Spouse or Civil Union Partner, if applicable, are eligible for Immediate Coverage.

Form No. OL9869-NJ

CHILDREN COVERAGE ONLY Children Proposed for Insurance (any additional children should be listed on a separate sheet):

Proposed Insured Name	Ht.	Wt.	Sex	Birthdate	Proposed Insured Name	Ht.	Wt.	Sex	Birthdate

CHILDREN HEALTH STATEMENT—To the best of my knowledge and belief, none of the children listed above for coverage have been treated for or told by a physician that they have or had any of the following medical conditions: Hypertension, heart or circulatory disorder, malignancy in any form, diabetes, sickle cell anemia, seizures, Down's Syndrome, cystic fibrosis, cerebral palsy, hydrocephalus, paralysis, or hospitalized for asthma or any respiratory disorder in past 12 months.

List the names of the children that are exceptions to the CHILDREN HEALTH STATEMENT. ***Children listed as an exception are excluded from the Children's Insurance Agreement Rider.*** **Exceptions are:**_____

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, other than for administrative purposes, 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 includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

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) 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 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 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 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 two years from this date. A copy of this authorization shall be as valid as the original.

ACKNOWLEDGMENT- (a) If the primary proposed insured only qualifies for a limited death benefit version, they should be aware that if they had applied for a policy with full and/or medical underwriting the primary proposed insured may have qualified for a policy that doesn't have a limited benefit. (b) I have received the Fair Credit Reporting Act Notice, MIB, Inc. Pre-Notice and Terminal Illness Rider Disclosure Form.

Proposed Insured Signature:_____ Date Signed: _____/_____/_____

Signed at _____ _____ _____
CITY STATE SIGNATURE OF OWNER (IF OTHER THAN PROPOSED INSURED) SIGNATURE OF SPOUSE OR CIVIL UNION PARTNER (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 Rider Disclosure Form has been presented to the applicant.

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

Mail Policy To: ☐ Insured ☐ Agent ☐ Owner Agent's remarks:_____

Agent (SIGNATURE) _____No: _____%_____ Agent (SIGNATURE)_____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.

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

Received of_____the sum of $_____as first payment on this application.

Date_____Agent_____

If (1) an amount equal to the first full premium is submitted; and if (2) all underwriting requirements, including any medical examinations required by the Company's rules, are completed; and (3) the proposed insured is, on the date of application, a risk acceptable for insurance exactly as applied for without modification of plan, premium rate, or amount under the Company's rules and practices, then insurance under the policy applied for shall become effective on the latest of (a) the date of application, or (b) the date of the latest medical exam required by the Company. THE AMOUNT OF LIFE INSURANCE, INCLUDING ANY AMOUNT IN FORCE OR BEING APPLIED FOR, WHICH MAY BECOME EFFECTIVE PRIOR TO THE DELIVERY OF THE POLICY SHALL IN NO EVENT EXCEED $150,000.00 (INCLUDING LIFE INSURANCE AND ACCIDENTAL DEATH BENEFITS).

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.

OCCIDENTAL LIFE INSURANCE COMPANY OF NORTH CAROLINA
WACO, TEXAS

DISCLOSURE STATEMENT

TERMINAL ILLNESS ACCELERATED BENEFIT RIDER

NOTE: PAYMENT OF AN ACCELERATED BENEFIT MAY BE TAXABLE. YOU SHOULD SEEK THE ASSISTANCE OF YOUR PERSONAL TAX AND/OR LEGAL ADVISOR IF YOU ARE CONSIDERING ELECTING THIS BENEFIT.

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 24 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. 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. 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
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
- ☐ 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