Application for
Individual Life Insurance ICC17 5140T

AMERICO

A PROPOSED INSURED INFORMATION

1. Name *(Last, First, Middle Initial)*	2. Date of Birth *(MM/DD/YYYY)*	3. Age	4. Gender
[redacted]	[redacted]	41	☒ Male ☐ Female

5. a. Mailing Address
[redacted] KY 41537

b. Street Address *(If different than Mailing Address.)*
[redacted] 41537

c. Years at current address: <5 If less than five (5) years, prior address is needed.
41537

d. Email Address [redacted]

6. Phone Number	7. SSN or Taxpayer ID	8. Place of Birth *(City, State, Country)*
☐ Home ☒ Cell ☐ Work [redacted]	[redacted]	United States Of America, Virginia

9 Is The Proposed Insured also the Owner? *(If Yes, skip B)* ☐ Yes ☒ No

B OWNER INFORMATION

1. Name *(Last, First, Middle Initial)*	2. Relationship to Proposed Insured	3. SSN or Taxpayer ID
[redacted]	Domestic Partner	[redacted]

4. a. Mailing Address
[redacted]

b. Street Address *(If different than Mailing Address.)*

c. Email Address [redacted]

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

If not specified, all beneficiaries will be Primary.	Name	Date of Birth *(MM/DD/YYYY)*	Phone Number	Relationship	% of Share *(Must total 100%)*
Primary	[redacted]	[redacted]		Domestic Partner	100
☐Primary ☐Contingent					
☐Primary ☐Contingent					
☐Primary ☐Contingent					
☐Primary ☐Contingent					
☐Primary ☐Contingent					

D PRODUCT INFORMATION

Product Name: Eagle Premier ☒ Face Amount: $ 10000 ☐ Solve for Face Amount
(if Guaranteed Issue product is elected, skip F)

Premium Mode: Monthly Bank Draft Modal Premium: $ 34.37 ☒ Check here to select Automatic Premium Loan

E REPLACEMENT INFORMATION

1. Is there any existing life insurance or annuity coverage on the life of any Proposed Insured? ☐ Yes ☒ No
If **Yes**, provide information in the table below and answer question 2. If **No**, skip question 2, and proceed to the next applicable section.

Proposed Insured's Name *(Last, First, Middle Initial)*	Company	Owner *(Last, First, Middle Initial)*	Amount	Accidental Death Benefit	Policy Date

2. Will the life insurance applied for replace, or otherwise reduce in value, any existing life insurance or annuity now in force? ☐ Yes ☐ No
Complete the replacement form(s) in accordance with applicable state replacement regulations. Replacement forms must be submitted with the application.
APPLICATION AND REPLACEMENT FORMS(S) MUST BE COMPLETED AND DATED ON THE SAME DAY.

F PROPOSED INSURED HEALTH INFORMATION

☐ N/A – Skip this section if Guaranteed Issue Product is Elected.

Information regarding Your insurability will be treated as confidential. Americo Financial Life and Annuity Insurance Company (Americo) is a member of MIB, Inc. (MIB). Americo, or its reinsurers, may make a brief report to MIB, which operates an information exchange on behalf of its members. If You apply to another member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB may supply such company with the information in its file. Americo or its reinsurers may also release information to other insurance companies to whom You may apply for life or health insurance, or to whom a claim for benefits may be submitted. It is Americo's practice to prohibit third parties who lawfully receive nonpublic health information from redisclosing or reusing the disclosed information. You may request to see the information kept in Your MIB file. You may also contact MIB and seek a correction for any errors in Your file.

Your authorization permits any insurance or reinsurance company, licensed medical physician, medical professional, hospital, pharmacy or pharmacy benefit manager, records custodians, other medical or medically related facility, clearing house, consumer reporting agency, and/or MIB, Inc. that has any information about You, or anyone listed in this application that are proposed to be insured, to give Americo, its reinsurers or any MIB authorized third-party administrator performing underwriting services on Americo's behalf, information about other insurance coverage, age, general character, habits, finances, motor vehicle records, medical care or advice about any physical or mental condition, including information about medications prescribed, chart notes, labs, x-rays and special tests, information on the diagnosis and treatment of Human Immunodeficiency Virus (HIV) infection, sexually transmitted diseases, and the use of drugs, alcohol, tobacco and psychotherapy notes and alcoholism, required by Americo to determine insurability and/or claims eligibility, for the duration of the claim. Health information obtained will not be re-disclosed without Your authorization unless permitted by law, in which case it may not be protected under federal privacy rules.

You may obtain a copy of this Medical Information Authorization on request. This Authorization will be valid for 2 years from the date signed, as permitted per applicable law in the state where the policy is delivered or issued for delivery. This Authorization may be revoked; however, it may not be revoked during the contestability period of the policy or to the extent Americo has taken action in reliance on this Authorization. Notice of revocation may be sent, in writing, to Americo at its Administrative Office address.

I understand that the aforementioned parties requesting access to my (electronic or paper) medical records are acting as a patient authorized representative and will attempt to access my medical records in the most efficient manner possible, including electronic interchange through a Health Information Exchange or directly through My Providers' electronic health record system.

Signature located on Medical Information Authorization — Signature of Proposed Insured *(required)*

8/26/2022 — Date

1. 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 last 12 months? ☒ Yes ☐ No

2. Height: 5' 8''

3. Weight: 170

	Yes	No
4. Have You ever been diagnosed, treated, tested positive, or been given medical advice, or prescribed medication by a licensed member of the medical profession for:		
a. Alzheimer's disease, dementia, memory loss, muscular dystrophy, or ALS (Lou Gehrig's disease)?	☐	☒
b. Congestive heart failure, defibrillator placement, cardiomyopathy, chronic kidney disease or kidney failure, or received kidney dialysis?	☐	☒
c. Cirrhosis of the liver, Hepatitis (all forms, excluding recovered Hepatitis A), or liver failure?	☐	☒
d. Emphysema, chronic obstructive pulmonary disease (COPD), or any other chronic respiratory or lung problem, excluding allergies or asthma?	☐	☒
e. Metastatic cancer (cancer that has spread to other parts of the body)?	☐	☒
f. Two or more occurrences of cancer of any kind or a reoccurrence of a previous cancer?	☐	☒
g. AIDS, ARC, or HIV?	☐	☒
5. In the past 24 months, have You been diagnosed, treated, tested positive, or been given medical advice by a licensed member of the medical profession for:		
a. Internal cancer, brain tumor, or malignant melanoma (excluding basal cell skin cancer)?	☐	☒
b. Complications of diabetes, including amputation, retinopathy (eye disease), nephropathy (kidney disease), neuropathy, insulin shock, or diabetic coma?	☐	☒
6. In the past 24 months, have You been diagnosed treated, tested positive received medical advice, counseling, or been prescribed medication by a licensed member of the medical profession for drug or alcohol abuse/dependency or addiction?	☐	☒
7. Within the last 12 months, have You been advised, by a licensed 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?	☐	☒
8. In the past 12 months, have You been diagnosed, treated, tested positive, been given medical advice or prescribed medication by a licensed member of the medical profession for:		
a. Angioplasty (balloon procedure), stent placement, or heart bypass surgery?	☐	☒
b. Stroke; heart attack, heart valve disease, coronary disease, angina (chest pain), or heart disorder (excluding hypertension)?	☐	☒
9. Have You received advice from a licensed member of the medical profession to have, are You waiting for, or have You ever received, an organ or tissue transplant?	☐	☒

	Yes	No
10. Are You now, or within the past 6 months have you been:		
a. Hospitalized for 48 hours or more, bedridden or confined to or living in a nursing facility or correctional facility?	☐	☒
b. Receiving or been advised by a member of the medical profession to receive hospice care?	☐	☒
c. Receiving home health care for a chronic or debilitating condition?	☐	☒
d. Receiving assistance with activities of daily living, including eating, bathing, toileting, or dressing due to a chronic or debilitating condition?	☐	☒
e. Confined to a wheelchair or using a walker for assistance (except in the case of a temporary condition immediately following injury or medical treatment not to exceed 3 months' time)?	☐	☒
f. Using oxygen to assist in breathing?	☐	☒
11. Have You been diagnosed with a terminal illness that is expected to result in death within 24 months?	☐	☒

ADDITIONAL QUESTIONS FOR APPLICANTS AGE 40-49 ONLY	Yes	No
12. Within the past 24 months, have You been convicted of, or pled guilty or no contest to, a felony?	☐	☐
13. Within the past 24 months, have You been diagnosed, treated or tested positive, or given medical advice by a licensed member of the medical profession for:		
a. Bipolar disorder, schizophrenia, mania or clinical depression, psychosis, mental incapacity, post-traumatic stress disorder or suicidal thoughts?	☐	☐
b. Brain tumor?	☐	☐
c. Huntington's disease?	☐	☐
14. Within the past 24 months, have You used narcotics (other than as prescribed by a licensed member of the medical profession), amphetamines, hallucinogens, heroin, or cocaine?	☐	☐
15. Within the past 12 months, have You been convicted of or pled guilty or no contest to driving while impaired, intoxicated or under the influence of drugs or alcohol, or had Your driver's license suspended or revoked for any reason?	☐	☐
16. Within the past 2 months, have You been diagnosed, tested positive, or been given medical advice by a licensed member of the medical profession for chronic pancreatitis?	☐	☐
17. Do You currently have felony charges pending against You, or are You currently on probation or parole?	☐	☐

G AUTHORIZATION AND 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.
- 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.

Signed at (State) KY on (Month/Day/Year) 8/26/2022

Signature of Proposed Insured *(required)*

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

Signature of Witnessing Agent *(required)*

Coronavirus

COVID-19 Questionnaire ICC22 5170

AMERICO FINANCIAL LIFE AND ANNUITY INSURANCE COMPANY

Proposed Insured *(Last, First, Middle Initial)* (please print)	**Birthdate** *(Month/Day/Year)*	**Policy Number** *(if known)*
[redacted]	04/13/1981	[redacted]

1. Are you currently receiving medical advice or treatment from a licensed member of the medical profession related to a diagnosis of COVID-19 (Coronavirus) infection? ☐ Yes ☒ No

2. Since January 1, 2020, have you:
   a. been admitted to, or received inpatient care in a hospital or any medical facility related to a diagnosis of COVID-19 (Coronavirus) infection? ☐ Yes ☒ No
   b. been treated by a licensed member of the medical profession by being placed on a respirator to assist in breathing related to a COVID-19 (Coronavirus) infection? ☐ Yes ☒ No

3. Within the past 6 months, have you sought treatment from or been advised by a licensed member of the medical profession for shortness of breath, extreme fatigue, difficulty concentrating or evidence of heart, lung, or kidney impairment related to a previous COVID-19 infection? ☐ Yes ☒ No

I represent to Americo Financial Life and Annuity Insurance Company that the above answers are true, complete, and correctly recorded to the best of my knowledge and belief. I also understand that this signed form will be used during the underwriting process and any misstatements may affect my ability to obtain coverage. I agree that the above answers will form a part of my application and that the Company can rely on these answers to determine my eligibility for insurance.

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) KY on (Month/day/Year) 8/26/2022 .

[redacted]
Signature of Proposed Insured *(required)*

[redacted]
Signature of Witness/Agent

[redacted]
Printed Name of Witness/Agent