HOME PROTECTOR

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: _____ (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	SS#	Height	Weight	Marital Status
☐ Male ☐ Female	Mo. Day Yr / /			SS# ___ — ___ — ___ DL# _____ SOI:	ft in	lbs	☐ Single ☐ Married

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

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

Plan: _____
☐ Return of Premium **Face Amount: $**

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

Riders: ☐ Waiver of Premium* ☐ Critical Illness*_____% *WOP and CIR cannot be issued on the same policy.
☐ CIA Units ☐ ADB $ ☐ Disability Income $ ☐ Spouse Level Term $ ☐ Other

Mode: ☐ Bank Draft ☐ Draft 1st Prem on Req. Date ☐ Other Modal Prem $
CWA: ☐ E-Check Immediate 1st Prem ☐ Collected $
Mail Policy To: ☐ Agent ☐ Insured ☐ Owner
Requested Policy Date: / /

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

SECTION A: Answer Questions 1 through 5 for all Proposed Insureds.

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 treated or diagnosed or been prescribed medication by a medical professional 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, 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, bipolar 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 disease or disorder of brain, eyes, throat, skin, thyroid or lymph nodes? ..... ☐ 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 or a licensed counselor to discontinue the use of alcohol or drugs or to have treatment or counseling for alcohol or drugs?..... ☐ Yes ☐ No
4. **Within the past 2 years** has any Proposed Insured:
   a. participated in, or in the next 2 years intend to participate in parachuting, hang gliding, rock or mountain climbing, rodeo events, sky diving, scuba diving, any professional sport or organized racing of any kind?..... ☐ Yes ☐ No
   b. made or in the next 2 years contemplate 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 (excluding AIDS/HIV tests) such as EKG, X-ray, 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 Condition	Dates	Treatment	Name and Address of Physician and/or Hospital
	/ /		
	/ /		
	/ /		
	/ /		

SECTION C: Answer Questions 1 through 3.

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

2. Has Primary Proposed Insured had a natural parent or sibling diagnosed or treated by a medical professional for 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? _____

SECTION D: Complete Mortgage and Employment Information

Mortgage Company:_____City/State/Zip:_____

Borrower(s) Name(s):_____

Mortgage Loan Amount: $_____Origination Date (MM/YY):_____Length of Loan:_____Years

Occupation/Duties:_____ Hire Date (MM/YY):_____ Annual Salary: $_____

Employer Name and Address:_____

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: _____%_____