F PROPOSED INSURED HEALTH INFORMATION

1. Height: 5' 11''	2. Weight: 160

3 a. Has a member of the medical profession ever diagnosed you with or have you ever tested positive for any of the listed conditions in 3b? *(Check all that apply.)*

b.
- ☐ HIV/AIDS
- ☐ Cancer
- ☒ Heart Disease
- ☐ Leukemia/Lymphoma
- ☐ Organ/Tissue Transplant
- ☐ Multiple Sclerosis
- ☐ None of the above apply to me
- ☒ Diabetes
- ☐ Stroke or TIA
- ☐ Liver Disease
- ☐ Systemic Lupus
- ☐ ALS (Lou Gehrig's Disease)
- ☐ Chronic Kidney Disease
- ☐ Alzheimer's or Dementia
- ☐ Alcohol Abuse or Addiction
- ☐ Drug Abuse or Addiction
- ☐ Blood/Circulation Disorder
- ☐ Huntington's Disease
- ☐ Brain Tumor
- ☐ Chronic Lung/Respiratory Disease
- ☐ Pancreatitis
- ☐ Parkinson's Disease
- ☐ Amputation due to Disease
- ☐ Nervous, Mental, or Psychiatric Disease or Disorder

c. Within the last 5 years, has a member of the medical profession consulted with you, provided care or treatment or prescribed medication for any of the listed conditions in 3b? *(Check all that apply.)*

4. Within the past 12 months, have You been advised, by a member of the medical profession to have tests, surgery, or hospitalization (except for those related to HIV or AIDS), which have not been completed, or are You waiting for a medical diagnosis or results of medical tests or procedures which have not been received or are You currently hospitalized? ☐ Yes ☒ No

5. Are You currently, or within the past 12 months have You: *(Check all that apply.)*
- ☐ Been confined to a nursing facility
- ☐ Received hospice care
- ☐ Used supplemental oxygen for breathing
- ☐ Received home health care
- ☐ Been dependent on a wheelchair or motorized mobility device
- ☐ Received assistance with activities of daily living, including bathing, toileting, or dressing because of a debilitating disease or being bedbound
- ☒ None of the above apply to me

6. Have You used any nicotine products (including, but not limited to, cigarettes, cigars, pipes, chewing tobacco, snuff, alternative nicotine delivery devices such as nicotine chewing gum or lozenges, nicotine patches or e-cigarettes, or any device used for the vaporization of liquid nicotine) within the past 12 months? ☐ Yes ☒ No

G ACKNOWLEDGMENT

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.

By providing Your Authorization and Acknowledgement, You:

- ACKNOWLEDGE any policy issued on this application will be deemed to be delivered in and governed by the laws of the jurisdiction of the Owner.
- 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.

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.

Signed at (State) OH on (Month/Day/Year) 11/7/2024

Signed by Electronic Signature
Signature of Proposed Insured *(required)*

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

Ronald Neal
Printed Name of Witnessing Agent *(required)*

Signed by Electronic Signature
Signature of Witnessing Agent *(required)*

Supplemental Application 1 for

Individual Life Insurance

ICC24 5427

AMERICO

Proposed Insured's Name *(Last, First, Middle Initial)*

Bunjevac, Milan R

I. Heart Disease *(To be completed when the Proposed Insured selects Heart Disease (Section F, Question 3) on the base application.)*

1. Date of diagnosis: 05/15/2021
2. Do You have coronary artery disease or chronic angina (heart/chest pain)? ☐ Yes ☒ No
   a. If Yes, date of diagnosis: ______
   b. Date of last physician visit for this condition: ______
3. Have You suffered a heart attack? ☒ Yes ☐ No
   a. If Yes, how many years since most recent event? ☐ 0-1 ☐ 2 ☐ 3 ☐ 4 ☒ 5+
   b. Have You had more than one heart attack? ☐ Yes ☒ No
4. In the past 5 years, have You had an angioplasty, stent placement, or heart bypass surgery? ☒ Yes ☐ No
   a. If Yes, how many years since initial intervention? ☐ 0-1 ☐ 2 ☒ 3 ☐ 4 ☐ 5
   b. Number of stents or arteries involved: ☒ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5+
5. Have You been diagnosed with cardiomyopathy, or had or been advised by a member of the medical profession to have placement of a defibrillator? ☐ Yes ☒ No
6. Do You have atrial fibrillation? ☐ Yes ☒ No
   a. If Yes, how many years since diagnosis? ☐ 0-1 ☐ 2 ☐ 3 ☐ 4 ☐ 5+
   b. Are You currently being treated for atrial fibrillation (medications, post ablation, implanted device)? ☐ Yes ☐ No
7. Do You have heart failure or pulmonary hypertension (excluding ordinary high blood pressure)? ☐ Yes ☒ No
8. Do You have a heart valve disorder? ☐ Yes ☒ No
   a. If Yes, which valve(s) are affected? *(Check all that apply.)* ☐ Aortic ☐ Pulmonary ☐ Tricuspid ☐ Mitral
   b. Which treatment or procedure have You had or been advised to have in the past 5 years? (*Check all that apply.*)
   ☐ Repair surgery ☐ Replacement surgery ☐ Medication only ☐ Monitoring only
9. Have You been diagnosed with a congenital heart condition that has not been treated? ☐ Yes ☒ No

II. Stroke and/or TIA *(To be completed when the Proposed Insured selects Stroke or TIA (Section F, Question 3) on the base application.)*

1. Which event did You have? *(Check all that apply.)*
   ☐ Stroke - date of initial event: ______ ☐ more than 1 Stroke ☐ TIA - date of initial event: ______ ☐ more than 1 TIA

III. Diabetes *(To be completed when the Proposed Insured selects Diabetes (Section F, Question 3) on the base application.)*

1. Date of diagnosis: 11/17/2021
2. Complications from diabetes? *(Check all that apply.)*
   ☐ Blood Circulation Disorder ☐ Insulin Shock ☐ Diabetic Eye Disease (Retinopathy) ☐ Diabetes with Amputation

You agree to the following:

- **This supplemental application is made a part of the policy to which it applies.**
- **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 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) OH on (Month/Day/Year) 11/7/2024

Signed by Electronic Signature
Signature of Proposed Insured *(required)*

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

Ronald Neal
Signature of Witnessing Agent *(required)*

Signed by Electronic Signature
Printed Name of Witnessing Agent *(required)*