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 taken medication or 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** disabled? ☐ 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 such as EKG, Xray, MRI, CAT scan? ☐ Yes ☐ No
   b. had any diagnostic testing (excluding Human Immunodeficiency Virus (HIV)), 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
	/ /		
	/ /		
	/ /		
	/ /		
	/ /		

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

1. Have you had a natural parent or sibling suffer from 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. **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?_____
3. **Within the past 5 years,** have you:
   a. been convicted of or pled guilty to any misdemeanor or felony charge (including DUI or DWI), had a driver's license suspended or revoked or is currently suspended or revoked, any motor vehicle violations, are you currently in prison or a correctional facility, or **within the past 6 months** been on probation or parole? ☐ Yes ☐ No
   b. participated in motorized racing, hang gliding, rock or mountain climbing, rodeo events, sky diving, or skin or scuba diving? ☐ Yes ☐ No
   c. made or contemplated making any flights as a pilot, student pilot, or crew member of any aircraft? ☐ 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; 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 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 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 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, 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: _____%_____

AMERICAN-AMICABLE LIFE INSURANCE COMPANY OF TEXAS
P.O. BOX 2549, WACO, TX 76702-2549

CONDITIONAL RECEIPT

NO COVERAGE WILL BECOME EFFECTIVE PRIOR TO POLICY DELIVERY UNLESS AND UNTIL ALL CONDITIONS OF THIS RECEIPT ARE MET. NO AGENT HAS THE AUTHORITY TO ALTER THE TERMS OR CONDITIONS OF THIS RECEIPT. THIS RECEIPT SHALL BE INVALID AND MAY NOT BE ISSUED WITH RESPECT TO PROPOSED PAYMENT OF THE INITIAL PREMIUM TENDERED BY MEANS OF A POST-DATED CHECK.

ALL PREMIUM CHECKS MUST BE PAYABLE TO THE COMPANY. DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE PAYEE BLANK.

Received from_____ the sum of $_____as first payment on this application for

Proposed Insured_____Date_____Agent_____

If (1) an amount equal to the first full premium is submitted or a payroll deduction authorization,a government allotment authorization, or a bank draft authorization has been fully implemented in an amount sufficient to pay the first full monthly premium, (2) any check or bank draft authorization given in payment of the initial premium is honored when first presented, (3) all underwriting requirements, including any medical examinations required by the Company's rules, are completed, and (4) the proposed insured is, on the date of application, a risk acceptable for insurance exactly as applied for without modification of plan, premium rate, or amount under the Company's rules and practices, then insurance under the policy applied for shall become effective on the latest of (a) the date of application, (b) the date the payroll deduction authorization or government allotment authorization is submitted for processing, or (c) the requested draft date specified in the bank draft authorization, or (d) the date of the latest medical exam required by the Company. THE TOTAL AMOUNT OF LIFE INSURANCE, INCLUDING ANY AMOUNT IN FORCE OR BEING APPLIED FOR, WHICH MAY BECOME EFFECTIVE PRIOR TO THE DELIVERY OF THE POLICY SHALL IN NO EVENT EXCEED $150,000.00. (INCLUDING LIFE INSURANCE AND ACCIDENTAL DEATH BENEFITS).

If any of the above conditions are not met exactly, the liability of the Company shall be limited to the return of any amount paid.

NOTICE

Printed in compliance with Public Law 91-508

Thank you for considering American-Amicable Life Insurance Company of Texas for your insurance needs. This is to inform you that as part of our procedure for processing your insurance application, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation and personal characteristics. You have the right to make a written request within a reasonable period of time to receive additional detailed information about the nature and scope of this investigation.

MIB, INC. PRE-NOTICE

Information regarding your insurability will be treated as confidential. American-Amicable Life Insurance Company of Texas, or its reinsurers, may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB, Inc. member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, Inc., upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information in your file. If you question the accuracy of information in MIB, Inc.'s file, you may contact MIB, Inc. and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB, Inc.'s information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

American-Amicable Life Insurance Company of Texas, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB, Inc. may be obtained on its website at www.mib.com.

AMERICAN-AMICABLE LIFE INSURANCE COMPANY OF TEXAS
WACO, TEXAS

DISCLOSURE STATEMENT

TERMINAL ILLNESS ACCELERATED BENEFIT RIDER

NOTE: PAYMENT OF AN ACCELERATED BENEFIT MAY BE TAXABLE. YOU SHOULD SEEK THE ASSISTANCE OF YOUR PERSONAL TAX AND/OR LEGAL ADVISOR IF YOU ARE CONSIDERING ELECTING THIS BENEFIT.

ANY MEDICAID OR OTHER GOVERNMENT ENTITLEMENT FOR WHICH YOU ARE ELIGIBLE MAY BE AFFECTED BY PAYMENTS RECEIVED UNDER THIS RIDER.

The Accelerated Benefit Rider attached to your Policy allows you to receive up to 100% of the Death Benefit proceeds of the Policy when the Insured has a medical condition that reasonably can be expected to result in death within 12 months. Upon receipt of proof satisfactory to the Company of the Insured's reduced life expectancy and written consent of any assignee or irrevocable beneficiary we will pay an accelerated benefit. It will be paid in a lump sum. It is payable only once.

The Benefit to be paid will be reduced by an Actuarial Adjustment Factor and an Administrative Charge of $150. We will deduct from the Benefit paid any outstanding indebtedness, but only in proportion to the percentage of Death Benefit paid. We will also return to you a proportionate amount of any premium paid beyond the date any Benefit under this Rider is paid. The Cash Value, the amount available for loans and the premium, excluding the Policy fee, for the Policy will decrease in proportion to the amount of Benefit paid. Continued payment of the reduced premium is necessary for the Policy to remain in force. If the entire Death Benefit is paid, then the Policy will terminate with no further value.

AMERICAN-AMICABLE LIFE INSURANCE COMPANY OF TEXAS
WACO, TEXAS

DISCLOSURE STATEMENT

ACCELERATED BENEFITS RIDER - CONFINED CARE

TAX IMPLICATIONS. The acceleration-of-life-insurance benefits offered under this Rider may or may not qualify for favorable tax treatment under the Internal Revenue Code of 1986. Whether such benefits qualify depends on factors such as your life expectancy at the time benefits are accelerated or whether you use the benefits to pay for necessary long term care expenses, such as nursing home care. If the acceleration-of-life-insurance benefits qualify for favorable tax treatment, the benefits will be excludable from your income and not subject to federal taxation. Tax laws relating to acceleration-of-life-insurance benefits are complex. You are advised to consult with a qualified tax advisor about circumstances under which you could receive acceleration-of-life-insurance benefits excludable from income under federal law.

ANY MEDICAID OR OTHER GOVERNMENT ENTITLEMENT FOR WHICH THE OWNER IS ELIGIBLE MAY BE AFFECTED BY PAYMENTS RECEIVED UNDER THIS RIDER.

The Rider provides early (pre-death) payments of life insurance proceeds if the Insured is receiving Confined Care as defined in the Accelerated Benefits Rider - Confined Care. Benefits are only paid at the Owner's option and request. The terms and conditions are detailed in the Rider. **THE RIDER IS NOT INTENDED TO PROVIDE HEALTH INSURANCE, NURSING HOME INSURANCE OR LONG TERM CARE INSURANCE. IT MAY NOT COVER ALL NURSING HOME EXPENSES. IT DOES NOT COVER HOME CARE OR ADULT DAY CARE SERVICES.**

Cash Value, if any, and the Face Amount are reduced if Accelerated Benefits are paid.

AMERICAN-AMICABLE LIFE INSURANCE COMPANY OF TEXAS

WACO, TEXAS

DISCLOSURE—ACCELERATED LIVING BENEFIT RIDER

TAXATION—Receipt of the accelerated benefit paid under the Rider may be taxable. Assistance should be sought from your personal tax advisor. The benefit paid may also affect your eligibility for Medicaid and other government benefits.

COVERED CONDITIONS—

Heart Attack—The death of a portion of the heart muscle (myocardium) resulting from a blockage of one or more coronary arteries and resulting in a loss of the normal function of the heart. A Physician must furnish us in writing a diagnosis of the condition. This diagnosis must include documentation supported by clinical, radiological, histological, or laboratory evidence of the condition. The following are excluded: Angina, chest pains associated with restricted blood supply to the heart.

Coronary Artery Bypass Graft (CABG)—10% of the accelerated living benefit will be paid for the first ever, following the policy effective date, open chest surgery to correct narrowing or blockage of two or more coronary arteries with bypass grafts, either saphenous vein or internal mammary graft. The surgery must have been proven to be necessary by means of coronary angiography. A cardiologist must recommend surgery. The following are excluded: angioplasty, laser relief of an obstruction, and other intra-arterial procedures.

Stroke—A cerebral vascular incident caused by hemorrhage, embolism, thrombosis producing measurable neurological deficit persisting for at least 30 days following the occurrence of the stroke. The diagnosis must be supported by new changes on a CT or MRI scan. The following are excluded: neurological symptoms due to transient ischemic attack (TIA) or mini-stroke, migraine, cerebral injury resulting from trauma or hypoxia, vascular disease affecting the eye, optic nerve and vestibular function.

Cancer—Only those types of cancer manifested by the presence of a malignant tumor, characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissue. Cancer includes: Leukemia, Malignant Lymphoma, Hodgkin's Disease (except Stage 1 Hodgkin's Disease). Diagnosis of cancer must be established according to the criteria of malignancy established by The American Board of Pathology after a study of the histocytologic architecture or pattern of the suspect tumor, tissue or specimen. The following are excluded: pre-malignant tumors or polyps, cancer in-situ (e.g. cervical dysplasia), transitional carcinoma of urinary bladder Stage 0, prostate cancer Stage A or equivalent TNM Classification (T1, T1a, T1b), colon cancer Dukes Stage A, all tumors in the presence of HIV, hyperkeratosis, basal cell and squamous skin cancers, malignant melanomas of the skin classified Clark Level 2 or less, or has a Breslow thickness measurement 0.75mm or less.

Kidney Failure—End stage kidney disease presented as chronic irreversible failure of both kidneys to function. The undergoing of regular renal dialysis or undergoing a renal transplant must evidence this. The following are excluded: single kidney failure, temporary kidney failure.

Major Organ Transplant Surgery—The actual undergoing as a recipient (human to human) of a transplant of the heart, lung, liver, pancreas, kidney or bone marrow. The transplant must be medically necessary and based on objective confirmation of organ failure.

Paralysis—Total and permanent loss of use of two or more limbs due to an injury or sickness. These conditions have to be medically documented by a neurologist for at least 3 months.

HIV Contracted Performing Occupational Duties as a Medical Professional Healthcare Worker—A medical professional healthcare worker who in the performance of their occupational duties is exposed to and ultimately acquires positive HIV resulting from an accidental injury. The following are excluded: HIV infection as a result of IV drug use, sexual intercourse.

Terminal Illness—The insured must be suffering from a condition, which in the opinion of a physician will lead to death within twelve (12) months.

FACE AMOUNT—In the Rider, the term "Face Amount" refers to the Face Amount under the Policy to which the Rider is attached.

PREMIUM CHANGE—The Company may change the premium for this Rider. The changed premium may be greater than or less than the Rider premium at issue but will not be greater than the maximum premium shown in the Benefit Description Page 3B of the Policy. The premium may not be changed before the end of the first five years and may not be changed more often than once a year thereafter. Notice of a change of premium will be sent to the Owner at least 30 days before the change becomes effective. Upon any Rider premium increase, the Owner has the option to: a) Pay the new Rider premium; or b) Reduce the Rider benefit proportionally. If the Owner does not elect a) above in writing within 60 days after notification of the premium increase, the Company will automatically reduce the benefit of this Rider Proportionally.

ACCELERATED LIVING BENEFIT—Upon receipt of proof of a qualifying event and written consent of all irrevocable beneficiaries and all assignees, we will pay an accelerated benefit. It will be paid in a single sum. To calculate the benefit, we will begin with the lesser of:

(Prior to the 91st day following the date of issue of the Policy): (a) ten percent (10%) of the percent, indicated in the Benefit Description Page, of the Face Amount, or (b) $25,000.

(Starting on the 91st day following the date of issue of the Policy): (a) the percent, indicated in the Benefit Description Page of the Policy, of the Face Amount, or (b) $250,000.

The applicable percentage shall be the lesser of a) or b) above divided by the Face Amount.

Then we will subtract: (a) the applicable percentage of any outstanding loan and loan interest due and unpaid on the date of the qualifying event; and (b) any premium due and unpaid which applies to a period prior to the date a qualifying event occurs.

On the date payment is made, the following will be reduced by the applicable percentage: 1) the Face Amount; 2) the Policy's base premium excluding the Policy fee (if any); 3) the cash value (if any); 4) any policy loans. The premium rate for any riders on the Policy will not be reduced. The accelerated benefit rider and its associated premium will terminate, unless the qualifying event for which payment was made is for Coronary Artery Bypass Graft. Upon payment of 10% of the accelerated benefit due to the occurrence of Coronary Artery Bypass Graft, the rider premium continues unchanged and future acceleration of any other benefit under the Rider will be reduced proportionately.

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:_____ Date:_____

Spouse (if applicable):_____ Date:_____

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

American-Amicable Life Insurance Company of Texas

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

P.O. Box 2549 Waco TX 76702-2549

Policy Number _____

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 _____

Bank Address _____

Transit/ABA Number _____ **Account Type:** ☐ Checking ☐ Savings

Account Number _____ **Amount $** _____

Would you like your draft to coincide with your Social Security payment schedule? ☐ Yes ☐ No

Please choose one of the following as your requested draft date (applies to first and future drafts of this account):

☐ Requested Draft Date, If Any (1st-28th) _____ OR ☐ 2nd Wednesday ☐ 3rd Wednesday ☐ 4th Wednesday

_____ _____ _____

PRINT NAME **SIGNATURE (AS ON FINANCIAL INSTITUTION RECORDS)** **DATE**

Bank Account Verification - Complete ONLY in absence of void check.

I have verified that the above account is a valid account and can be drafted for insurance premiums. I understand that if the information provided is found to be falsified, I may be subject to disciplinary action up to and including termination of my agent contract. This information was verified by a verification call with a bank representative.

Please provide the phone number and name of the person you spoke to at the Bank:_____

_____ _____

AGENT SIGNATURE / AGENT NUMBER **DATE**

By signing below, I authorize the Company indicated above and/or one of their representatives to receive information from the banking facility named above so my banking information can be verified.

_____ _____

SIGNATURE (of bank account holder) **DATE**

E-Check Bank Draft Authorization
COMPLETE THIS SECTION TO IMMEDIATELY DRAFT PREMIUM

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

_____ _____

SIGNATURE **DATE**

AMERICAN-AMICABLE LIFE INSURANCE COMPANY OF TEXAS

P.O. Box 2549, Waco, TX 76702-2549

ADDENDUM TO INDIVIDUAL LIFE INSURANCE APPLICATION

Application Addendum Forming a Part of my Application for Insurance

CHILDREN'S INSURANCE AGREEMENT-CIA

Primary Proposed Insured Name (Print): _____

CHILDREN'S COVERAGE ONLY Children Proposed for Insurance:

Proposed Insured Name	Ht.	Wt.	Sex	Birthdate

CHILDREN 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 within the past 12 months been hospitalized for asthma or any respiratory disorder.

List the names of the children that are exceptions to the CHILDREN HEALTH STATEMENT.
Children listed as an exception are excluded from the Children's Insurance Agreement Rider.

Exceptions are:_____

AGREEMENT—I agree with American-Amicable Life Insurance Company of Texas (the Company) as follows: To the best of my knowledge and belief, all answers and statements contained in this application addendum are true, complete and correctly recorded.

I hereby agree that this amendment shall be an amendment to and form a part of my application for insurance, and be a part of any contract of insurance issued on the basis of such application.

Signed at _____ Application Date _____
CITY STATE MONTH DAY YEAR

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

_____
WITNESS-LICENSED AGENT SIGNATURE

AMERICAN-AMICABLE LIFE INSURANCE COMPANY OF TEXAS
PO Box 2549 Waco, Texas 76702-2549

Addendum to Application for COVID-19

Proposed Insured's Name (Please Print) _____

1. Within the past 6 months, have you been hospitalized or have ongoing medical complications due to the novel coronavirus (COVID-19) or are you currently diagnosed with or being treated for the novel coronavirus (COVID-19)? .....☐ Yes ☐ No

This Addendum to Application amends and is made a part of my individual life insurance application. 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.

Fraud Notice: Any person who knowingly presents a false statement in application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Signed at _____ Application Date _____
(City and State)

Signature of Proposed Insured _____

Signature of Owner (If other than Proposed Insured) _____