This is only a sample application. It is not a promise to issue coverage.

You cannot buy this application directly from Aetna.

It is sold only via licensed agencies such as Choice Mutual.

To apply, call Choice Mutual (licensed to sell from Aetna products) at 1-800-644-2926.
Application
Whole Life Insurance

Underwritten by
American Continental Insurance Company

Arizona

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Application for Whole Life Insurance
from American Continental Insurance Company

Page 1 of 5

• Print clearly and use blue or black ink.
• Use Section 4 for additional remarks, requests, or explanations.
• If completing electronically, fill in all blue highlighted areas.
When complete, print form, sign, and send to us.

1. Proposed insured information

Full name of proposed insured: First, M.I., Last

Residential address (No P.O. Boxes) Phone

City State Zip

E-mail Social Security Number

Birth date mm/dd/yyyy Age

Height Feet and inches Weight Pounds ○ Male ○ Female

Are you a legal resident of the United States? ○ Yes ○ No

Have you used any form of tobacco in the past 12 months? ○ Yes ○ No

2. Benefits, beneficiary and replacement information

Initial amount of insurance applied for: 

$ Plan requested: ○ Modified benefit plan ○ Graded benefit plan ○ Level benefit plan

Riders requested (if available):

Requested effective date:

Nonforfeiture options: (select only one)

○ Automatic premium loan ○ Paid-up insurance ○ Extended term insurance

Initial premium amount: Initial premium method: ○ EFT ○ Check or money order

$ Payment mode: ○ Annually ○ Semi-Annually ○ Quarterly ○ Monthly EFT (Electronic Funds Transfer only)

Full name of primary beneficiary: First, M.I., Last Relationship to insured

Contingent beneficiary: First, M.I., Last Relationship to insured

Does the proposed insured currently have any life insurance or annuity in force? ○ Yes ○ No

Will insurance applied for in this application replace, reduce or modify premiums paid for any existing life insurance or an annuity in force? ○ Yes ○ No

If the answer to either question is “yes”, please provide the information below:

Company name Face amount Policy number

Your agent can explain the differences in modes and help you decide which is best for you.
## 3. Health questions

### A. Modified benefit plan
If you answered "yes" to any questions in this section, you are not eligible for insurance coverage.

If you answered "no" to ALL questions in this section, continue to Section B.

<table>
<thead>
<tr>
<th>Question</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do any of the following apply to you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. currently hospitalized, in a nursing facility, confined to a bed, receiving hospice care</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>B. currently prescribed to use oxygen for any lung or respiratory disorder</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>C. have been diagnosed by a medical professional as having an aneurysm that has not been surgically repaired</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>2. At any time have you been diagnosed or treated by a medical professional or had surgery for any of the following?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. any condition requiring bone marrow, stem cell, or organ transplant</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>B. kidney disease requiring dialysis</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>C. Alzheimer’s Disease, dementia, mental incapacity</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>D. Lou Gehrig’s Disease (ALS)</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>E. have been diagnosed as having a life expectancy of 12 months or less</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>F. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), tested positive for the Human Immunodeficiency Virus (HIV)</td>
<td>Y</td>
<td>N</td>
</tr>
</tbody>
</table>

### B. Graded benefit plan
If you answered "yes" to any questions in this section, you qualify for the Modified benefit plan.

If you answered "no" to ALL questions in this section, continue to Section C.

<table>
<thead>
<tr>
<th>Question</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Do you have:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. diabetes diagnosed by a medical professional before age 40</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>B. diabetes in combination with any heart or circulatory disorder diagnosed by a medical professional (excluding high blood pressure)</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>C. diabetes requiring 40 or more units of insulin daily</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>4. Within the past 12 months, have you been diagnosed or treated by a medical professional or had surgery for any of the following?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. heart attack, heart valve disorder, heart blockage, stroke or transient ischemic attack (TIA)</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>B. any lung or respiratory disorder requiring the use of a nebulizer</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>C. any lung or respiratory disorder and currently use tobacco</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>D. internal cancer, melanoma, lymphoma, multiple myeloma, leukemia, systemic lupus (SLE)</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>E. chronic pancreatitis, chronic hepatitis, cirrhosis</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>5. Within the past 12 months, have you been recommended by a medical professional to have any of the following?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. treatment or counseling for alcohol or drug abuse</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>B. test, surgery, treatment or further evaluation that has not been performed or are there any test results pending</td>
<td>Y</td>
<td>N</td>
</tr>
</tbody>
</table>

### C. Level benefit plan
If you answered "yes" to any questions in this section, you qualify for the Graded benefit plan.

If you answered "no" to ALL questions in Section C, you qualify for the Level benefit plan.

<table>
<thead>
<tr>
<th>Question</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Within the past 24 months, have you been diagnosed or treated by a medical professional or had surgery for any of the following?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. aneurysm, heart attack, any circulatory disorder, stroke or transient ischemic attack (TIA)</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>B. emphysema, chronic obstructive pulmonary disease (COPD)</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>C. internal cancer, melanoma, leukemia</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>D. neuromuscular disorder including, but not limited to, cerebral palsy, multiple sclerosis, muscular dystrophy</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>E. any connective tissue disorder, ulcerative colitis, Crohn’s disease</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>7. At any time, have you been diagnosed or treated by a medical professional or had surgery for any of the following?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. congestive heart failure, cardiomyopathy, Parkinson’s disease</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>B. any permanent paralysis, amputation caused by disease</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>8. Are you dependent on a wheelchair or motorized mobility device?</td>
<td>Y</td>
<td>N</td>
</tr>
</tbody>
</table>
Application for Whole Life Insurance

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Applicant Initials ________________________________

4. Remarks


5. Privacy notice

Your application and telephone interview are American Continental Insurance Company’s primary sources of information in determining whether to provide coverage to you. The Company, its affiliates, or its reinsurer[s] may also in certain circumstances release information collected by us to third parties without authorization from you. Upon written request, we will provide you with the information contained in your file. Should you wish to request correction, amendment or deletion of any information in your file, which you believe inaccurate, please contact us and we will advise you of the necessary procedures.

6. Producer compensation

When you purchase insurance from us, we pay compensation to the licensed agent, who represents us for such limited purposes as taking your insurance application, collecting your initial premiums and delivering your policy, and to any intermediaries through which the licensed agent works. This compensation may include commissions when a policy is purchased or renewed, and fees for marketing and administrative services and educational opportunities. The compensation may vary by the type of insurance purchased, or the particular features included with your policy. Additionally, some licensed agents and/or their intermediaries may also receive discounts on their own policy premiums and bonuses, and incentive trips or prizes associated with sales contests based on sales criteria, such as the overall sales volume of an agent or intermediary with our company, or for the percentage of completed sales. (Generally, this will not be the case for registered variable insurance products or for fixed products sold through banks or broker-dealers.) Intermediaries may also pay compensation directly to the licensed agent. If the licensed insurance agent can sell insurance policies from other insurance carriers, those carriers may pay compensation that differs from ours.

7. Applicant agreement

I hereby apply to American Continental Insurance Company for a policy to be issued in reliance on my answers to the questions in this application. The applicant and agent represent that the applicant has read, or has read to applicant, the completed application, and the applicant understands that any false statements or misrepresentations made in the application may result in loss of coverage under the policy to which this application is a part.

I, the applicant, represent that the statements and answers given in the application are true, complete and correctly recorded to the best of my knowledge and belief. I agree that no insurance shall be in effect until the application has been accepted and approved by the Company and the first full modal premium has been paid. I understand that no insurance agent is authorized to waive any part of any answer on the application, to approve insurability, make or modify any contract or waive any of the Company’s rights or requirements.

I understand and agree that, if I choose to pay my premium by electronic funds transfer (EFT) from my checking or savings account, I am accepting the terms and conditions of the EFT authorization attached to this application.

Any person who, knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Applicant signature ________________________________ Date signed _____________

X

Owner signature (if not proposed insured) ________________________________ Owner Social Security Number ________________________________

X

Signed in City and State ________________________________

If owner is different than insured, indicate name, address and relationship to insured in remarks (Section 4).

ACIFE01238AZ 083112
Application for Whole Life Insurance

8. Account information

Complete this section if you are requesting electronic funds transfer (EFT) for premium payment.

Include a voided check with the application.

Proposed insured’s name

Account owner name, if different than proposed insured’s

Account owner relationship to proposed insured:

- Business owned by proposed insured
- Living trust
- Power of Attorney
- Employer
- Conservator/guardian
- Family member
- Other, specify:

Financial institution name

- Checking
- Savings

Routing number

Account number

Do you prefer to have the initial premium drafted on the effective date? Yes No

Initial premium will be drafted when the policy is approved and issued, unless “yes” is checked.

This is an example of a personal check. A business check may be different.

For all other checks, use the nine-character bank routing number, which appears between the 12 symbols, usually at the bottom left corner of the check.

9. Electronic funds transfer (EFT) authorization

I understand and accept these terms and conditions:

- We are authorized to withdraw funds periodically from your account to pay insurance premiums for the insured.
- If your financial institution does not honor an EFT request, we will NOT consider your premium paid.
- If your financial institution does not honor an EFT request, we may make a second attempt within five business days.
- We have the right to end EFT payments at any time and bill you directly either quarterly or less frequently for premiums due.
- Information as to each EFT charge will be provided by entry on your account statement or by any other means provided by your financial institution. You will not receive premium notices from us.
- If you want to cancel or change this authorization, you must contact us at least three business days before a scheduled withdrawal.
- Any refund of unearned premium will be made to the policy owner or the policy owner’s estate.

Signature of account owner

Date

Signature only required if the account owner is different than the proposed insured.
Application for Whole Life Insurance

10. Agent Statement

I represent the following:
1. That the insurance being applied for is suitable for the owner’s insurance needs.
2. I have explained to the applicant the premium mode options.
3. I have provided all required forms on or before the date the application was taken.
4. I have accurately recorded the information supplied by the applicant.

Does the proposed insured have any existing life insurance or annuity contracts?  ○ Yes  ○ No
Will the policy applied for be a replacement or change existing life insurance or an annuity?  ○ Yes  ○ No
If the answer to either question is “yes”, have you complied with the requirements of the Company and your state regarding this replacement?  ○ Yes  ○ No

The writing number reflects where commissions will be paid.

Agent name Printed

Writing number (agent or company)

Agent signature

X

Phone

E-mail

11. Policy delivery requirements

Unless otherwise indicated policy will be mailed to agent.

Mail policy to:  ○ Agent  ○ Policyholder

12. Agent request to split commissions

This section must be completed with this application in order to split commissions.

If this application results in an issued policy through American Continental Insurance Company (ACI), the agents listed below have agreed to split the commissions earned on the policy.

• Both agents must be properly licensed and appointed with ACI in the policy’s state of issue.
• Split commissions are calculated as a percentage of commissionable premium and will apply while the policy remains in force.
• The percentage of the premium split can be for any amount but must be stated in whole numbers and total 100%. (For example, the percentage for the premium split can be from 1% to 99% but cannot be 0% or 100%.)
• Calculation of each agent’s commissions are based on their respective ACI commission schedule.

Writing agent Printed

Percentage

Secondary agent Printed

Writing number

Percentage

Writing agent signature

X
Receipt
from American Continental Insurance Company

Page 1 of 1

• Print clearly and use blue or black ink.
• Applicant keeps this receipt for their records.

<table>
<thead>
<tr>
<th>Proposed insured’s name</th>
<th>Printed</th>
<th>Date of application</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Initial payment collected (if applicable)
$ _____________________________

☐ Check ☐ Money order

EFT draft amount
$ _____________________________

This acknowledges receipt of your application for an American Continental Insurance Company Whole Life insurance policy.

Agent name | Printed | Phone |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Agent signature
X

• Payment will be refunded for any coverage not issued.
• All premium payments must be made payable to American Continental Insurance Company.
• DO NOT make any check payable to the agent and do not leave the payee blank on the check.
• A recorded interview may be required as part of the underwriting on your application for insurance.

Thank you for choosing American Continental Insurance Company!