INDIVIDUAL LIFE INSURANCE APPLICATION (Please print in black ink)

AMERICAN-AMICABLE LIFE INSURANCE COMPANY OF TEXAS
P.O. BOX 2549, WACO, TX 76702-2549 • (254) 297-2777

EASY TERM

Telephone Case Number_____

Proposed Insured: _____ (First) (Middle) (Last)
Address: (No. & Street) _____
City: State: Zip Code:

Telephone interview done (if applicable) ☐ Yes ☐ No ☐ am ☐ pm
_____ Phone _____ Best time to call
E-mail Address @

Sex	Date of Birth	Age	State of Birth		
☐ Male ☐ Female	Mo. Day Yr / /			SS# — —	Height: ____ft___in
				DL#	Weight: lbs
				SOI:	

Occupation: _____
Annual Salary: $

Owner: Name _____ SS#_____ Address:_____
Payor: Name SS# Address:

Primary Beneficiary _____ SS#_____ Relationship _____
Contingent Beneficiary SS# Relationship

Plan: _____ ☐ Return of Premium (not available on 10 year term plan)
During the past 12 months have you used tobacco in any form (excluding occasional pipe and cigar use)?..... ☐ Yes ☐ No

Face Amount
$

Riders: ☐ Waiver of Premium ☐ ADB $_____ ☐ CIA_____Units
☐ Disability Income $ ☐ Critical Illness % ☐ Other

Policy Date Request: / /
Mail Policy: ☐ Agent ☐ Insured ☐ Owner

Mode: ☐ Bank Draft ☐ Draft 1st Prem on Req. Date ☐ Payroll Deduction
☐ Qtrly ☐ Other Modal Prem $

CWA: ☐ E-Check Immediate 1st Prem
☐ Collected $

Do you have any existing life or disability insurance or annuity contract? ..... ☐ Yes ☐ No
Will you replace or change any existing life or disability insurance or annuity? .. ☐ Yes ☐ No

Company
Policy # Amount of Coverage $

Other Proposed Insureds: Name	Rider	Amt.	Sex	Birthdate	St. of Birth	Height	Weight	Relationship

SECTION A: Answer Questions 1, 2, and 3 for all Proposed Insureds.

1. Has any Proposed Insured been diagnosed, treated or been prescribed medication by a medical professional or currently under treatment for *(circle condition that applies):*
   a. high blood pressure, heart attack, angina, arrhythmia, aneurysm, stroke, TIA, heart or circulatory disease or disorder? ..... Yes ☐ No ☐
   b. diabetes, pancreas disorder, hepatitis, Crohn's Disease, ulcerative colitis, liver or digestive disease or disorder? ..... Yes ☐ No ☐
   c. cancer in any form, lung disease or disorder, seizures, mental or nervous disorder, bipolar disorder, paralysis, blindness? ..... Yes ☐ No ☐
   d. any disease or disorder of the kidneys, urinary bladder, prostate, reproductive organs, or sexually transmitted disease? ..... Yes ☐ No ☐
   e. connective tissue disease, systemic lupus (SLE), anemia, arthritis, or any disorder of the back, joints, muscles?..... Yes ☐ No ☐
   f. any other disease or disorder, injury, surgery **within the past 24 months**? ..... Yes ☐ No ☐
2. **Within the past 2 years** has any proposed insured participated in motorized racing, hang gliding, rock or mountain climbing, rodeo events, sky diving, or skin or scuba diving or made any flights as a pilot, student pilot, or crew member of any aircraft?..... Yes ☐ No ☐
3. Has any Proposed Insured:
   a. 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)? ..... Yes ☐ No ☐
   b. **within the past 5 years,** 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 or **within the past 6 months,** been on probation or parole?..... Yes ☐ No ☐
   c. **within the past 5 years,** 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 ☐
   d. **within the past 6 months,** been prohibited from actively working full time (30 hours or more per week) at their regular occupation due to any illness, injury, or health related problem, or are you **currently** disabled? ..... Yes ☐ No ☐
   e. **within the past 12 months,** consulted a physician, had surgery, been hospitalized, or had diagnostic tests (excluding AIDS/HIV tests) such as EKG, X-ray, MRI, CAT scan?..... Yes ☐ No ☐
   f. **within the past 12 months,** had 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, or been referred to a medical professional? Yes ☐ No ☐

SECTION B: If applying for Critical Illness Rider answer Question 4. *(Provide: name, relationship, age at onset, medical condition.)*

4. Has any Proposed Insured 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 diagnosed with heart disease, cerebrovascular disease, or internal cancer prior to age 60?..... Yes ☐ No ☐

SECTION C: Give details to all "Yes" answers in Section A and B and list current medications (use COMMENTS section on back for additional space).

Illness, Injury, Disease, or Condition	Dates	Treatment	Name and Address of Physician and/or Hospital
	/ /		
	/ /		
	/ /		

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, 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.

CERTIFICATION—I hereby certify, under penalties of perjury, that (1) the social security number indicated above is my correct taxpayer identification number and (2) that I am not subject to backup withholding under Section 3406 (a) (1) (c) of the Internal Revenue Code. The Internal Revenue Service does not require your consent to any provision of this document other than the certification required to avoid backup withholding.

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

Signed at _____ Date of Application _____

CITY STATE MONTH DAY YEAR

_____ _____

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 and Confined Care Accelerated Benefit Rider Disclosure Forms have 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

Agent Signature _____ Agent Printed Name _____ No: _____ % _____

Agent Signature _____ Agent Printed Name _____ 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)_____

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

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. THIS RECEIPT SHALL BE INVALID AND MAY NOT BE ISSUED WITH RESPECT TO PROPOSED PAYMENT OF THE INITIAL PREMIUM TENDERED BY MEANS OF A POST-DATED CHECK.

ALL PREMIUM CHECKS MUST BE PAYABLE TO THE COMPANY. DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE PAYEE BLANK.

Received from_____ the sum of $_____as first payment on this application for Proposed Insured _____Date_____Agent_____

If (1) an amount equal to the first full premium is submitted or a payroll deduction authorization,a government allotment authorization, or a bank draft authorization has been fully implemented in an amount sufficient to pay the first full monthly premium, (2) any check or bank draft authorization given in payment of the initial premium is honored when first presented, (3) all underwriting requirements, including any medical examinations required by the Company's rules, are completed, and (4) 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, (b) the date the payroll deduction authorization or government allotment authorization is submitted for processing, or (c) the requested draft date specified in the bank draft authorization, or (d) the date of the latest medical exam required by the Company. THE TOTAL 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 exactly, 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.