FINAL EXPENSE

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

You must always get a Phone Int w this app

LIFE INSURANCE APPLICATION (Please print in black ink)

Telephone Case No: 15834219

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

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

City: Dallas State: TX Zip Code: 75001

Telephone interview completed ☑ Yes ☐ No

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

E-mail Address:

☒ Male ☐ Female	Date of Birth	Age	State of Birth	Social Security Number	Height	Weight
	05/05/55	54	TX	123/45/6789	6 ft 0 in	200 lbs

Owner: Name _____ Relationship _____ SS# ___/___/____

Address _____ City/State/Zip _____

Primary Beneficiary	Relationship	Contingent Beneficiary	Relationship
Mary Smith	wife	(If they want to have one)	

Plan: ☒ Immediate Death Benefit
☐ Graded Death Benefit (Percentage of Face Amount)
Face Amount of Insurance $ 20,000

☐ 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 death benefit for the first two (2) years, a face amount less than any indicated on this application, and riders may not be available.

check the box in this section that applies

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

Rider: ☐ Grandchild/Great Grandchild Coverage ____ Number of Children Applying ____ Units ☐ Other _____
☐ Child Rider ____ Units ☐ ADB Amt $

Automatic Premium Loan Elected? ☒ Yes ☐ No

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: / /

A. Do you have existing life insurance or an annuity contract? ☐ Yes ☒ No
B. Will you replace an existing life insurance policy or an annuity? ☐ Yes ☒ No

Company (If yes put Co. Poliy + Ant Co.) _____
Policy # _____ Amount of Coverage $ _____

Physician Name: Dr. David Scott City/State: Dallas, TX Phone (987) 654-3210

HEALTH INFORMATION

If you check yes to a ? Circle the illness, no need to explain

1. Are you currently hospitalized, confined to a bed or nursing facility, confined to a wheelchair due to chronic illness or disease, or using oxygen equipment to assist in breathing, or receiving Hospice Care? ☐ Yes ☒ No
2. Have you had or been medically advised to have an organ transplant, or have you been medically diagnosed as having metastatic cancer, Alzheimer's, dementia, mental incapacity, or have you been diagnosed, treated (including dialysis) or taken medication for renal insufficiency, kidney failure, liver failure, or respiratory failure? ☐ Yes ☒ No
3. 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 or tested positive for the Human Immunodeficiency Virus (HIV)? ☐ Yes ☒ No
4. Have you been medically diagnosed with diabetes combined with a medical history of any of the following: stroke, TIA, heart disease, heart attack, coronary artery bypass, angioplasty, circulatory disease, or peripheral vascular disease? ☐ Yes ☒ No
5. Have you taken insulin shots prior to age 50 or been treated for insulin shock or diabetic coma? ☐ Yes ☒ No
6. Have you ever been medically diagnosed, treated, or taken medication for congestive heart failure, cardiomyopathy, Lou Gehrig's disease, Huntington's disease, had an amputation caused by disease, or more than one occurrence of cancer (excluding basal or squamous cell skin cancer) in your lifetime? ☐ Yes ☒ No
7. Within the past 12 months have you:
   a. been medically diagnosed or treated for angina (chest pain), stroke or TIA, 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
   b. had a heart attack, aneurysm, heart valve surgery, coronary artery bypass surgery, angioplasty, or stent implant or had or been medically advised to have surgery for brain or heart disorders (including, but not limited to catheterization, a pacemaker insertion, defibrillator placement), or any procedure to improve circulation? ☐ Yes ☒ No
   c. been medically diagnosed, treated, or taken medication for internal cancer, lymphoma, melanoma, leukemia, or systemic lupus (SLE)? ☐ Yes ☒ No
   d. had any diagnostic testing, surgery, or hospitalization recommended by a medical professional which has not been completed or for which the results have not been received? ☐ Yes ☒ No
   e. used illegal drugs or abused alcohol or drugs, or had or been recommended to have treatment or counseling for alcohol or drug use, or been convicted of any felony or driving under the influence of alcohol or drugs? ☐ Yes ☒ No

If any answer to questions 1 through 7 is answered "Yes" the Proposed Insured is not eligible for any coverage.

8. Within the past 24 months have you been medically diagnosed or treated, or hospitalized for:
   a. stroke, angina (chest pain), heart attack, aneurysm, heart or circulatory surgery or any procedure to improve circulation? ☐ Yes ☒ No
   b. or taken medication for internal cancer, leukemia, melanoma, emphysema, chronic bronchitis, chronic obstructive pulmonary disease (COPD), ulcerative colitis, cirrhosis, Hepatitis C, liver disease? ☐ Yes ☒ No
   c. paralysis of two or more extremeties or any neuro-muscular disease (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.

Form No. AA9466-AR(Rev.11/11)

You only need to mark yes in this section if they own Insurance outside of their work. If you do select Yes, then you MUST Always fill out and submit the replacement form. You can put a ? next to policy # to the right of the check box

Only need to fill out if you are adding on grandchildren ryders to the policy

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's 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 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.

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

Signed at Dallas (CITY), TX (STATE)

(X) John D. Smith
SIGNATURE OF PROPOSED INSURED

Date of Application 05 (MONTH) / 14 (DAY) / 14 (YEAR)

SIGNATURE OF OWNER (IF OTHER THAN PROPOSED INSURED)

AGENT'S REPORT

You would select yes, only if they own ins. or annuity outside of work. This MUST match what you selected on the previous page.

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 and Confined Care Accelerated Benefit Rider Disclosure Forms have been presented to the applicant, if applicable. AGENT'S REMARKS: If this is your first app with the company & you do not have an agent number you will put your SS# & write pending above it.

Brad Smith (AGENT'S PRINTED NAME) 5/14/14 (DATE)

Agent _____ (SIGNATURE) No: 111111 % 100

_____ (AGENT'S PRINTED NAME) _____ (DATE)

Agent _____ (SIGNATURE) No: _____ % _____

PREAUTHORIZATION CHECK PLAN - AUTHORIZATION TO HONOR CHARGE DRAWN

Insured John D. Smith Account Holder John D. Smith

Financial Institution Chase Bank Address Dallas, TX 75001

Transit/ABA Number 001230045b Account Number 0042001578 ☒ 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.

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

5/14/14
DATE

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 001230045 6

Account Number 0042001578

Account Type: (Checking) Savings (Circle One)

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 ... an be drafted for ins ... I new business with ... ation provided is fc ...

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

VOID

By signing be ... nking facility name ...

E-Check Bank Draft Authorization

COMPLETE THIS SECTION TO IMMEDIATELY DRAFT PREMIUM

Immediately upon receipt of My Application, please draft $ 150.34 don't miss this 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.	You would only fill this section out if you are replacing a policy. Make sure to speak to your MGR			
2.	before considering replacing a policy.			
3.				

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.)