**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:

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# | DL# | Height | Weight |
|---|---|---|---|---|---|---|---|
| ☐ Male ☐ Female | Mo. Day Yr / / | | | — — | State of Issue | ft in | lbs |

**Occupation/Duties:** Hire date (MM/YY): Annual Salary: $

**Owner:** Name _____ SS# _____ Address: _____

**Payor:** Name SS# Address:

**Primary** Primary Beneficiary _____ SS# _____ Relationship _____

**Insured:** Contingent Beneficiary SS# Relationship

**Plan:** _____ **Face Amount $** _____ ☐ Non-Tobacco ☐ Tobacco ☐ Preferred Non-Tobacco

Have you used tobacco or nicotine products in any form in the past 12 months? ☐ Yes ☐ No.....or during the past 36 months? ☐ Yes ☐ No

**Riders:** ☐ Waiver of Premium ☐ Unemployment Rider ☐ Return of Premium ☐ Other: _____

☐ Critical Illness % ☐ Child Rider (complete Form No. 3215) Units ☐ ADB $

☐ Disability Income $ ☐ Spouse Level Term $

**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

**Policy Date Request:** / /

Physician: Name: City/State Phone:

List current prescribed medications:

**SECTION A: Health Questions-Answer Questions 1 through 4 for Proposed Insured.** ***(circle all conditions that apply)***

1. **Within the past 10 years,** have you been treated for, or tested positive for, or been diagnosed by a medical professional with:
   a. high blood pressure, high cholesterol, heart attack, angina (cardiac chest pain), angioplasty, bypass surgery or stent, pacemaker or defibrillator, cardiomyopathy, congestive heart failure (CHF), irregular heartbeat, peripheral vascular disease (PVD), carotid artery disease, or any heart or circulatory disease or disorder? ☐ Yes ☐ No
   b. stroke, transient ischemic attack (TIA), amputation caused by disease, aneurysm, hemophilia, or anemia? ☐ Yes ☐ No
   c. diabetes, cirrhosis, hepatitis, pancreas disorder, Crohn's disease, ulcerative colitis, or any digestive or liver disease or disorder? ☐ Yes ☐ No
   d. asthma, emphysema, chronic obstructive pulmonary disease (COPD), sleep apnea, or any respiratory or lung disease or disorder? ☐ Yes ☐ No
   e. cancer in any form, Hodgkin's disease, leukemia, lymphoma, multiple myeloma, or organ transplant? ☐ Yes ☐ No
   f. migraine headaches, seizures, bi-polar disorder, schizophrenia, Alzheimer's, memory loss, dementia, anxiety or depression, mental retardation, mental incapacity, mental or nervous disorder, psychiatric disorder, or a suicide attempt? ☐ Yes ☐ No
   g. any disease or disorder of the kidneys, urinary bladder, prostate, breast, reproductive organs, or sexually transmitted disease? ☐ Yes ☐ No
   h. connective tissue disease, systemic lupus (SLE), multiple sclerosis, Parkinson's, cerebral palsy, muscular dystrophy, cystic fibrosis? ☐ Yes ☐ No
   i. arthritis, paralysis of two or more extremities or any disorder of the back, joints, muscles, or nervous system? ☐ Yes ☐ No
   j. any other disease or disorder, injury, surgery, birth defect, or deformity? ☐ Yes ☐ No
   k. Acquired Immune Deficiency Syndrome (AIDS), or any immune deficiency related disorder or the Human Immunodeficiency Virus (HIV)? ☐ Yes ☐ No
2. Are you currently unemployed due to medical reasons 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? ☐ Yes ☐ No
3. Are you currently hospitalized, confined to a nursing facility, receiving Hospice Care or home health care, or do you require assistance (from anyone) with activities of daily living such as bathing, dressing, eating or toileting? ☐ Yes ☐ No
4. **Within the past 12 months,** have you:
   a. consulted a medical professional, had surgery, or been hospitalized, or had diagnostic tests (excluding HIV/AIDS) such as EKG, Xray, MRI, CAT scan? ☐ Yes ☐ No
   b. had any diagnostic testing (excluding HIV/AIDS), surgery, or hospitalization recommended by a medical professional which has not been completed or for which the results have not been received, or been referred to a medical professional? ☐ 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).

| Condition | Dates | Treatment | Name/Address/Phone No. of Physician/Hospital |
|---|---|---|---|
| | / / | | |
| | / / | | |
| | / / | | |

**SECTION C: Answer Questions 1 through 5 for Proposed Insured.** ***(circle all conditions that apply)***

1. Have you had a natural parent or sibling diagnosed or treated by a licensed medical professional for diabetes, kidney disease, require a major organ transplant, or been medically 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
2. a. **Within the next 24 months,** do you intend to work, travel, or reside outside of the U.S. for more than 30 days? ..... ☐ Yes ☐ No
   If yes, where?_____
   b. **Within the past 24 months,** have you made or contemplated making any flights as a pilot, student pilot, or crew member of any aircraft? ..... ☐ Yes ☐ No
3. a. **Within the past 5 years,** have you pled guilty to or been convicted of a felony or misdemeanor (including DUI or DWI) or do you have such charge currently pending against you or have you had a driver's license suspended or revoked or is currently suspended or revoked, have you plead guilty to or been convicted of any motor vehicle violations or **within the past 6 months,** have you been on probation or parole?..... ☐ Yes ☐ No
   b. **Within the past 5 years,** participated in motorized racing, hang gliding, rock or mountain climbing, rodeo events, sky diving, or skin or scuba diving? ..... ☐ Yes ☐ No
4. **Within the past 10 years,** have you used illegal drugs, or abused alcohol or drugs, or had or been recommended by a medical professional or a licensed counselor to discontinue the use of alcohol or drugs or to have treatment or counseling for alcohol or drugs? ☐ Yes ☐ No

| | |
|---|---|
| 5. Do you have any existing life or disability insurance or annuity contract? ☐ Yes ☐ No | Company |
| Will you replace or change an existing life or disability insurance policy or an annuity? ☐ Yes ☐ No | Policy # Coverage Amount $ |

**COMMENTS:**_____

_____

_____

**AGREEMENT—**I agree with American-Amicable Life Insurance Company of Texas (the Company) as follows: (1) To the best of my knowledge and belief, and with the intent to induce the Company to issue the plan of insurance, all answers and statements contained in this application are true, complete, and correctly recorded; and (2) This application, supplemental applications, addendums, amendments, questionnaires, and any policy issued on the basis of such applications 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 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, LLC (MIB)] 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. This medical or health information includes information on the diagnosis and treatment of mental illness, alcohol, and drug use. This also includes information on the diagnosis, treatment, and testing results related to HIV, AIDS, and sexually transmitted diseases, unless otherwise restricted by state law. 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, 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; (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.

**ACKNOWLEDGEMENT**

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

Signed at (City)_____(State)_____ Date of Application (MM/DD/YY) _____

_____ _____

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 Rider Disclosure Form, the Confined Care Accelerated Benefit Rider and Chronic Illness Accelerated Death Benefit Rider Disclosure Forms have been presented to the applicant, if applicable.*

Agent's Remarks:_____

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
Has the proposed insured applied for any life insurance or annuity in the last ninety (90) days?..... ☐ Yes ☐ No

Agent Signature _____ Agent Printed Name_____ No: _____%_____

Agent Signature _____ Agent Printed Name_____ No: _____%_____

**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 (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 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, 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 member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB'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 may be obtained on its website at www.mib.com.

**AMERICAN-AMICABLE LIFE INSURANCE COMPANY OF TEXAS**
**WACO, TEXAS**

# DISCLOSURE STATEMENT

# TERMINAL ILLNESS ACCELERATED DEATH BENEFIT RIDER

**TAX IMPLICATIONS. The acceleration-of-life-insurance benefits offered under this Rider are not intended to qualify for favorable tax treatment. Tax laws relating to acceleration-of-life-insurance benefits are complex. You are advised to consult with a qualified tax advisor. The acceleration-of-life-insurance benefits do not, and are not intended to, qualify as long-term care insurance.**

**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 Terminal Illness Accelerated Death Benefit Rider attached to your Policy allows you to receive up to 100% of the Death Benefit proceeds of the Policy when the Insured has a medical condition that reasonably can be expected to result in death within 24 months or less. 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.

**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.**

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.

**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:_____

# 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** |

# AMERICAN-AMICABLE LIFE INSURANCE COMPANY OF TEXAS

P.O. Box 2549, Waco, TX 76702-2549

## ADDENDUM TO INDIVIDUAL LIFE INSURANCE APPLICATION

Application Addendum Forming a Part of my Application for Insurance

## CHILDREN'S INSURANCE AGREEMENT-CIA

**Primary Proposed Insured Name (Print):** _____

**CHILDREN'S COVERAGE ONLY** Children Proposed for Insurance:

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

**CHILDRENS HEALTH INFORMATION—**To the best of your knowledge and belief, have any of the children listed above for coverage been treated for or told by a medical professional that they have or had any of the following medical conditions: Hypertension, heart or circulatory disorder, malignancy in any form, diabetes, sickle cell anemia, seizures, Down's Syndrome, cystic fibrosis, cerebral palsy, hydrocephalus, paralysis, or within the past 12 months been hospitalized for asthma or any respiratory disorder?..... ☐ Yes ☐ No

If answered yes to the CHILDRENS HEALTH INFORMATION, please list the names of the children that your answer applies. **These children are excluded from the Children's Insurance Agreement Rider.**

**Children Excluded for "Yes" answer:** _____

**AGREEMENT—**I agree with American-Amicable Life Insurance Company of Texas (the Company) as follows: To the best of my knowledge and belief, all answers and statements contained in this application addendum are true, complete and correctly recorded.

I hereby agree that this amendment shall be an amendment to and form a part of my application for insurance, and be a part of any contract of insurance issued on the basis of such application.

Signed at _____ Application Date _____

CITY STATE MONTH DAY YEAR

_____ _____

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

_____

WITNESS-LICENSED AGENT SIGNATURE

## 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 6 months, have you been hospitalized or diagnosed by a medical professional with ongoing medical complications due to the novel coronavirus (COVID-19) or are you currently diagnosed by a medical professional with or being treated for the novel coronavirus (COVID-19)?
   .....☐ 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) _____