



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

You **cannot buy** this application **directly** from Americo.

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

To apply, call Choice Mutual
(licensed to sell from Americo products)

at 1-800-644-2926.

A PROPOSED INSURED INFORMATION

1. Name (Last, First, Middle Initial)	2. Date of Birth (MM/DD/YYYY) 12/15/1955	3. Age 63	4. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
5. a. Mailing Address			
b. Street Address (If different than Mailing Address.)			
c. Years at current address: _____ If less than five (5) years, prior address is needed.			d. Email Address
6. Phone Number <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	7. SSN or Taxpayer ID	8. Place of Birth (City, State, Country)	
9. Is The Proposed Insured also the Owner? (if Yes, skip B)..... <input type="checkbox"/> Yes <input type="checkbox"/> No			

B OWNER INFORMATION

1. Name (Last, First, Middle Initial)	2. Relationship to Proposed Insured	3. SSN or Taxpayer ID
4. a. Mailing Address		
b. Street Address (If different than Mailing Address.)		c. Email Address

C BENEFICIARY INFORMATION (Include percentage shares. If shares are not given, they will be equal.)

If not specified, all beneficiaries will be Primary.	Name	Date of Birth (MM/DD/YYYY)	Phone Number	Relationship	% of Share (Must total 100%)
Primary					
<input type="checkbox"/> Primary <input type="checkbox"/> Contingent					
<input type="checkbox"/> Primary <input type="checkbox"/> Contingent					
<input type="checkbox"/> Primary <input type="checkbox"/> Contingent					
<input type="checkbox"/> Primary <input type="checkbox"/> Contingent					
<input type="checkbox"/> Primary <input type="checkbox"/> Contingent					

D PRODUCT INFORMATION

Product Name: <u>Eagle Premier Series</u>	<input type="checkbox"/> Face Amount: \$ _____	<input checked="" type="checkbox"/> Solve for Face Amount
(if Guaranteed Issue product is elected, skip F)		
Premium Mode: <u>Monthly Bank Draft</u>	Modal Premium: \$ _____	<input type="checkbox"/> Check here to select Automatic Premium Loan

E REPLACEMENT INFORMATION

1. Is there any existing life insurance or annuity coverage on the life of any Proposed Insured? ☐ Yes ☐ No
If Yes, provide information in the table below and answer question 2. If No, skip question 2, and proceed to the next applicable section.

Proposed Insured's Name (Last, First, Middle Initial)	Company	Owner (Last, First, Middle Initial)	Amount	Accidental Death Benefit	Policy Date

2. Will the life insurance applied for replace, or otherwise reduce in value, any existing life insurance or annuity now in force? ☐ Yes ☐ No

Complete the replacement form(s) in accordance with applicable state replacement regulations. Replacement forms must be submitted with the application.

APPLICATION AND REPLACEMENT FORMS(S) MUST BE COMPLETED AND DATED ON THE SAME DAY.

F PROPOSED INSURED HEALTH INFORMATION☐ **N/A – Skip this section if Guaranteed Issue Product is Elected.**

Information regarding Your insurability will be treated as confidential. Americo Financial Life and Annuity Insurance Company (Americo) is a member of MIB, Inc. (MIB). Americo, or its reinsurers, may make a brief report to MIB, which operates an information exchange on behalf of its members. If You apply to another member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB may supply such company with the information in its file. Americo or its reinsurers may also release information to other insurance companies to whom You may apply for life or health insurance, or to whom a claim for benefits may be submitted. It is Americo's practice to prohibit third parties who lawfully receive nonpublic health information from redisclosing or reusing the disclosed information. You may request to see the information kept in Your MIB file. You may also contact MIB and seek a correction for any errors in Your file.

Your authorization permits any insurance or reinsurance company, licensed medical physician, medical professional, hospital, pharmacy or pharmacy benefit manager, records custodians, other medical or medically related facility, clearing house, consumer reporting agency, and/or MIB, Inc. that has any information about You, or anyone listed in this application that are proposed to be insured, to give Americo, its reinsurers or any MIB authorized third-party administrator performing underwriting services on Americo's behalf, information about other insurance coverage, age, general character, habits, finances, motor vehicle records, medical care or advice about any physical or mental condition, including information about medications prescribed, chart notes, labs, x-rays and special tests, information on the diagnosis and treatment of Human Immunodeficiency Virus (HIV) infection, sexually transmitted diseases, and the use of drugs, alcohol, tobacco and psychotherapy notes and alcoholism, required by Americo to determine insurability and/or claims eligibility, for the duration of the claim. Health information obtained will not be re-disclosed without Your authorization unless permitted by law, in which case it may not be protected under federal privacy rules.

You may obtain a copy of this Medical Information Authorization on request. This Authorization will be valid for 2 years from the date signed, as permitted per applicable law in the state where the policy is delivered or issued for delivery. This Authorization may be revoked; however, it may not be revoked during the contestability period of the policy or to the extent Americo has taken action in reliance on this Authorization. Notice of revocation may be sent, in writing, to Americo at its Administrative Office address.

I understand that the aforementioned parties requesting access to my (electronic or paper) medical records are acting as a patient authorized representative and will attempt to access my medical records in the most efficient manner possible, including electronic interchange through a Health Information Exchange or directly through My Providers' electronic health record system.

Signature located on Medical Information Authorization _____

Signature of Proposed Insured (required) _____

Date _____

1. Have You used any nicotine products (including, but not limited to, cigarettes, cigars, pipes, chewing tobacco, snuff, alternative nicotine delivery devices such as nicotine chewing gum or lozenges, nicotine patches or e-cigarettes or any device used for the vaporization of liquid nicotine) within the last 12 months? ☐ Yes ☐ No
2. Height: " 3. Weight:
4. Have You ever been diagnosed, treated, tested positive, or been given medical advice, or prescribed medication by a licensed member of the medical profession for:

	Yes	No
a. Alzheimer's disease, dementia, memory loss, muscular dystrophy, or ALS (Lou Gehrig's disease)?	<input type="checkbox"/>	<input type="checkbox"/>
b. Congestive heart failure, defibrillator placement, cardiomyopathy, chronic kidney disease or kidney failure, or received kidney dialysis?....	<input type="checkbox"/>	<input type="checkbox"/>
c. Cirrhosis of the liver, Hepatitis (all forms, excluding recovered Hepatitis A), or liver failure?	<input type="checkbox"/>	<input type="checkbox"/>
d. Emphysema, chronic obstructive pulmonary disease (COPD), or any other chronic respiratory or lung problem, excluding allergies or asthma?	<input type="checkbox"/>	<input type="checkbox"/>
e. Metastatic cancer (cancer that has spread to other parts of the body)?	<input type="checkbox"/>	<input type="checkbox"/>
f. Two or more occurrences of cancer of any kind or a reoccurrence of a previous cancer?	<input type="checkbox"/>	<input type="checkbox"/>
g. AIDS, ARC, or HIV?	<input type="checkbox"/>	<input type="checkbox"/>
5. In the past 24 months, have You been diagnosed, treated, tested positive, or been given medical advice by a licensed member of the medical profession for:

a. Internal cancer, brain tumor, or malignant melanoma (excluding basal cell skin cancer)?.....	<input type="checkbox"/>	<input type="checkbox"/>
b. Complications of diabetes, including amputation, retinopathy (eye disease), nephropathy (kidney disease), neuropathy, insulin shock, or diabetic coma?.....	<input type="checkbox"/>	<input type="checkbox"/>
6. In the past 24 months, have You been diagnosed treated, tested positive received medical advice, counseling, or been prescribed medication by a licensed member of the medical profession for drug or alcohol abuse/dependency or addiction? ☐ Yes ☐ No
7. Within the last 12 months, have You been advised, by a licensed member of the medical profession, to have tests, surgery or hospitalization (except for those related to HIV or AIDS), which have not been completed, or are You waiting for a medical diagnosis or results of medical tests or procedures which have not been received? ☐ Yes ☐ No
8. In the past 12 months, have You been diagnosed, treated, tested positive, been given medical advice or prescribed medication by a licensed member of the medical profession for:

a. Angioplasty (balloon procedure), stent placement, or heart bypass surgery?	<input type="checkbox"/>	<input type="checkbox"/>
b. Stroke; heart attack, heart valve disease, coronary disease, angina (chest pain), or heart disorder (excluding hypertension)?	<input type="checkbox"/>	<input type="checkbox"/>
9. Have You received advice from a licensed member of the medical profession to have, are You waiting for, or have You ever received, an organ or tissue transplant? ☐ Yes ☐ No

- | | Yes | No |
|--|--------------------------|--------------------------|
| 10. Are You now, or within the past 6 months have you been: | | |
| a. Hospitalized for 48 hours or more, bedridden or confined to or living in a nursing facility or correctional facility? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Receiving or been advised by a member of the medical profession to receive hospice care? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Receiving home health care for a chronic or debilitating condition? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Receiving assistance with activities of daily living, including eating, bathing, toileting, or dressing due to a chronic or debilitating condition? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Confined to a wheelchair or using a walker for assistance (except in the case of a temporary condition immediately following injury or medical treatment not to exceed 3 months' time)? | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Using oxygen to assist in breathing? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have You been diagnosed with a terminal illness that is expected to result in death within 24 months? | <input type="checkbox"/> | <input type="checkbox"/> |

ADDITIONAL QUESTIONS FOR APPLICANTS AGE 40-49 ONLY

- | | Yes | No |
|---|--------------------------|--------------------------|
| 12. Within the past 24 months, have You been convicted of, or pled guilty or no contest to, a felony? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Within the past 24 months, have You been diagnosed, treated or tested positive, or given medical advice by a licensed member of the medical profession for: | | |
| a. Bipolar disorder, schizophrenia, manic or clinical depression, psychosis, mental incapacity, post-traumatic stress disorder or suicidal thoughts? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Brain tumor? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Huntington's disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Within the past 24 months, have You used narcotics (other than as prescribed by a licensed member of the medical profession), amphetamines, hallucinogens, heroin, or cocaine? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Within the past 12 months, have You been convicted of or pled guilty or no contest to driving while impaired, intoxicated or under the influence of drugs or alcohol, or had Your driver's license suspended or revoked for any reason? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Within the past 2 months, have You been diagnosed, tested positive, or been given medical advice by a licensed member of the medical profession for chronic pancreatitis? | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Do You currently have felony charges pending against You, or are You currently on probation or parole? | <input type="checkbox"/> | <input type="checkbox"/> |

G AUTHORIZATION AND ACKNOWLEDGMENT

IMPORTANT FRAUD NOTICE: 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.

By providing Your Authorization and Acknowledgement, You:

- ACKNOWLEDGE any policy issued on this application will be deemed to be delivered in and governed by the laws of the jurisdiction of the Owner.
- ACKNOWLEDGE that the **USA PATRIOT ACT** requires all financial institutions, including insurance companies, to verify the identity of their customers. Providing Your name, address, date of birth and taxpayer identification number allows Americo to verify Your identity. Americo's verification process may include the use of third-party sources to verify the information You provide.
- AUTHORIZE Americo to act on electronic and/or telephonic information from all parties specified in this application. This authorization may be revoked by sending written notice to Americo at its administrative office address. The absence of this authorization constitutes a rejection of this authorization.

You furthermore Agree to the following:

- The answers and statements in the application for insurance are the basis for any policy issued by Americo and no information will be considered to have been given to Americo unless it is stated in the application.
- Your sales representative does not have Americo's authorization to waive the answer to any question in this application, nor decide on the insurability, nor waive any of the company's underwriting requirements, nor change any contract.
- All answers and statements in this application for insurance, as they pertain to You, are true and complete to the best of Your knowledge and belief.

Signed at (State) ^{NV} _____ on (Month/Day/Year) _____

Signature of Proposed Insured (required)

Signature of Owner (if different than Proposed Insured)

Signature of Witnessing Agent (required)

Bank Draft Authorization Form

AF55019 (06/15)



DRAFT INFORMATION	<p>As a convenience to me, I hereby request and authorize the banking institution below (the "Bank") to pay and charge to my account drafts on my account by and payable to the order of the company who issued or assumed the policy listed below (the "Company") administering my insurance policy provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that the Bank's rights in respect to such draft shall be the same as if it were a check drawn on the bank and signed personally by me. This authorization will remain in effect until revoked by me or the Company. Notifications should be sent to PO BOX 410288, Kansas City, MO 64141-0288, Attention Customer Service. Our toll-free number is 800.231.0801. I agree that the Bank shall be fully protected in honoring any such draft. I further agree that if any such draft be dishonored, whether with or without cause and whether intentionally or inadvertently, the Bank shall be under no liability whatsoever. Should any draft not be honored by the Bank upon presentation, I understand that this method of payment may be terminated. I further understand that should any draft not be honored for the reason of "insufficient funds", a second attempt to draft may occur within 5 business days from the returned draft date.</p> <p>I understand that Americo requires a 5 business day advance notice to set up, change, or discontinue my bank draft information. I also understand that my insurance policy may lapse if said draft is returned unpaid by my Bank, or if I discontinue payments, prior to receiving confirmation of draft processing from the Company. Please keep a copy of this authorization with your banking records.</p> <p>FOR EXISTING POLICIES: Unless otherwise requested, premium draft date will be the existing premium due date.</p> <p>DRAFT DATE: (If no option is selected, Draft Date will default to the first option listed below)</p> <p><input type="checkbox"/> Upon issue and on the policy's regular due date thereafter</p> <p><input checked="" type="checkbox"/> Specific start date: _____ / _____ (must be within 10 days of the Due Date and cannot be on the 29th, 30th, or 31st of the month. It may take up to 4 business days from the day we initiate the draft for your bank to process this transaction.) <div style="display: flex; justify-content: space-around; width: 100%;"> Month Day </div> </p> <p>Additional option for Final Expense and Mortgage applications (Also available for in-force policy numbers starting with "AM" issued after December 2011.)</p> <p><input type="checkbox"/> Day of week: _____ / _____ (Draft day must be specified using Monday through Friday Example: Second / Monday <div style="display: flex; justify-content: space-around; width: 100%;"> Week of Month Day of Week </div> for a specific week of the month (First-Fourth). The actual date of draft could vary each month.)</p> <p>ACCOUNT TYPE: (If no option is selected, Account Type will default to the checking account option)</p> <p><input type="checkbox"/> Checking Account (attach voided check)</p> <p><input type="checkbox"/> Savings Account (attach deposit slip)</p> <p><input type="checkbox"/> Check with Application (use the deposit and routing numbers from the enclosed check in lieu of a voided check)</p> <p><input type="checkbox"/> Please use Bank Draft information from Americo policy number: _____</p>		
INSURED INFORMATION	Insured Name(s)		Policy Number(s)
PAYOR INFORMATION	Name	Relationship to Proposed Insured	Phone Number
	Address (If mailing address is a PO Box, a street address is also required)		
	How long at current address? _____ If less than 5 years at current address, prior address required.		
SIGNATURE	Payor's Signature (REQUIRED, as it appears on bank records)		Date

Attach Voided Check/Deposit Slip Here

Complete below only when voided check or deposit slip is not available

ALTERNATE ACCOUNT VERIFICATION	<p>Routing Number _____</p> <p>Account Number _____</p> <p><input type="checkbox"/> Check here if this is a business account</p> <p>Agent's Certification (For New Business only)</p> <p>I do hereby attest that I personally verified this information. I understand that any misrepresentation or falsification on my part will rescind my privilege to use this form and may lead to immediate termination of my appointment with the Company.</p> <p style="text-align: right;">123</p> <p>Agent's Signature (REQUIRED) _____ Agent's Number _____</p>		
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This disclosure must be signed and returned with the application when applying for:

Eagle Premier – Smoker Class

This disclosure is a brief description of the Eagle Premier – Smoker Class modified whole life insurance policy. This disclosure is not an insurance contract. Please refer to your policy for all terms, exclusions, and limitations.

The Eagle Premier – Smoker Class policy allows the Insured, a nicotine user, to receive non-smoker premium rates for the first three policy years. After the third policy anniversary, your policy will continue under one of three Benefit Options:

- **Benefit Option A** – Under Option A, the Policy's Death Benefit will decrease and the Policy Premium will remain level. **Option A is the automatic Benefit Option.**
- **Benefit Option B** – Under Option B, the Policy Death Benefit will remain level and the Policy Premium will increase.
- **Benefit Option C** – Under Option C, the Policy Death Benefit and the Policy Premium will remain level. In order to elect Option C, the Insured must attest that they have been nicotine free during the previous 12 months and the Company must receive verification, obtained at the Company's expense, that the Insured is nicotine free.

Option A is the automatic Benefit Option, the Owner may elect Benefit Option B or C by contacting Americo any time **BEFORE** the 3rd Policy Anniversary. Once elected, the Benefit Option cannot be changed.

If a Benefit Option is not elected before the 3rd Policy Anniversary, Benefit Option A will be in effect.

ACKNOWLEDGEMENT

I, the undersigned Insured (and Policy Owner, if other than the Insured), acknowledge that I have read this Disclosure and I understand the above-stated benefits and will consult the policy and riders, if applicable, for all other terms, limitations, and exclusions.

Signed at State ^{NV} _____ on (Month/Day/Year) _____

Signature of Proposed Insured (required)

Signature of Owner (if different than the Proposed Insured)

Eagle Premier (Policy Series 311) is underwritten by Americo Financial Life and Annuity Insurance Company (Americo), Kansas City, MO, and may vary in accordance with state laws. Product and benefits may not be available in all states. Certain restrictions apply. Consult policy for all terms, exclusions, and limitations.

MIB, INC. PRE-NOTICE

Information regarding your insurability will be treated as confidential. However, Americo Financial Life and Annuity Insurance Company or its reinsurers may make a brief report to the MIB, Inc. formerly known as Medical Information Bureau, a not-for-profit membership organization of life insurance companies operating as an information exchange for its members. If you apply to another MIB member company for life or health insurance or a claim is submitted to such a company, upon request the MIB will supply the company with the information it has in its file.

Upon receipt of a request from you, the MIB, Inc., will arrange disclosure of any information it has in your file. Please contact MIB at 866.692.6901. If you question the accuracy of information in the file, you may contact the MIB and seek a correction in accordance with the procedures in the Fair Credit Reporting Act. The MIB's information office address is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734. The Company and its reinsurers may release information in its file to its reinsurers and to other life and health insurance companies to whom you apply for insurance or to whom a claim is submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

MEDICAL INFORMATION AUTHORIZATION

Information regarding your insurability will be treated as confidential. Americo Financial Life and Annuity Insurance Company (Americo) is a member of MIB, Inc. (MIB). Americo, or its reinsurers, may make a brief report to MIB, which operates an information exchange on behalf of its members. If you apply to another member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB may supply such company with the information in its file. Americo or its reinsurers may also release information to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. It is Americo's practice to prohibit third parties who lawfully receive nonpublic health information from redisclosing or reusing the disclosed information. You may request to see the information kept in Your MIB file. You may also contact MIB and seek a correction for any errors in your file.

Your authorization permits any insurance or reinsurance company, licensed medical physician, medical professional, hospital, pharmacy or pharmacy benefit manager, records custodians, other medical or medically related facility, clearing house, consumer reporting agency, and/or MIB, Inc. that has any information about you, or anyone listed in this application who are proposed to be insured, to give Americo, its reinsurers or any MIB-authorized third-party administrator performing underwriting services on Americo's behalf, information about other insurance coverage, age, general character, habits, finances, motor vehicle records, medical care or advice about any physical or mental condition, including medications prescribed, chart notes, labs, x-rays and special tests, information on the diagnosis and treatment of Human Immunodeficiency Virus (HIV) infection, sexually transmitted diseases, and the use of drugs, alcohol, tobacco and psychotherapy notes and alcoholism, required by Americo to determine insurability and/or claims eligibility, for the duration of the claim. Health information obtained will not be re-disclosed without your authorization unless permitted by law, in which case it may not be protected under federal privacy rules.

You, may obtain a copy of this Medical Information Authorization on request. This authorization will be valid for 2 years from the date signed. This authorization may be revoked; however, it may not be revoked during the contestability period of the policy or to the extent Americo has taken action in reliance on this authorization. Notice of revocation must be sent, in writing, to Americo at its Administrative Office address.

I understand that the aforementioned parties requesting access to my (electronic or paper) medical records are acting as a patient authorized representative and will attempt to access my medical records in the most efficient manner possible, including electronic interchange through a Health Information Exchange or directly through My Providers' electronic health record system.

Name of Proposed Insured (please print)

Signature of Proposed Insured

Date

Name of Additional Proposed Insured (please print) (if applicable)

Signature of Additional Proposed Insured

Date

Signature of Child

Signature of Child

Signature of Child

Signature of Child

Signature of Child

Signature of Child

Signature of Parent/Legal Guardian

Disclosure Statement for
Accelerated Benefit Payment Rider

AAA8565



The owner may make a one-time election to receive a lump sum accelerated benefit payment if the insured is diagnosed with a terminal illness that is expected to result in a limited life span of 12 months or less.

The accelerated benefit payment amount may be up to 50% of the policy's proceeds payable upon death, subject to a minimum of \$1,000.

There is no premium for this rider; however, a one-time administrative fee not to exceed \$250 will be added to the rider benefit at the time of acceleration and interest will be charged on the accelerated benefit payment.

The rider benefit payment, the administrative fee and any accrued interest will be a lien against the policy, and along with any outstanding policy loans, will reduce the amount otherwise available under the policy's death benefit and cash value.

Any accidental death benefit provided by policy provision or rider will not be impacted by the accelerated benefit payment.

All premiums under the policy and any riders will be waived for 12 months following the benefit payment. If the insured is living after 12 months, the waiver will no longer apply and premiums will be due.

Accelerated benefits may be taxable and may adversely affect the ability for Medicaid benefits or other state or federal government benefits. Assistance should be sought from a personal tax advisor.

Please acknowledge that you were provided this disclosure at the time of application for insurance by providing your signature below.

Owner's Signature

Date

Agent's Signature

Date

PRODUCER'S STATEMENT

Proposed Insured's Name: _____

1. Is the Agent related to the Proposed Insured(s)? ☐ Yes ☐ No If Yes, provide relationship: _____

2. How long has the Agent known the Proposed Insured(s)? _____

Provide details of all Yes answers in the Agent Comments/Remarks section.

- | | Yes | No |
|---|--------------------------|--------------------------|
| 3. Did the applicant approach you to purchase insurance? <i>If Yes, list their stated need for the insurance in the Agent Comments/Remarks section.</i> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Is there any existing life insurance or annuity coverage on the life of any Proposed Insured?
<i>If Yes, answer question 5. If No, skip question 5 and proceed to the next applicable section.</i> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Will the life insurance applied for replace, or otherwise reduce in value, any existing life insurance or annuity now in force?
<i>Complete replacement form(s) in accordance with applicable state replacement regulations. Provide copies of replacement form(s) to the Owner and the Company. Leave copies of sales materials with Owner. If you used an electronic sales presentation, you must mail a copy to the Owner.</i> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Were appropriate replacement forms left with the client? | <input type="checkbox"/> | <input type="checkbox"/> |

State Specific Questions.

- | | | |
|--|--------------------------|-------------------------------------|
| 7. Is this application being taken in the state of ALABAMA ? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| <i>If Yes be advised: ANY PAYMENT BY CHECK MUST BE MADE PAYABLE TO AMERICO FINANCIAL LIFE AND ANNUITY INSURANCE COMPANY. THE CHECK MUST NOT BE MADE PAYABLE TO THE AGENT/INSURANCE PRODUCER OR THE PAYEE BE LEFT BLANK.</i> | | |
| 8. a. Is this application being taken in the state of CALIFORNIA ? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| b. If Yes and the Proposed Insured is 65 or older: Did you meet with the senior in his/her own residence? | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>If Yes, form 03-185-1 CA must be completed 24 hours prior to the appointment. This form must be submitted with the application.</i> | | |
| 9. Is this application being taken in the state of FLORIDA ? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| If Yes, do you authorize Americo to act on electronic and/or telephonic information specified in this application? | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>This authorization may be revoked by sending written notice to Americo at its administrative office address. The absence of this authorization constitutes rejection of this authorization.</i> | | |

Agent Comments/Remarks:

I hereby certify that I have personally asked each question on this application to the Proposed Insured(s), the Proposed Insured(s) directly responded to each application question, all Proposed Insured(s) were present and I witnessed their signatures, a government-issued picture I.D. was requested, reviewed, and confirmed (by reviewing a second document such as a utility bill, tax return, etc.) for the Proposed Insured, Owner, and Payor (if different than the Proposed Insured) and that I have truly and accurately recorded on the application the information supplied by him/her, and that I have no reason to believe that any of the information provided is inaccurate or incomplete. If not, I have set forth my reservations in the Agent Comments/Remarks section above.

Agent Signature	Print Agent Name	Agent Phone Number	Agent Email Address	Americo Producer #	State License # (if required)	%
		215-4359301				

**Important Notice Regarding
Replacement of Life Insurance**

ANV8328 (2012)



IMPORTANT NOTICE REGARDING THE REPLACEMENT OF YOUR POLICY OF LIFE INSURANCE

You have been offered a policy to replace all or part of your existing policy of life insurance.

Before you replace your existing policy you should consider whether you could suffer a FINANCIAL LOSS under the new policy because of your AGE or the condition of your HEALTH. You should also consider whether you will pay more for premiums because of your age or health.

You WILL incur additional costs to acquire the new policy, including the payment of commissions to the agent advocating the replacement of your existing policy.

To make an informed decision about the replacement of your policy, you should discuss the provisions of your existing policy with your agent or the company which issued it to determine whether your policy can be changed to meet your present needs.

Your new policy provides 30 days for you to decide whether you wish to keep it.

The agent who is offering to replace your existing policy is required to obtain your signature on this notice. Also, the agent will be notifying your existing company that you are considering the replacement of your policy.

I have read this notice and received a copy of it for my records.

Applicant's Signature

Date

Agent's Signature

Date

Important Note: Application and replacement notice must be signed on the same date.