

# FINAL EXPENSE

AMERICAN-AMICABLE LIFE INSURANCE COMPANY OF TEXAS

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

## LIFE INSURANCE APPLICATION (Please print in black ink)

Telephone Case No: \_\_\_\_\_

Proposed Insured _____ <small>(First) (Middle) (Last)</small>			Telephone interview completed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> am <input type="checkbox"/> pm		
Address (No. & Street) _____			Phone _____ Best time to call _____		
City _____		State _____		Zip Code _____	
E-mail Address _____		Social Security Number _____		Height _____ ft _____ in Weight _____ lbs	
<input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth _____ / _____ / _____		Age _____	
State of Birth _____		Social Security Number _____		Height _____ ft _____ in Weight _____ lbs	
Owner: Name _____ Relationship _____ SS# _____ / _____ / _____			Address _____ City/State/Zip _____		
Primary Beneficiary _____		Relationship _____		Contingent Beneficiary _____ Relationship _____	
Plan: _____ Face Amount of Insurance \$ _____ <input type="checkbox"/> Check here if you are willing to accept any plan for which you qualify based on this application. The insurance for which you qualify may have a graded or return of premium death benefit for the first two (2) or three (3) years, a face amount less than any indicated on this application, and riders may not be available.					
<input type="checkbox"/> Immediate Death Benefit					
<input type="checkbox"/> Graded Death Benefit (Percentage of Face Amount)					
<input type="checkbox"/> Return of Premium Death Benefit					
During the past 12 months have you used tobacco in any form (excluding occasional pipe and cigar use)? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Rider: <input type="checkbox"/> Grandchild/Great Grandchild Coverage _____			Number of Children Applying _____ Units <input type="checkbox"/> Other _____		
<input type="checkbox"/> Child Rider* _____ Units <input type="checkbox"/> ADB* Amt \$ _____			(*not available on Return of Premium Death Benefit)		
Automatic Premium Loan Elected? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Mode: <input type="checkbox"/> Bank Draft <input type="checkbox"/> Draft 1st Prem on Req. Date _____		CWA: <input type="checkbox"/> E-Check Immediate 1st Prem _____		Mail Policy To: <input type="checkbox"/> Agent <input type="checkbox"/> Insured <input type="checkbox"/> Owner	
<input type="checkbox"/> Other _____ Modal Prem \$ _____		<input type="checkbox"/> Collected \$ _____		Requested Policy Date: _____ / _____ / _____	
A. Do you have existing life insurance or an annuity contract? <input type="checkbox"/> Yes <input type="checkbox"/> No			Company _____		
B. Will you replace an existing life insurance policy or an annuity? <input type="checkbox"/> Yes <input type="checkbox"/> No			Policy # _____ Amount of Coverage \$ _____		
Physician Name: _____		City/State: _____		Phone: _____	

### HEALTH INFORMATION

- Are you currently hospitalized, confined to a nursing facility, a bed, or a wheelchair due to chronic illness or disease, currently using oxygen equipment to assist in breathing, receiving Hospice Care or home health care, or had an amputation caused by disease, or do you currently have any form of cancer (excluding basal cell skin cancer), or do you require assistance (from anyone) with activities of daily living such as bathing, dressing, eating or toileting? .....  Yes  No
  - Have you had or been medically advised to have an organ transplant or kidney dialysis, or have you been medically diagnosed as having congestive heart failure (CHF), Alzheimer's, dementia, mental incapacity, Lou Gehrig's disease (ALS), liver failure, respiratory failure, or any terminal illness or end-stage disease? .....  Yes  No
  - 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 (excluding HIV status) or tested positive for the Human Immunodeficiency Virus (HIV) limited in scope to prior testing for the purpose of obtaining insurance? .....  Yes  No
- If any answer to questions 1 through 3 is answered "Yes" the Proposed Insured is not eligible for any coverage.**
- Have you ever been medically diagnosed or treated for complications of diabetes, including insulin shock, diabetic coma, retinopathy (eye), nephropathy (kidney), neuropathy (nerve damage/pain), or used insulin prior to age 50? .....  Yes  No
  - Have you ever been medically diagnosed, treated or taken medication for renal insufficiency, kidney failure, chronic kidney disease, or more than one occurrence of cancer in your lifetime (excluding basal cell skin cancer)? .....  Yes  No
  - Within the past 2 years have you had any diagnostic testing (excluding tests related to Human Immunodeficiency Virus (HIV)), surgery, or hospitalization advised by a medical professional which has not been completed or for which the results have not been received? .....  Yes  No
  - Within the past 2 years have you:
    - been medically diagnosed or treated for angina (chest pain), stroke or TIA, cardiomyopathy, systemic lupus (SLE), cirrhosis, Hepatitis C, chronic hepatitis, chronic pancreatitis, chronic obstructive pulmonary disease (COPD), emphysema, chronic bronchitis, or required oxygen equipment to assist in breathing? .....  Yes  No
    - had a heart attack or aneurysm, or had or been medically advised to have any type of heart, brain or circulatory surgery (including, but not limited to a pacemaker insertion, defibrillator placement), or any procedure to improve circulation? .....  Yes  No
    - been medically diagnosed, or treated, or taken medication for any form of cancer (excluding basal cell skin cancer)? .....  Yes  No
    - used illegal drugs, abused alcohol or drugs, had or been recommended by a medical professional to have treatment or counseling for alcohol or drug use or been advised to discontinue use of alcohol or drugs? .....  Yes  No
- If any answer to questions 4 through 7 is answered "Yes" the Proposed Insured should apply for the Return of Premium Death Benefit Plan.**
- Within the past 3 years have you been medically diagnosed or treated, or hospitalized for:
    - stroke, angina (chest pain), heart attack, aneurysm, heart or circulatory surgery or any procedure to improve circulation? ...  Yes  No
    - or taken medication for any form of cancer (excluding basal cell skin cancer), emphysema, chronic bronchitis, chronic obstructive pulmonary disease (COPD), ulcerative colitis, cirrhosis, Hepatitis C, or liver disease? .....  Yes  No
    - paralysis of two or more extremities or any neuro-muscular disease or disorder (including, but not limited to cerebral palsy, multiple sclerosis, seizures, or Parkinson's disease)? .....  Yes  No

**If any answer to question 8 is answered "Yes" the Proposed Insured should apply for the Graded Death Benefit Plan.**

**If all questions 1 through 8 are answered "No" the Proposed Insured should apply for the Immediate Death Benefit Plan.**

**CHILD, GRANDCHILD, AND GREAT GRANDCHILD COVERAGE** - Children Proposed for Insurance (list additional children on a separate sheet):

Proposed Insured Name	Sex	Birthdate	Relationship	Proposed Insured Name	Sex	Birthdate	Relationship

**PROPOSED CHILDREN'S HEALTH STATEMENT**—To the best of my knowledge and belief, none of the children listed above for coverage have been treated for or told by a physician 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 Syndrome, cystic fibrosis, cerebral palsy, hydrocephalus, paralysis, or hospitalized for asthma or any respiratory disorder in past 12 months. List the names of children that are exceptions to PROPOSED CHILDREN'S HEALTH STATEMENT.

**Children listed as an exception are excluded from the appropriate Child Rider Coverage.** 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, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application containing a false or deceptive statement may be guilty of insurance fraud.

**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, Inc. or inspection company 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 two years from this date. A copy of this authorization shall be as valid as the original.

I acknowledge receiving the Fair Credit Reporting Act Notice, the MIB, Inc. Pre-Notice and the Terminal Illness Accelerated Benefit Rider Disclosure Form.

Signed at \_\_\_\_\_  
CITY STATE

Date of Application \_\_\_\_\_  
MONTH DAY YEAR

\_\_\_\_\_  
SIGNATURE OF PROPOSED INSURED

\_\_\_\_\_  
SIGNATURE OF OWNER (IF OTHER THAN PROPOSED INSURED)

**AGENT'S REPORT**

Does the proposed insured have any existing life insurance or annuity contract? .....  Yes  No

Is the proposed insurance intended to replace or change any existing life insurance or annuity? .....  Yes  No

*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 Accelerated Benefit Rider Disclosure Form has been presented to the applicant.

AGENT'S REMARKS: \_\_\_\_\_

AGENT'S PRINTED NAME \_\_\_\_\_ DATE \_\_\_\_\_  
 Agent \_\_\_\_\_ No: \_\_\_\_\_ % \_\_\_\_\_  
SIGNATURE

AGENT'S PRINTED NAME \_\_\_\_\_ DATE \_\_\_\_\_  
 Agent \_\_\_\_\_ No: \_\_\_\_\_ % \_\_\_\_\_  
SIGNATURE

**PREAUTHORIZATION CHECK PLAN - AUTHORIZATION TO HONOR CHARGE DRAWN**

Insured \_\_\_\_\_ Account Holder \_\_\_\_\_

Financial Institution \_\_\_\_\_ 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 \$30,000.00 (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](http://www.mib.com).