

FINAL EXPENSE

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 _____ <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 _____	
<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		ADB* Amt \$		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

1. 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) diagnosed or treated by a medical professional, or do you require assistance (from anyone) with activities of daily living such as bathing, dressing, eating or toileting? Yes No
2. 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 been diagnosed by a medical professional as having a terminal medical condition or end-stage disease that is expected to result in death in the next 12 months? 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

If any answer to questions 1 through 3 is answered "Yes" the Proposed Insured is not eligible for any coverage.

4. 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
5. 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
6. 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
7. Within the past 2 years have you:
 - a. 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
 - b. 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
 - c. been medically diagnosed, or treated, or taken medication for any form of cancer (excluding basal cell skin cancer)? Yes No
 - d. 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.

8. Within the past 3 years 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 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
 - c. paralysis of two or more extremities or cerebral palsy, multiple sclerosis, seizures, Parkinson's disease or muscular dystrophy? 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.