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

TERM MADE SIMPLE

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#	DL#	Height	Weight
☐ Male ☐ Female	Mo. Day Yr / /			— —	State of Issue	ft in	lbs

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

Owner: Name _____ SS# _____ Address: _____

Payor: Name SS# Address:

Primary Primary Beneficiary _____ SS# _____ Relationship _____

Insured: Contingent Beneficiary SS# Relationship

Plan: _____ **Face Amount $** _____ ☐ Non-Tobacco ☐ Tobacco ☐ Preferred Non-Tobacco

Have you used tobacco or nicotine products in any form in the past 12 months? ☐ Yes ☐ No.....or during the past 36 months? ☐ Yes ☐ No

Riders: ☐ Waiver of Premium ☐ Unemployment Rider ☐ Other: _____
☐ Critical Illness % ☐ Child Rider (Units): (complete Form No. 3215) ☐ ADB $

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
Policy Date Request: / /

Physician: Name: City/State Phone:

List current prescribed medications:

SECTION A: Health Questions-Answer Questions 1 through 4 for Proposed Insured. ***(circle all conditions that apply)***

1. **Within the past 10 years,** have you been treated for, or tested positive for, or been diagnosed by a medical professional with:
   a. high blood pressure, high cholesterol, heart attack, angina (cardiac chest pain), angioplasty, bypass surgery or stent, pacemaker or defibrillator, cardiomyopathy, congestive heart failure (CHF), irregular heartbeat, peripheral vascular disease (PVD), carotid artery disease, or any heart or circulatory disease or disorder? ☐ Yes ☐ No
   b. stroke, transient ischemic attack (TIA), amputation caused by disease, aneurysm, hemophilia, or anemia? ☐ Yes ☐ No
   c. diabetes, cirrhosis, hepatitis, pancreas disorder, Crohn's disease, ulcerative colitis, or any digestive or liver disease or disorder? ☐ Yes ☐ No
   d. asthma, emphysema, chronic obstructive pulmonary disease (COPD), sleep apnea, or any respiratory or lung disease or disorder? ☐ Yes ☐ No
   e. cancer in any form, Hodgkin's disease, leukemia, lymphoma, multiple myeloma, or organ transplant? ☐ Yes ☐ No
   f. migraine headaches, seizures, bi-polar disorder, schizophrenia, Alzheimer's, memory loss, dementia, anxiety or depression, mental retardation, mental incapacity, mental or nervous disorder, psychiatric disorder, or a suicide attempt? ☐ Yes ☐ No
   g. any disease or disorder of the kidneys, urinary bladder, prostate, breast, reproductive organs, or sexually transmitted disease? ☐ Yes ☐ No
   h. connective tissue disease, systemic lupus (SLE), multiple sclerosis, Parkinson's, cerebral palsy, muscular dystrophy, cystic fibrosis? ☐ Yes ☐ No
   i. arthritis, paralysis of two or more extremities or any disorder of the back, joints, muscles, or nervous system? ☐ Yes ☐ No
   j. any other disease or disorder, injury, surgery, birth defect, or deformity? ☐ Yes ☐ No
   k. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or any immune deficiency related disorder or the Human Immunodeficiency Virus (HIV)? ☐ Yes ☐ No
2. Are you currently unemployed due to medical reasons or been prohibited from actively working full time (30 hours or more per week) at your regular occupation due to any illness, injury, or health related problem, or are you currently receiving benefits, compensation, or pension for disability? ☐ Yes ☐ No
3. Are you currently hospitalized, confined to a nursing facility, receiving Hospice Care or home health care, or do you require assistance (from anyone) with activities of daily living such as bathing, dressing, eating or toileting? ☐ Yes ☐ No
4. **Within the past 12 months,** have you:
   a. consulted a medical professional, had surgery, or been hospitalized, or had diagnostic tests (excluding HIV/AIDS) such as EKG, Xray, MRI, CAT scan? ☐ Yes ☐ No
   b. had any diagnostic testing (excluding HIV/AIDS), surgery, or hospitalization recommended by a medical professional which has not been completed or for which the results have not been received, or been referred to a medical professional? ☐ 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).

Condition	Dates	Treatment	Name/Address/Phone No. of Physician/Hospital
	/ /		
	/ /		
	/ /		
	/ /		

Form No. ICC15-AA3188

SECTION C: Answer Questions 1 through 5 for Proposed Insured. ***(circle all conditions that apply)***

1. Have you had a natural parent or sibling diagnosed or treated by a licensed medical professional for diabetes, kidney disease, require a major organ transplant, or been medically 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
2. a. **Within the next 24 months,** do you intend to work, travel, or reside outside of the U.S. for more than 30 days? ..... ☐ Yes ☐ No
   If yes, where?_____
   b. **Within the past 24 months,** have you made or contemplated making any flights as a pilot, student pilot, or crew member of any aircraft? ..... ☐ Yes ☐ No
3. a. **Within the past 5 years,** have you pled guilty to or been convicted of a felony or misdemeanor (including DUI or DWI) or do you have such charge currently pending against you or have you had a driver's license suspended or revoked or is currently suspended or revoked, any motor vehicle violations or **within the past 6 months,** have you been on probation or parole? ..... ☐ Yes ☐ No
   b. **Within the past 5 years,** participated in motorized racing, hang gliding, rock or mountain climbing, rodeo events, sky diving, or skin or scuba diving? ..... ☐ Yes ☐ No
4. **Within the past 10 years,** have you 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

5. 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 $

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. I will notify the Company of any changes in the statements or answers given in this application between the time of application and delivery of the policy; 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 disclosed 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 Accelerated Benefit Rider Disclosure Form, the Accelerated Benefit Rider-Confined Care Rider and Chronic Illness Accelerated Death Benefit Rider Disclosure Forms if applicable.

Signed at (City)_____(State)_____ Date of Application (MM/DD/YY) _____

_____ _____

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

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 Rider Disclosure Form, the Confined Care Accelerated Benefit Rider and Chronic Illness Accelerated Death Benefit Rider Disclosure Forms have been presented to the applicant, if applicable.

Agent's Remarks:_____

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
Has the proposed insured applied for any life insurance or annuity in the last ninety (90) days?..... ☐ Yes ☐ No

Agent Signature _____ Agent Printed Name_____ No: _____%_____

Agent Signature _____ Agent Printed Name_____ No: _____%_____