You would check yes and do a phone interview if required. Only req if 56-65 & the face amount ovr $150k nvr req on ages 20-55

HOME CERTAINTY

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: John (First) D. (Middle) Smith (Last)

Address: (No. & Street) 123 Easy St.

City: Dallas State: TX Zip Code: 75001

Telephone interview done (if applicable) ☐ Yes ☐ No

(555) 555-5555 Phone ☐ am ☐ pm Best time to call

E-mail Address Johnsmith234 @ gmail

Sex	Date of Birth Mo. Day Yr	Age	State of Birth	SS#	Height	Weight	Marital Status
☒ Male ☐ Female	05/05/55	54	TX	123-45-6789 DL# 987654321	6 ft 0 in	200 lbs	☐ Single ☒ Married

Owner: Name _____ SS# _____ Address: _____

Payor: Name _____ SS# _____ Address: _____

Primary Insured: Primary Beneficiary Mary M. Smith SS# (you can get this later) Relationship Wife

Contingent Beneficiary _____ SS# _____ Relationship _____

Plan: 20 year

☒ Return of Premium Rider (if available)

Face Amount $ 100,000

During the past 12 months have you used tobacco in any form (excluding occasional pipe and cigar use)? ☐ Yes ☒ No check the box in this section that applies

If yes: ☐ Chewing Tobacco or Snuff (Preferred Tobacco) ☐ All other forms (Standard Tobacco)

Riders: ☐ Waiver of Premium* ☒ Critical Illness* 25 % *Waiver of Premium and Critical Illness Accelerated Benefit cannot be issued on the same policy.

☐ CIA Units ☒ ADB $ 100,000 ☐ Disability Income $ ☐ Spouse Level Term $ ☐ Other

Mode: ☒ Bank Draft ☐ Draft 1st Prem on Req. Date ☐ Other Modal Prem $ 150.34

CWA: ☒ E-Check Immediate 1st Prem ☐ Collected $ 150.34

Mail Policy To: ☒ Agent ☐ Insured ☐ Owner

Requested Policy Date: / /

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

SECTION A: Answer Questions 1 through 5 for all Proposed Insureds. If you check yes to a ? Circle the illness and exp in comments

1. Has any Proposed Insured 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
2. Within the past 7 years, has any Proposed Insured been diagnosed with, treated for, or taken medication for: *(circle condition that applies)*
   a. high blood pressure, heart attack, angina, arrhythmia, stroke, aneursym, or any heart or circulatory disease or disorder? ☐ Yes ☒ No
   b. diabetes, cirrhosis, hepatitis, pancreatitis, Crohn's disease, ulcerative colitis, or any digestive or liver disease or disorder? ☐ Yes ☒ No
   c. asthma, emphysema, chronic obstructive pulmonary disease (COPD), sleep apnea or any respiratory disease or disorder? ☐ Yes ☒ No
   d. cancer in any form, anemia, seizure, bi-polar disorder, schizophrenia, Alzheimer's, dementia, or mental or nervous disorder? ☐ Yes ☒ No
   e. any disease or disorder of the kidneys, urinary bladder, prostate, reproductive organs, or sexually transmitted disease? ☐ Yes ☒ No
   f. connective tissue disease, systemic lupus (SLE), arthritis, or any disorder of the back, joints, muscles, or nervous system? ☐ Yes ☒ No
   g. any other disease or disorder, injury, surgery, birth defect, or deformity? ☐ Yes ☒ No
3. Within the past 5 years has any Proposed Insured:
   a. been convicted of any misdemeanor or felony charge (including DUI or DWI), had a driver's license suspended or revoked, or is currently on probation or parole, or driver's license is currently suspended or revoked? ☐ Yes ☒ No
   b. 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 use? ☐ Yes ☒ No
4. Within the past 2 years has any Proposed Insured:
   a. participated in, or intend to participate in parachuting, hang gliding, rock or mountain climbing, rodeo events, sky diving, scuba diving, any professional sport, organized racing of any kind, or any other hazardous sport/activity? ☐ Yes ☒ No
   b. made or contemplated making any flights as a pilot, student pilot, or crew member of any aircraft? ☐ Yes ☒ No
5. Within the past 12 months has any Proposed Insured:
   a. consulted a medical professional, had surgery, been hospitalized, or had diagnostic tests such as EKG, Xray, MRI, CAT scan? ☒ Yes ☐ No
   b. 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? ☐ 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).

Illness, Injury, Disease, or Symptoms	Dates	Treatment	Name and Address of Physician and/or Hospital
5A. Broken Ankle	01/05/14	Brace + Pain med.	Dr. David Scott
	/ /		321 Medical Ln.
	/ /		Dallas, TX 75001
	/ /		

Form No. ICC14-AA3093 -> Wether they have any health issues or not, ALWAYS write down the doctors name and address I always say on question 5A "this is a good question to answer yes to, have you been to the DR in the last year." Write in the month & yr last seen the DR and the reason. Usually a routing checkup

You only need to mark yes in this section if they own Ins outside of their work. If you select Yes, then you MUST

SECTION C: Answer Questions 1 through 3. Always fill out and submit the replacement form. You can put a ? next to policy #

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

2. Has Primary Proposed Insured had a natural parent or sibling suffer from diabetes, kidney disease, require a major organ transplant, or been 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
3. Within the next 24 months, does any Proposed Insured intend to work, travel, or reside outside of the U.S. for more than 30 days?..... ☐ Yes ☒ No
If yes, where? If on question 2 you answer yes above, circle the illness and provide details in the comments

SECTION D: Complete Mortgage and Employment Information

Mortgage Company: Chase Bank City/State/Zip: Dallas, TX 75001

Borrower(s) Name(s): John D. Smith They need to be on the mortgage to qualify for this product!!!!!

Mortgage Loan Amount: $ 100,000 Origination Date (MM/YY): 03/14 Length of Loan: 30 Years

Occupation/Duties: Accountant Hire Date (MM/YY): 05/05 Annual Salary: $ 70,000

Employer Name and Address: Accounting Firm, Inc. 1000 Money Ln., Dallas, TX 75001

COMMENTS: John broke his ankle on a step. He was prescribed Percocet for Pain. He appears to be in excellent health.

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 two years from this date. 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 Dallas, TX (CITY, STATE) Date of Application 05 / 14 / 2014 (MONTH / DAY / YEAR)

(X) John D. Smith
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

You would select yes here if they have ins outside of work

Agent Signature [signature] Agent Printed Name Brad Smith No: 11111 % 100

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

If this is your first app with the company & you do not have an agent numbet you will put your SS# & write pending above it.

Form No. ICC14-AA3093

Make sure to check this box

- [x] American-Amicable Life Insurance Company of Texas
- [ ] IA American Life Insurance Company
- [ ] Occidental Life Insurance Company of North Carolina
- [ ] Pioneer American Insurance Company
- [ ] Pioneer Security Life Insurance Company

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

P.O. Box 2549 Waco TX 76702-2549

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 Chase Bank

Bank Address Dallas, TX

Transit/ABA Number 0012300456 **Account Type:** (Checking) Savings (Circle One)

Account Number 0042001578 **Amount $** 150.34 dont miss this

Requested Draft Date, if Any (1st-28th) _____ **OR Circle One of the Following:** 1st 2nd 3rd 4th Wednesday of Every Month

Do NOT fill the above section in unless you speak to your mgr

(X) John D. Smith — SIGNATURE (AS ON FINANCIAL INSTITUTION RECORDS)

5/14/14 — DATE

Bank Account Verification

COMP

John D. Smith Check

Telephone No:

I certify that I
drafted for ins
business with
provided is fc

This section would need to be filled out and signed if there is NOT a voided Check attached with the applicaiton.

an be
I new
ation

VOID

By signing be
facility name

nking

E-Check Bank Draft Authorization

COMPLETE THIS SECTION TO IMMEDIATELY DRAFT PREMIUM

don't miss this

Immediately upon receipt of My Application, please draft $ 150.34 from my account listed above and identified with a void check, deposit slip, bank statement or Bank Account Verification above.

(X) John D. Smith — SIGNATURE

5/14/14 — DATE

9903(10/13)

CN10-034

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: (X) John D. Smith Date: 5/14/14

Spouse (if applicable): _____ Date: _____

Signature of minor's parent or legal guardian: _____ Date: _____

I always get this form filled out just in case I need it, but it is required if you mark YES on the app, to the fact that they have any insurance policies outside of work that they own themselves .

B

AMERICAN-AMICABLE LIFE INSURANCE COMPANY OF TEXAS
P.O. BOX 2549, Waco, Texas 76702-2549

IMPORTANT NOTICE
REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

Note-This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing life insurance policy or annuity contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A *replacement* occurs when a new life insurance policy or annuity contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing life insurance policy or annuity contract, or an existing life insurance policy or annuity contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A *financed purchase* occurs when the purchase of a new life insurance policy or annuity contract involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing life insurance policy or annuity contract to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interest. You will pay acquisition costs and there may be surrender costs deducted from your life insurance policy or annuity contract. You may be able to make changes to your existing life insurance policy or annuity contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing life insurance policy or annuity contract? _____YES ___x___NO
2. Are you considering using funds from your existing life insurance policy or annuity contract to pay premiums due on the new life insurance policy or annuity contract? _____YES ___x__NO

If you answered "yes" to either of the above questions, list each existing life insurance policy or annuity contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the life insurance policy or annuity contract number if available) and whether each life insurance policy or annuity contract will be replaced or used as a source of financing:

	INSURER NAME	CONTRACT OR POLICY #	INSURED OR ANNUITANT	REPLACED (R) OR FINANCING (F)
1.				
2.				
3.				

You would only fill this section out if you are replacing a policy. Make sure to speak to your MGR before considering replacing a policy.

Make sure you know the facts. Contact your existing company or its agent for information about the old life insurance policy or annuity contract. If you request one, an in force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing life insurance policy or annuity contract is being replaced because_____
(If you are ever considering replacing an insurance policy for your client, please consult FIRST with your mgr.)

I certify that the responses herein are, to the best of my knowledge, accurate.

05/14/14	05/14/14
Applicant's Signature and Date	Insurance Producer's Signature and Date
John Smith	Brad Smith
Applicant's Printed Name	Insurance Producer's Printed Name

I do not want this notice read aloud to me. _____(Applicants must initial only if they do not want the notice read aloud.)