Application for Individual

Life Insurance ICC18 5160

Americo Financial Life and Annuity Insurance Company

SECTION 1. PROPOSED INSURED INFORMATION

1. Proposed Insured's Name *(Last, First, MI)* [redacted]

2. ☐ Single ☐ Married

3. ☒ Male ☐ Female

4. a. Height: _____'_____"

b. Weight: _____ lbs.

5. Mailing Address *(Include City, State, and ZIP. If mailing address is a PO Box, a street address is also required.)*

6. Street Address *(Include City, State, and ZIP)*

7. Has the Proposed Insured lived at their current address for less than 6 years? ..... ☐ Yes ☐ No If **Yes**, prior ZIP Code is required:_____

8. Phone Number: ☐ Home ☐ Cell ☐ Work

9. Email Address

10. Social Security Number	11. Date of Birth *(MM/DD/YYYY)*	12. Age	13. Place of Birth *(State, Country)*
	08/23/1959	61	

14. a. Is the Proposed Insured a U.S. Citizen? *(If **No**, complete 14b. and 14c. below.)* ..... ☐ Yes ☐ No

b. Is the Proposed Insured a Permanent Resident? *(If **Yes**, provide Permanent Resident Visa or Green Card ID Number.)* ..... ☐ Yes ☐ No

c. *Permanent Resident Visa or Green Card ID #: _____

*A copy of the Permanent Resident Visa or Green Card must be provided to underwriting as a delivery requirement.

15. What is your current employment status? *(Please choose one.)*

☐ Employed: If selected, provide: Annual Salary: $_____ Occupation: _____

☐ Disabled ☐ Student

☐ Retired ☐ Stay-at-Home Person If either of these is selected, provide Household Income: $_____

☐ Unemployed: If selected, provide: Date Unemployment Started:_____ Usual Occupation: _____

SECTION 2. PRODUCT INFORMATION *(Verify that the product is available in the state where the application is being signed.)*

1. ☐ CBO 100 ☐ Term 125 ☐ CBO 50 ☒ Term 100

☐ Continuation ☐ Payment Protector Continuation ☐ Payment Protector ☐ Other: _____

☐ ADB *(if selected, skip 2 & 3)*
Base Face Amount: $1,000
ADB Rider: $_____

2. Guarantee Periods *(Level Period/Guarantee Period)*

☐ 15/15 ☐ 20/20 ☐ 25/25 ☐ 30/30
☐ 15/5 ☐ 20/5 ☐ 25/5 ☐ 30/5
☐ To Age 70 *(Payment Protector or Payment Protector Continuation products only)*
☐ Other: _____

IMPORTANT NOTE: 5-Year Guarantee Periods are only available on Term products.

3. Payment Information

Face Amount $_____

Monthly Income*: $_____

**Payment Protector or Payment Protector Continuation only.*

4. Mode Premium $_____

Mode: ☐ Monthly Bank Draft ☐ Annually

5. Effective Date

(If not checked, will be "Issue Date". Date cannot be the 29th, 30th, or 31st of the month.)

☐ Issue Date
☐ Save Age of _____
☐ Specific Date _____

6. Automatic Premium Loan *(Continuation product only.)*

☐ Yes ☐ No ☐ NA

SECTION 3. RIDERS *(Verify rider availability. Riders are not available in all states or with all products. Please refer to your Agent Guide.)*

☐ Accidental Death Benefit ..... ☐ $10,000 ☐ $25,000
(Payment Protector or Payment Protector Continuation only)

☐ Accidental Death Benefit *(CBO products only)*...$ _____

☐ Additional Insured Term Insurance* .....$ _____

☐ Children's Term* .....$ _____

☐ Term Insurance .....$ _____

☐ Waiver of Premium

☐ Disability Income*

☐ Primary Insured ☐ 1 Year ☐ 2 Year $_____

☐ Additional Insured ☐ 1 Year ☐ 2 Year $_____

☐ Monthly Income Death Benefit: $_____

Income Period: ☐ 15 ☐ 20 ☐ 25 ☐ 30 ☐ To Age 70

*Additional Insured, Children's Term, and Disability Income riders require supplemental applications.

SECTION 4. BENEFICIARY INFORMATION *(Include percentage shares. If shares are not given, they will be equal.)*

If not specified, all beneficiaries will be Primary.	Name	Social Security Number or Taxpayer ID	Relationship	Date of Birth	Phone Number	Email	% of Share *(Must total 100%)*
☐ Primary							
☐ Primary ☐ Contingent							
☐ Primary ☐ Contingent							
☐ Primary ☐ Contingent							
☐ Primary ☐ Contingent							
☐ Primary ☐ Contingent							

SECTION 5. OWNER INFORMATION *(If different from the Proposed Insured.)*

1. Owner's Name *(Last, First, MI)*: Gallagher, Michael
2. Relationship to Proposed Insured:
3. SSN or Taxpayer ID:
4. Mailing Address *(Include City, State, and ZIP. If mailing address is a PO Box, a street address is also required.)*:
5. Street Address *(Include City, State, and ZIP)*:
6. Has the Owner lived at their current address for less than 6 years? ☐ Yes ☐ No If **Yes**, prior ZIP Code is required: _____
7. Phone Number: ☐ Home ☐ Cell ☐ Work
8. Email Address:
9. Date of Birth *(MM/DD/YYYY)*: 08/23/1959
10. Place of Birth *(State, Country)*:
11. a. Is the Owner a U.S. Citizen? *(If **No**, complete 11b. and 11c. below.)* ☐ Yes ☐ No
    b. Is the Owner a Permanent Resident? *(If **Yes**, provide Permanent Resident Visa or Green Card ID Number.)* ☐ Yes ☐ No
    c. *Permanent Resident Visa or Green Card ID #: _____

*A copy of the Permanent Resident Visa or Green Card must be provided to underwriting as a delivery requirement.

SECTION 6. PERSONAL HISTORY

*If you answer **Yes** to any of the personal history questions below (1-4), you will not be eligible for coverage under this application.* **Yes** **No**

1. Within the last 12 months used, any of the following: walker, wheelchair, electric scooter, supplemental oxygen, or catheter? ☐ ☐
2. Within the past 2 years have you engaged in any motor sports racing; boat racing; parachuting/skydiving; hang gliding; base jumping; rock or mountain climbing; cave diving, underwater photography, canyoning, or Scuba diving over 100 ft.? ☐ ☐
3. In the past 10 years, have you:
   a. Used heroin, morphine, other unprescribed narcotics, ecstasy, opium derivatives, marijuana for medical purposes, cocaine, crack, barbiturates, amphetamines, methamphetamines, or hallucinogens or any other illegal, restricted or controlled substances; or been treated or been advised by a licensed member of the medical profession to seek treatment for the intake of any drug? ☐ ☐
   b. Used alcohol to a degree that required treatment or was advised to limit or discontinue its use by a licensed member of the medical profession? ☐ ☐
   c. Used or been convicted of possession of unlawful drugs or used prescription drugs other than as prescribed by a licensed member of the medical profession in any form? ☐ ☐
   d. Been convicted of, pled guilty to, or currently awaiting trial for a felony? ☐ ☐
   e. Served or been released from incarceration, probation, parole, or other court-ordered supervision for a misdemeanor or felony conviction? ☐ ☐
4. Are you currently under an order for probation, parole or other court-ordered supervision for a misdemeanor or felony conviction? ☐ ☐
5. Within the past 2 years, have you made any flights as a pilot or student pilot? ***(If Yes, aviation exclusion will be included.)*** ☐ ☐
6. Within the next 2 years, do you intend to work, travel, or reside in Saudi Arabia, Iraq, Afghanistan, Syria, Somalia, Sudan, or Yemen for more than 30 days, or reside outside the United States at any location more than 180 days? ☐ ☐
7. Are you a member of the United States Military on active duty? (*If **Yes**, complete 7a. below.)* ☐ ☐
   a. If **Yes**, are you currently deployed or do you have orders to be deployed in Saudi Arabia, Iraq, Afghanistan, Syria, Somalia, Sudan, or Yemen? ☐ ☐
8. Do you currently have a valid driver's license? ☐ ☐
   a. If **No**, choose a reason from the list below:
      ☐ I use public or commercial transportation
      ☐ I have a medical restriction to driving
      ☐ Parking violations or child support
      ☐ I am unable to physically appear
      ☐ My license has been suspended or revoked
      ☐ I have never had a driver's license due to personal choice
   b. If **Yes**, in the past 2 years, have you been convicted, pled guilty, or entered into a plea agreement for driving under the influence of drugs, alcohol, or reckless driving; have you pled guilty to or been convicted of 3 or more moving violations; or had your driver's license suspended or revoked for any driving-related criticism? ☐ ☐

SECTION 7. MEDICAL HISTORY

If you are applying for the ADB product, do not answer questions 1-13; These questions will not be considered for this product.

1. a. During the last 24 months, which of the statements below describes your nicotine use *(check all that apply)*:

☐ No nicotine products ☐ Occasional use of nicotine products ☐ Less than 10 cigarettes per day ☐ More than 10 cigarettes per day

☐ Other nicotine products such as cigars, pipes, chewing tobacco, snuff, and alternative nicotine delivery devices such as nicotine chewing gum, nicotine patches, devices for vaping, or electronic cigarettes

	Yes	No
b. If you are **NOT** a **CURRENT** nicotine user, have you used any nicotine products listed in Question 1a. (above) in the past? If **Yes**, what was your last date of use? _____	☐	☐
c. During the last 24 months, have you smoked marijuana for recreational purposes?	☐	☐

*If you answer **Yes** to any of the health questions below (2-8), you will not be eligible for coverage under this application.*

	Yes	No
2. Have you ever (1) been diagnosed with, or (2) received care or treatment for, or (3) consulted with or been advised by a licensed member of the medical profession to seek treatment for:		
a. Coronary Artery Disease, Heart Attack, Coronary Artery Bypass Surgery, Angioplasty, Stent Placement, Angina (chest pain), Valvular Heart Disease, Cerebrovascular Disease, Cardiomyopathy, Congestive Heart Failure, Congenital Heart Disease, Stroke, Transient Ischemic Attack(TIA, Mini Stroke), abnormal heart rhythm, had placement of a Pacemaker or Defibrillator, Cerebral, Aortic or Thoracic Aneurysm, or Abdominal Aortic Aneurysm?	☐	☐
b. Chronic Lung Disease (except mild Asthma), including Chronic Obstructive Pulmonary Disease (COPD), Chronic Bronchitis, Emphysema, Sarcoidosis, Pulmonary Hypertension, or Cystic Fibrosis?	☐	☐
c. Major Depression, Bipolar Disorder, Schizophrenia, Alzheimer's Disease, Dementia, Memory Loss, Down Syndrome, Autism, mental incapacity, suicide attempt, eating disorders, Chronic Depression, or any other nervous disorder?	☐	☐
d. Chronic Kidney Disease, End-Stage Renal Disease, Renal Insufficiency, or any condition within the last 5 years that required dialysis?	☐	☐
e. Parkinson's disease, Sickle Cell Anemia, Pernicious Anemia, Thalassemia, clotting disorders, or other disorders of the blood, Lou Gehrig's Disease (ALS), Muscular Dystrophy, Demyelinating Disease including Multiple Sclerosis, Huntington's Disease, Hydrocephalus, Cerebral Palsy, Quadriplegia, or Paraplegia?	☐	☐
f. Liver Disease, Liver Failure, Cirrhosis or any form of Hepatitis (excluding Hepatitis A from which you have fully recovered)?	☐	☐
g. Cancer, Leukemia, Melanoma, any tumor (benign or malignant) of the brain, or any other internal cancer (except basal cell cancer)?	☐	☐
h. Connective tissue or autoimmune disorder including Rheumatoid, debilitating or disabling arthritis; chronic joint or disc disease, Systemic Lupus, or Scleroderma?	☐	☐
i. Been the recipient of an organ transplant?	☐	☐
j. Ulcerative Colitis or Crohn's Disease?	☐	☐
3. Have you (1) been diagnosed with, or (2) received care or treatment for, or (3) consulted with or been advised by a licensed member of the medical profession to seek treatment for:		
a. Epilepsy or Seizure Disorder which has been diagnosed within the past 6 months, has caused you to be hospitalized within the last 12 months, or do you have any driving restriction due to Epilepsy or Seizure Disorder?	☐	☐
b. Sleep Apnea, diagnosed within the last 6 months, or for which you are not being treated (CPap or BiPap)?	☐	☐
c. Mild or Situational Depression or Anxiety, diagnosed within the last 6 months, or for which you have been hospitalized?	☐	☐
d. Psoriatic or other inflammatory Arthritis diagnosed within the last 6 months or for which you are undergoing infusion therapy or being prescribed by a licensed member of the medical profession biologics or take daily oral steroids?	☐	☐
e. Any disease or disorder of the Bones or Muscles for which you have had surgery within the last 12 months and have not secured a release from a licensed member of the medical profession?	☐	☐
f. Asthma for which you take **daily oral steroid** medications or for which, in the past 12 months, you have visited an Emergency Department, or been hospitalized?	☐	☐
4. Have you been prescribed narcotics by a licensed member of the medical profession to alleviate the pain of a chronic condition and have continued this medication for a period lasting more than 6 months?	☐	☐
5. In the past 2 years, other than for wellness visits, minor injuries, or illnesses for which a licensed member of the medical profession has deemed you fully recovered and requiring no further treatment or follow up, have you had:		
a. any labs, diagnostic testing, or procedure(s) completed with abnormal results, or results that require additional or follow-up diagnostic testing or treatment, or for which results are still pending?	☐	☐
b. referral to another licensed member of the medical profession or facility for consultation or treatment that has not been completed, or consulted any licensed member of the medical profession not already identified for any reason?	☐	☐
6. Are you, at the time of this application, confined to any hospital or other medical or rehabilitation facility?	☐	☐
7. Are you currently pregnant? *(If **Yes**, complete 7a. below.)*	☐	☐
a. Have you been diagnosed by a licensed member of the medical profession with any complications of pregnancy including Gestational Diabetes, pregnancy-induced high blood pressure or toxemia, a multiple fetal pregnancy, or have you been advised by a licensed member of the medical profession to limit your normal activities, stop work, or be on bed rest?	☐	☐
8. In the past 12 months, have you been recommended by a licensed member of the medical profession, but not yet completed, any treatment, surgery, or hospitalization?	☐	☐

SECTION 7. MEDICAL HISTORY (CONTINUED)

	Yes	No
9. Within the past 10 years, have you (1) been diagnosed with, or (2) received care or treatment for, or (3) consulted with or been advised by a licensed member of the medical profession to seek treatment for:		
a. Diabetes in any form including Pre-Diabetes or elevated blood sugar? *(If **Yes**, complete i.-vii. below.)*	☐	☐
i. Was your initial diagnosis within the past 6 months?	☐	☐
ii. Was your original diagnosis given prior to age 35?	☐	☐
iii. How is your diabetes currently treated? *(Check all that apply.)* ☐ Oral Medications or Non-Insulin Injectable ☐ Oral Medications and Insulin ☐ Insulin ☐ Diet and Exercise		
iv. How often, on average, do you check your blood sugar?: ☐ Daily ☐ Weekly ☐ Monthly ☐ Never		
v. Within the past 3 months have you taken more than 2 medications prescribed by a licensed member of the medical profession to control your blood sugar?	☐	☐
vi. In the past 6 months, have you had an A1c reading of more than 8.0 or has a licensed member of the medical profession told you that your diabetes is uncontrolled?	☐	☐
vii. Have you been treated for cellulitis, neuropathy or amputation of either your right or left foot or leg?	☐	☐
b. Hypertension (High Blood Pressure)? *(If **Yes**, complete i.-vi. below.)*	☐	☐
i. Was your initial diagnosis within the past 4 months?	☐	☐
ii. Was your original diagnosis given prior to age 30?	☐	☐
iii. Are you currently taking more than 3 medications prescribed by a licensed member of the medical profession to control your high blood pressure?	☐	☐
iv. Have you had an **abnormal** electrocardiogram (EKG) or **echocardiogram** (echo) within the last 12 months?	☐	☐
v. In the past 6 months has a licensed member of the medical profession communicated to you that your blood pressure was uncontrolled?	☐	☐
vi. Have you ever been treated by a licensed member of the medical profession for any heart disease or disorder including chest pain (angina) or blood circulation condition?	☐	☐
10. Within the past 10 years, have you been:		
a. Diagnosed by a licensed member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)?	☐	☐
b. Diagnosed or treated by a licensed member of the medical profession for specified symptoms such as: immune deficiency, recurrent fever, unexplained weight loss, fever of unknown origin, severe night sweats, unexplained infections or skin lesions, unexplained swelling of the lymph glands, Kaposi's Sarcoma, or *Pneumocystis Carinii* Pneumonia?	☐	☐

11. Provide the name and contact information of your current Personal Care Physician

Physician's Name	Physician's Phone Number
Physician's Address	

12. Provide name and contact information of the last physician you have seen within the last 15 years: ☐ Check here if it is same as the Personal Care Physician listed above.

Physician's Name	Physician's Phone Number
Physician's Address	

13. ☐ Check here if you have not seen a licensed medical provider of any kind in the past 15 years.

SECTION 8. LIFE INSURANCE IN FORCE AND REPLACEMENT INFORMATION

1. Is there any existing life insurance, annuity, or disability income insurance coverage on the life of any Proposed Insured? *If **Yes**, provide details below, including whether the life insurance applied for will replace or otherwise reduce in value any existing life insurance or annuity in force.* ..... ☐ Yes ☐ No

Insured's Name	Company	Owner's Name	Date *(mo/yr)*	Face Amount	Accidental Death Benefit	
						☐ Internal ☐ External ☐ Replacement
						☐ Internal ☐ External ☐ Replacement
						☐ Internal ☐ External ☐ Replacement
						☐ Internal ☐ External ☐ Replacement
						☐ Internal ☐ External ☐ Replacement
						☐ Internal ☐ External ☐ Replacement

☐ There is other existing life insurance or annuities.

SECTION 9. AUTHORIZATION AND ACKNOWLEDGMENT

REQUEST FOR OWNER(S) TAXPAYER IDENTIFICATION NUMBER AND W-9 CERTIFICATION: Under penalties of perjury, I as the Owner certify that (check all that apply):

☐ **I am a U.S. citizen or other U.S. person, and the number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and,**

☐ **I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding.**

By providing Your Authorization and Acknowledgment, You:

- **AGREE** any policy issued on this application will be deemed to be delivered in and governed by the laws of the jurisdiction where the Owner resides at the time of the application, as evidence by the address provided in this application.
- **ACKNOWLEDGE** that the USA PATRIOT ACT requires all financial institutions, including insurance companies, to verify the identity of their customers. Providing your name, address, date of birth and taxpayer identification number allows Americo to verify your identity. Americo's verification process may include the use of third-party sources to verify the information you provide.
- **AUTHORIZE** Americo to act on electronic and/or telephonic information from all parties specified in this application. This authorization may be revoked by sending written notice to Americo at its administrative office address. The absence of this authorization constitutes a rejection of this authorization.

You furthermore Agree to the following:

- **THE ANSWERS AND STATEMENTS IN THE APPLICATION FOR INSURANCE ARE THE BASIS FOR ANY POLICY ISSUED BY AMERICO AND NO INFORMATION WILL BE CONSIDERED TO HAVE BEEN GIVEN TO AMERICO UNLESS IT IS STATED IN THE APPLICATION.**
- **YOUR SALES REPRESENTATIVE DOES NOT HAVE AMERICO'S AUTHORIZATION TO WAIVE THE ANSWER TO ANY QUESTION IN THIS APPLICATION, NOR DECIDE ON THE INSURABILITY, NOR WAIVE ANY OF THE COMPANY'S UNDERWRITING REQUIREMENTS, NOR CHANGE ANY CONTRACT.**
- **ALL ANSWERS AND STATEMENTS IN THIS APPLICATION FOR INSURANCE, AS THEY PERTAIN TO YOU, ARE TRUE AND COMPLETE TO THE BEST OF YOUR KNOWLEDGE AND BELIEF. CONSISTENT WITH STATE LAWS, ANY FALSE ANSWER MAY SERVE AS A BASIS FOR A DENIAL OF A CLAIM AND/OR RESCISSION OF THE POLICY.**

IMPORTANT FRAUD NOTICE:
ANY PERSON WHO KNOWINGLY PRESENTS A FALSE STATEMENT IN AN APPLICATION FOR INSURANCE MAY BE GUILTY OF A CRIMINAL OFFENSE AND SUBJECT TO PENALTIES UNDER STATE LAW.

Signed at (State) PA on (Month/Day/Year) 05/27/2021

Signature of Proposed Insured *(required)*

Signature of Owner (*if different than the Proposed Insured)*

Printed Name of Witnessing Agent *(required)*

Signature of Witnessing Agent *(required)*