FAMILY PLAN

AMERICAN-AMICABLE LIFE INSURANCE COMPANY OF TEXAS

P.O. BOX 2549, WACO, TX 76702-2549 • (254) 297-2777

INDIVIDUAL 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#	Height	Weight	Occupation
☐ Male ☐ Female	Mo. Day Yr / /			DL#	ft in	lbs	

Owner: Name _____ SS#_____ Address:_____

Payor: Name SS# Address:

Primary Insured: Primary Beneficiary _____ SS#_____ Relationship _____

Contingent Beneficiary SS# 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 Insurance Agreement $_____ ☐ ADB $ ☐ Other

☐ Spouse 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

Will you replace or change an existing life or disability insurance policy or an annuity? ☐ Yes ☐ No

Company

Policy # Amt. of Coverage $

Physician: Name City/State Phone:

HEALTH INFORMATION - Answer Questions for all Proposed Insureds.

	PROPOSED INSURED		*PROPOSED SPOUSE*	
	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 or tested positive for the Human Immunodeficiency Virus (HIV)?	☐	☐	☐	☐
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 by a medical professional 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 are you currently receiving benefits, compensation, or pension for disability, or are you currently unemployed due to medical reasons?	☐	☐	☐	☐
4. **Within the past 5 years** have you been treated, diagnosed, or been prescribed medication by a medical professional for internal cancer, melanoma, Hodgkin's disease, or lymphoma?	☐	☐	☐	☐
5. Have you been treated, diagnosed, or been prescribed medication by a medical professional for diabetes prior to age 21, or do you currently take insulin shots, or been 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 treated, diagnosed, or been prescribed medication by a medical professional 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 treated, diagnosed, or been prescribed medication by a medical professional 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 (excluding AIDS/HIV tests), 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 treated or diagnosed or been prescribed medication by a medical professional 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 is not eligible for any coverage.

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

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 INFORMATION—To the best of your knowledge and belief, have any of the children listed above for coverage been diagnosed or treated by a medical professional for 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? ☐ Yes ☐ No

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

AGREEMENT—I agree with American-Amicable Life Insurance Company of Texas (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 statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

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) American-Amicable Life Insurance Company of Texas; 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 American-Amicable Life Insurance Company of Texas 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 the time limit, if any, permitted by applicable law in the state where the policy is delivered or issued for delivery. A copy of this authorization shall be as valid as the original.

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

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

Signed at _____ _____ _____
CITY STATE 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 and Confined Care Accelerated Benefit Rider Disclosure Forms has 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

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 American-Amicable Life Insurance Company of Texas, 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_____

AMERICAN-AMICABLE LIFE INSURANCE COMPANY OF TEXAS

P.O. BOX 2549, WACO, TX 76702-2549

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).

If any of the above conditions are not met, 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 American-Amicable Life Insurance Company of Texas 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. American-Amicable Life Insurance Company of Texas, or its reinsurers, may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-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. 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.

American-Amicable Life Insurance Company of Texas, 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.

AMERICAN-AMICABLE LIFE INSURANCE COMPANY OF TEXAS
WACO, TEXAS

DISCLOSURE STATEMENT

ACCELERATED BENEFIT RIDER FOR LIMITED LIFE EXPECTANCY DUE TO A TERMINAL CONDITION

PAYMENT OF AN ACCELERATED BENEFIT WILL REDUCE THE CASH VALUE, THE AMOUNT AVAILABLE FOR LOANS, AND THE PREMIUM, EXCLUDING THE POLICY FEE (IF ANY), FOR THE POLICY IN PROPORTION TO THE AMOUNT OF BENEFIT PAID.

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 an illness, physical condition or injury 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. 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. This rider terminates if the policy matures or expires.**

AMERICAN-AMICABLE LIFE INSURANCE COMPANY OF TEXAS
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.

Receipt of acceleration-of-life-insurance benefits may affect your, your spouse or your family's eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children (AFDC), supplementary social security income (SSI), and drug assistance programs. You are advised to consult with a qualified tax advisor and with social service agencies concerning how receipt of such a payment will affect you, your spouse and your family's eligibility for public assistance.

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 values (if any), loan values (if any), the associated premium and death benefit under the life insurance policy to which the Rider is attached will be reduced if an accelerated benefit is paid. There is no premium or administrative fee for this Rider.

□ American-Amicable Life Insurance Company of Texas
□ Pioneer American Insurance Company
□ Pioneer Security Life Insurance Company
□ Occidental Life Insurance Company of North Carolina
□ IA American Life Insurance Company
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:_____Application No.: _____

Height:_____ Weight:_____ Date of Birth: _____

1) Does the child reside with the father and/or mother that are listed on the application? Yes ☐ No ☐
If **No**, list the name, address and relationship with whom the child resides:
Name:_____Relationship:_____
Address/City/State: _____

2) Does the child have any existing life insurance or a pending application for life coverage? Yes ☐ No ☐
If **Yes**, provide the following information: Company Name:_____ Coverage Amount:_____
Will the existing coverage be replaced or changed? Yes ☐ No ☐

3) List any and all brothers and sisters by name and age:

Name/Age	Name/Age
1. _____	4. _____
2. _____	5. _____
3. _____	6. _____

4) Has insurance been requested on the applicant's brother(s) and/or sister(s) or do they have life coverage in force? Yes ☐ No ☐ If **Yes**, indicate the amount of coverage for each sibling:

Name/Coverage Amount	Name/Coverage Amount
1. _____	4. _____
2. _____	5. _____
3. _____	6. _____

5) Do the parent(s) or guardian(s) have coverage in force or has insurance been requested on the parent(s) or guardian(s)? Yes ☐ No ☐ If **Yes**, indicate the amount of coverage for each parent or guardian:
Father's/Guardian's amount of life coverage in-force and company name:_____
_____
Mother's/Guardian's amount of life coverage in-force and company name:_____
_____

6) Provide the annual income for the household for which the juvenile resides: _____

7) **Medical information for child:**
List child's current physician's name and address: _____
_____
Date last seen and reason: _____
_____
List current treatment and all medications: _____
_____

This Questionnaire amends and is made a part of my individual life insurance application. To the best of my knowledge and belief, and with the intent to induce the Company to issue the insurance coverage, all answers and statements contained in this questionnaire are true, complete, and correctly recorded. I will notify the Company of any changes in the statements or answers given in this application between the time of application and delivery of the policy.

Fraud Notice: Any person who knowingly presents a false statement in application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Signed at:_____ Date: _____
(City and State) Month Day Year
Signature of Parent/Guardian of Proposed Insured:_____
Signature of Agent: _____
Signature of Owner (If other than Parent/Guardian):_____

American-Amicable Life Insurance Company of Texas

Please note charge may appear on statement under American-Amicable Group of Companies

P.O. Box 2549 Waco TX 76702-2549

Policy Number _____

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

Account Number _____ **Amount $** _____

Would you like your draft to coincide with your Social Security payment schedule? ☐ Yes ☐ No

Please choose one of the following as your requested draft date (applies to first and future drafts of this account):

☐ Requested Draft Date, If Any (1st-28th) _____ OR ☐ 2nd Wednesday ☐ 3rd Wednesday ☐ 4th Wednesday

_____	_____	_____
PRINT NAME	**SIGNATURE (AS ON FINANCIAL INSTITUTION RECORDS)**	**DATE**

Bank Account Verification - Complete ONLY in absence of void check.

I have verified that the above account is a valid account and can be drafted for insurance premiums. I understand that if the information provided is found to be falsified, I may be subject to disciplinary action up to and including termination of my agent contract. This information was verified by a verification call with a bank representative.

Please provide the phone number and name of the person you spoke to at the Bank:_____

_____	_____
AGENT SIGNATURE / AGENT NUMBER	**DATE**

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 banking information can be verified.

_____	_____
SIGNATURE (of bank account holder)	**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**

AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS
American-Amicable Life Insurance of Texas (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:_____

DISCLOSURE STATEMENT

THIS DISCLOSURE STATEMENT WITH ALL APPLICABLE BLANKS FILLED IN IS FOR YOUR PROTECTION. IT GIVES YOU BASIC INFORMATION ABOUT THE COST AND COVERAGE OF THE INSURANCE BEING SOLICITED. READ IT CAREFULLY BEFORE SIGNING ANY AGREEMENT TO BUY LIFE INSURANCE.

THIS DISCLOSURE STATEMENT SHALL NOT BE CONSIDERED AS AN OFFER TO CONTRACT OR AS ALTERING OR MODIFYING ANY POLICY OR RIDER THAT MAY BE ISSUED.

Name of Proposed Insured_____ Age_____ Sex_____

Name of Agent preparing disclosure_____

Agent home or agency address_____

Telephone number of Agent_____

Name of Insurer: AMERICAN-AMICABLE LIFE INSURANCE COMPANY OF TEXAS

Home Office Address of Insurer: P.O. Box 2549 / Waco, Texas 76702-2549

Direct all correspondence to Insurer's Home Office.

	Descriptive Title of Coverage	Face Amount of Coverage (1) If not applicable, Description of Coverage	Annual Premium If not known, Premium for Mode Quoted (2)
Policy			
* Rider(s) and Supplemental Benefit(s)			

*(1) The face amount of coverage of the ☐ Policy ☐ Rider ☐ Supplemental Benefit changes as follows

_____

_____

*(2) The premium for the ☐ Policy ☐ Rider ☐ Supplemental Benefit changes; the ultimate ☐ Annual ☐ Monthly premium will be $_____ at policy year_____.

Total (Initial) ☐ Annual ☐ Monthly premium for the policy and rider will be $_____.

* Guaranteed Cash Value. If you continuously pay your premiums on this policy as they come due, you will have the following guaranteed cash value for each $1,000 (or face amount).

* You may borrow against this cash value at an annual 7.4% loan interest charge.

Number of Years Policy Has Been in Force	5	10	20	AGE 65
Total Accumulated Cash Value per $1,000 (or Total Face Amount)				

* A Surrender Comparison Index will be provided upon delivery of the policy or earlier if requested. This Index provides one means of comparing the relative costs of two or more similar policies.

* The prospective insured has ☐ has not ☐ requested an earlier delivery of the Index.

Upon request either the company or agent will furnish you with additional information about the insurance described.

* If inapplicable to insurance being offered, section may be deleted entirely or clearly marked "Not Applicable".

I certify that this written Disclosure Statement was given to the applicant at the time the application was signed.

_____

Agent's Signature

AMERICAN-AMICABLE LIFE INSURANCE COMPANY OF TEXAS
PO Box 2549 Waco, Texas 76702-2549

Addendum to Application for COVID-19

Proposed Insured's Name (Please Print):_____

1. **Within the past 12 months**, have you been advised by a medical professional to be quarantined, for any period of time for the novel coronavirus (COVID-19)?..... ☐ Yes ☐ No

2. **Within the past 12 months**, have you been treated for, examined for, diagnosed with, or tested positive for the novel coronavirus (COVID-19) by a medical professional?..... ☐ Yes ☐ No

3. **Within the past 30 days**, have you been advised by a medical professional to get specified medical care (such as any diagnostic testing or hospitalization) which was not completed; as result of fever, cough, shortness of breath, fatigue (excluding HIV/AIDS)? ..... ☐ Yes ☐ No

This Addendum to Application amends and is made a part of my individual life insurance application. To the best of my knowledge and belief, all answers and statements contained in this application are true, complete, and correctly recorded. I will notify the Company of any changes in the statements or answers given in this application between the time of application and delivery of the policy.

Fraud Notice: Any person who knowingly presents a false statement in application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Signed at_____ Application Date_____
(City and State)

Signature of Proposed Insured_____

Signature of Owner (If other than Proposed Insured)_____