HOME PROTECTOR

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:

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	Weight	Marital Status
☐ Male ☐ Female	Mo. Day Yr / /			DL#	ft in	lbs	☐ Single ☐ Married

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

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

Plan: _____
☐ Return of Premium Rider **Face Amount $**

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

Riders: ☐ Waiver of Premium* ☐ Other Insured Rider $_____ ☐ CIA_____Units ☐ ADB $_____
☐ Disability Income $_____ ☐ Critical Illness*_____% ☐ Other_____
*Waiver of Premium Rider and Critical Illness Accelerated Benefit Rider cannot be issued on the same policy.

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
Requested Policy Date: / /

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 abused alcohol or drugs, or had or been recommended by a medical professional to have treatment or counseling for alcohol or drug use? ☐ 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
   c. been declined, postponed, rated, or modified for life or medical insurance? ☐ 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
	/ /		
	/ /		
	/ /		
	/ /		

SECTION C: Answer Questions 1 through 3.

1. 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 $

2. Has Primary Proposed Insured had a natural parent or sibling suffer from diabetes, kidney disease, require a major organ transplant, or been diagnosed with heart disease, cerebrovascular disease, internal cancer prior to age 60? (If yes, list in COMMENTS section: name, relationship, age at onset, medical condition, age if living or age at death.) ..... ☐ Yes ☐ No
3. Within the next 24 months, does any Proposed Insured intend to work, travel, or reside outside of the U.S. for more than 30 days?..... ☐ Yes ☐ No
   If yes, where? _____

SECTION D: Complete Mortgage and Employment Information

Mortgage Company:_____City/State/Zip:_____

Borrower(s) Name(s):_____

Mortgage Loan Amount: $_____Origination Date (MM/YY):_____Length of Loan:_____Years

Occupation/Duties:_____ Hire Date (MM/YY):_____ Annual Salary: $_____

Employer Name and Address:_____

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, 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 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.

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

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

Signed at _____ Date of Application _____
CITY STATE MONTH DAY YEAR

_____ _____
SIGNATURE OF PROPOSED INSURED SIGNATURE OF OWNER (IF OTHER THAN PROPOSED INSURED)

_____
SIGNATURE OF SPOUSE (IF APPLYING FOR COVERAGE)

AGENT'S REPORT

I certify that I have personally asked each question on this application to the proposed insured(s), I have truly and completely recorded on the application the information supplied by him/her, and I witnessed their signature. I certify that the Accelerated Living Benefit Rider Disclosure Form, the Terminal Illness and Confined Care Accelerated Benefit Rider Disclosure Forms 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: _____%_____

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.

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.

OCCIDENTAL LIFE INSURANCE COMPANY OF NORTH CAROLINA

WACO, TEXAS

DISCLOSURE—ACCELERATED LIVING BENEFIT RIDER

TAXATION—Receipt of the accelerated benefit paid under the Rider may be taxable. Assistance should be sought from your personal tax advisor. The benefit paid may also affect your eligibility for Medicaid and other government benefits.

COVERED CONDITIONS—

Heart Attack—The death of a portion of the heart muscle (myocardium) resulting from a blockage of one or more coronary arteries and resulting in a loss of the normal function of the heart. A Physician must furnish us in writing a diagnosis of the condition. This diagnosis must include documentation supported by clinical, radiological, histological, or laboratory evidence of the condition. The following are excluded: Angina, chest pains associated with restricted blood supply to the heart.

Coronary Artery Bypass Graft (CABG)—10% of the accelerated living benefit will be paid for the first ever open chest surgery to correct narrowing or blockage of two or more coronary arteries with bypass grafts, either saphenous vein or internal mammary graft. The surgery must have been proven to be necessary by means of coronary angiography. A cardiologist must recommend surgery. The following are excluded: angioplasty, laser relief of an obstruction, and other intra-arterial procedures.

Stroke—A cerebral vascular incident caused by hemorrhage, embolism, thrombosis producing measurable neurological deficit persisting for at least 30 days following the occurrence of the stroke. The diagnosis must be supported by new changes on a CT or MRI scan. The following are excluded: neurological symptoms due to transient ischemic attack (TIA) or mini-stroke, migraine, cerebral injury resulting from trauma or hypoxia, vascular disease affecting the eye, optic nerve and vestibular function.

Cancer—Only those types of cancer manifested by the presence of a malignant tumor, characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissue. Cancer includes: Leukemia, Malignant Lymphoma, Hodgkin's Disease (except Stage 1 Hodgkin's Disease). Diagnosis of cancer must be established according to the criteria of malignancy established by The American Board of Pathology after a study of the histocytologic architecture or pattern of the suspect tumor, tissue or specimen. The following are excluded: pre-malignant tumors or polyps, cancer in-situ (e.g. cervical dysplasia), transitional carcinoma of urinary bladder Stage 0, prostate cancer Stage A or equivalent TNM Classification (T1, T1a, T1b), colon cancer Dukes Stage A, all tumors in the presence of HIV, hyperkeratoses, basal cell and squamous skin cancers, malignant melanomas of the skin classified Clark Level 2 or less, or has a Breslow thickness measurement 0.75mm or less.

Kidney Failure—End stage kidney disease presented as chronic irreversible failure of both kidneys to function. The undergoing of regular renal dialysis or undergoing a renal transplant must evidence this. The following are excluded: single kidney failure, temporary kidney failure.

Major Organ Transplant Surgery—The actual undergoing as a recipient (human to human) of a transplant of the heart, lung, liver, pancreas, kidney or bone marrow. The transplant must be medically necessary and based on objective confirmation of organ failure.

Paralysis—Total and permanent loss of use of two or more limbs due to an injury or sickness. These conditions have to be medically documented by a neurologist for at least 3 months.

Blindness—Total, permanent, and uncorrectable loss of sight in both eyes confirmed by an ophthalmologist. The corrected visual acuity must be worse than 20/200 in both eyes or the field of vision must be less than 20 degrees in both eyes.

HIV Contracted Performing Occupational Duties as a Medical Professional Healthcare Worker—A medical professional healthcare worker who in the performance of their occupational duties is exposed to and ultimately acquires positive HIV resulting from an accidental injury. The following are excluded: HIV infection as a result of IV drug use, sexual intercourse.

Terminal Illness—The insured must be suffering from a condition, which in the opinion of a physician will lead to death within twelve (12) months.

FACE AMOUNT—In the Rider, the term "Face Amount" refers to the Face Amount under the Policy to which the Rider is attached.

PREMIUM CHANGE—The Company may change the premium for this Rider. The changed premium may be greater than or less than the Rider premium at issue but will not be greater than the maximum premium shown in the Benefit Description Page 3B of the Policy. The premium may not be changed before the end of the first five years and may not be changed more often than once a year thereafter. Notice of a change of premium will be sent to the Owner at least 30 days before the change becomes effective. Upon any Rider premium increase, the Owner has the option to: a) Pay the new Rider premium; or b) Reduce the Rider benefit proportionally. If the Owner does not elect a) above in writing within 60 days after notification of the premium increase, the Company will automatically reduce the benefit of this Rider Proportionally.

ACCELERATED LIVING BENEFIT—Upon receipt of proof of a qualifying event and written consent of all irrevocable beneficiaries and all assignees, we will pay an accelerated benefit. It will be paid in a single sum. To calculate the benefit, we will begin with the lesser of:

(Prior to the 91st day following the date of issue of the Policy): (a) ten percent (10%) of the percent, indicated in the Benefit Description Page, of the Face Amount, or (b) $25,000.

(Starting on the 91st day following the date of issue of the Policy): (a) the percent, indicated in the Benefit Description Page of the Policy, of the Face Amount, or (b) $250,000.

The applicable percentage shall be the lesser of a) or b) above divided by the Face Amount.

Then we will subtract: (a) the applicable percentage of any outstanding loan and loan interest due and unpaid on the date of the qualifying event; and (b) any premium due and unpaid which applies to a period prior to the date a qualifying event occurs.

On the date payment is made, the following will be reduced by the applicable percentage: 1) the Face Amount; 2) the Policy's base premium excluding the Policy fee (if any); 3) the cash value (if any); 4) any policy loans. The premium rate for any riders on the Policy will not be reduced. The accelerated benefit rider and its associated premium will terminate, unless the qualifying event for which payment was made is for Coronary Artery Bypass Graft. Upon payment of 10% of the accelerated benefit due to the occurrence of Coronary Artery Bypass Graft, the rider premium continues unchanged and future acceleration of any other benefit under the Rider will be reduced proportionately.

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 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 INSTITUTION 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**