APPLICATION FOR INDIVIDUAL LIFE INSURANCE (**Please print in black ink**)

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

Proposed Insured: ______________________ (First) (Middle) (Last)

Address (No. & Street) ______________________

City ______________ State ________ Zip Code ________

E-mail Address: @

Employer's Name and Address
____
Group #:

Occupation ______________
Date of Hire ______________
Annual Salary

Sex At Birth	Date of Birth	Age	State of Birth	SS# — — / DL# SOI	Height	Weight	Home Phone No.
☐ Male ☐ Female	Mo. Day Yr / /			SS# — — DL# SOI	ft in	lbs	( )

Owner: Name ______________ SS# ______________ Address: ______________
Payor: Name SS# Address:

Primary Beneficiary ______________ SS# ______________ Relationship ______________
Contingent Beneficiary SS# Relationship

Plan: ______________ **Face Amount $** ______________

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

Riders: ☐ GIR ☐ Level Term Rider Amt. $________ ☐ ADB Amt. $________
☐ DIR ☐ CIA ______ Units ☐ Annuity Rider Amt. $________
☐ WP ☐ FIA ______ Units ☐ Other

Mail Policy To: ☐ Agent ☐ Insured ☐ Owner
Requested Policy Date: / /

Mode: ☐ Bank Draft ☐ Draft 1st Prem Modal Prem $________
☐ Payroll Deduction $ ☐ Other

☐ E-Check Immediate 1st Prem Collected $

Do you have existing life or disability insurance or an annuity contract? ☐ Yes ☐ No Company
Will you replace or change any existing life or disability insurance or an annuity? ☐ Yes ☐ No Policy # Amt of Coverage $

Other Persons Proposed for Insurance (Complete for Level Term, Family, and Child Riders):

Name	Rider	Amt.	Sex	Birthdate	St. of Birth	Height	Weight	Relationship

	Yes	No
1. Has any Proposed Insured:		
a. within the past 5 years, been convicted of a crime including driving under the influence of alcohol or drugs, or had their driver's license revoked, or used illegal drugs or received medical treatment or counseling for, or been advised by a physician to discontinue the use of alcohol or prescribed or non-prescribed drugs, or within the past 12 months been on probation or parole?	☐	☐
b. within the past 10 years, been medically treated or diagnosed by a medical professional as having Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC), or any immune deficiency related disorder or tested positive for the Human Immunodeficiency Virus (HIV)?	☐	☐
c. within the past 2 years participated in, or intend within the next 2 years to participate in, parachuting, hang gliding, mountain climbing, rodeo events, sky diving, scuba diving, organized racing of any kind, or any professional sport?	☐	☐
d. within the past 5 years, had any diagnostic testing (excluding AIDS/HIV tests) recommended by a medical professional which has not been completed or for which the results have not been received?	☐	☐
e. been prohibited from actively working full time (30 hours or more per week) at their regular occupation during the last 6 months due to any illness, injury, or health related problem or are they **currently** disabled?	☐	☐
f. been hospitalized or consulted a physician, including regular checkups, during the past 5 years?	☐	☐

2. Within the past 10 years, and to the best of your knowledge and belief, has any Proposed Insured been treated for or told by a physician that they had:

a. Hypertension? Yes ☐ No ☐
b. Internal cancer, leukemia, or melanoma? Yes ☐ No ☐
c. Heart disease, heart attack, or chest pain? Yes ☐ No ☐
d. Stroke, TIA, or circulatory disorder? Yes ☐ No ☐
e. Genitourinary or sexually transmitted disease? Yes ☐ No ☐
f. Cirrhosis, chronic hepatitis, or liver disease? Yes ☐ No ☐
g. Schizophrenia, bipolar, mental or nervous disorder? Yes ☐ No ☐
h. Rectal bleeding or gastrointestinal disease? Yes ☐ No ☐
i. Paralysis, blindness, or temporary vision loss? Yes ☐ No ☐
j. Diabetes or pancreas disorder? Yes ☐ No ☐
k. Lung or respiratory disorder? Yes ☐ No ☐
l. Any other disease, injury, operation or deformity? Yes ☐ No ☐

Give details of any "Yes" answer to Questions 1 and 2 and list all current medications: (use COMMENTS section on back for additional space)

Illness, Injury or Disease	Month/Year	Duration	Result	Name and Address of Physician and/or Hospital

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, and with the intent to induce the Company to issue the plan of insurance, all answers contained in this application are true, complete and correctly recorded; and (2) This application, supplemental applications, questionnaires, and any policy issued on the basis of such applications shall form the entire contract; and (3) No change in this contract shall be effected without my written consent with regard to: (a) the amount of insurance; (b) age at issue; (c) classification of risk; (d) plan of insurance; or (e) benefits. If this application is declined by the Company, I will accept the return of any premium paid. Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

AUTHORIZATION—In order to properly classify my application for life insurance, I authorize any and all licensed physicians, medical practitioners, hospitals, clinics, medical or medically-related facilities, health plans, pharmacy benefit managers, pharmacies or pharmacy-related facilities; insurance companies and their business associates and those persons or entities providing services to the insurer's business associates which are related in any way to their insurance plans; the MIB, Inc. or other organization that has knowledge or records of me and my health to give such information to: (a) American-Amicable Life Insurance Company of Texas; and (b) its reinsurers. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization or the insurance company exercises a legal right to contest a claim or the policy itself. I may revoke the authorization by sending a written revocation to the Company address of 425 Austin Ave., Waco TX 76701. I understand that if I refuse to sign this authorization to release my complete medical records, my application for insurance with the Company will be rejected.

All said sources, except the MIB, Inc., are authorized to give records or knowledge such as statements regarding hobbies, employment, criminal records or medical history that might be required to determine eligibility for insurance to any agency employed by the Company to collect and transmit data. I authorize American-Amicable Life Insurance Company of Texas to disclose any personal data gathered while processing this application. This data may be released to the following: (a) reinsuring companies; (b) the MIB, Inc.; (c) other persons or groups performing services in connection with this application; or (d) any others to whom it may be lawfully required or authorized. This authorization shall remain valid for two years from this date, or the time limit, if any, permitted by the 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.

I acknowledge receiving the Fair Credit Reporting Act Notice, MIB, Inc. Pre-Notice Forms, if applicable.

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 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.

Signed at ______________________ ______________ Proposed Insured Signature: ______________________
CITY STATE

Date Signed: ________/_______/________ ______________________ ______________________
SIGNATURE OF OWNER (IF OTHER THAN PROPOSED INSURED) SIGNATURE OF SPOUSE (IF APPLYING FOR COVERAGE)

AGENT'S REPORT

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 annuities? ☐ Yes ☐ No

Agent's remarks: ____

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 physically witnessed their signature, or attest that it was signed electronically by the Proposed Insured.

Agent (SIGNATURE) ______________________No: ________%_____ Agent (SIGNATURE)______________________No: ________%______

PREAUTHORIZATION CHECK PLAN - AUTHORIZATION TO HONOR CHARGE DRAWN

Insured______________________________________ Account Holder______________________________

Financial Institution (name/address)____

Transit / ABA Number__________________ Account Number________________ ☐ Checking ☐ Savings Requested Draft Day (1st-28th)______

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

☐ 1st ☐ 3rd ☐ 2nd Wednesday ☐ 3rd Wednesday ☐ 4th Wednesday

ATTACH VOIDED CHECK OR DEPOSIT SLIP

As a convenience to me, I hereby request and authorize you to pay and charge to my account amounts drawn on my account, whether by electronic or paper means, by and payable to the order of American-Amicable Life Insurance Company of Texas, for the purpose of paying premiums on life insurance policy, provided there are sufficient funds in said account to pay the same upon presentation. I agree that your rights with respect to each such charge shall be the same as if it were signed personally by me. This authorization is to remain in effect until revoked by me in writing and until you actually receive such notice. I agree that you shall be fully protected in honoring any such check. I further agree that if any such check be dishonored, whether with or without cause, and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

SIGNATURE (As on Financial Institution Records)____ DATE________________

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 UNTIL ALL CONDITIONS OF THIS RECEIPT ARE MET. NO AGENT HAS THE AUTHORITY TO ALTER THE TERMS OR CONDITIONS OF THIS RECEIPT. IF TEMPORARY INSURANCE EXISTS UNDER THIS CONDITIONAL RECEIPT, IT WILL END UPON DELIVERY OF A POLICY OR 60 DAYS AFTER THE DATE OF THIS RECEIPT, IF EARLIER.

Received of______________________________ the sum of $____________________ as first payment on this application.
Date__________________________________ Agent__________________________________

If (1) an amount equal to the first full premium is submitted or if a payroll deduction authorization has been fully implemented in an amount sufficient to pay the first full monthly premium; and if (2) all underwriting requirements, including any medical examinations required by the Company's rules, are completed; and (3) 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 is submitted for processing, or (c) the date of the latest medical exam required by the Company. THE 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, the liability of the Company shall be limited to the return of any amount paid.

FAIR CREDIT REPORT ACT PRE-NOTIFICATION

We may request a consumer report, including an investigative consumer report, in connection with this application for insurance. The report may include information about your character, general reputation, personal characteristics or mode of living and may involve personal interviews with neighbors, friends, employers, business associates, financial sources, or others with whom you are acquainted.

You have the right to request a written summary of your rights under the federal Fair Credit Reporting Act. You also have the right to make a written request within a reasonable period of time for a complete and accurate disclosure regarding the nature and scope of the requested investigation. Upon written request, we will disclose whether an investigative consumer report was requested as well as the name and address of the consumer reporting agency to whom the request was made. By contacting the agency, you may inspect and receive a copy of the report.

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.

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
Ph: 800-736-7311 • Fax: 254-297-2102 • E-mail: underwriting@aatx.com

JUVENILE QUESTIONNAIRE

Proposed Insured Name:________________________________Application Number: ________________
Ht/Wt:__________Date of Birth: _____________________

Does the child reside with the father and/or mother that is listed on the application? __yes __no
If not, name and address and relationship with whom the child resides:
Name____Relationship_______________________________
Address/City/State ____

Does the child have any existing life insurance or a pending application for life coverage? __yes __no
If yes, provide: Company Name:_____________________Coverage Amt: ___________________
Will the existing coverage be replaced? __yes __no

List any and all brothers and sisters by name and age:

Name/Age	Name/Age
1. ________________________________	4. ________________________________
2. ________________________________	5. ________________________________
3. ________________________________	6. ________________________________

Has insurance been requested on the applicant's brother(s) and/or sister(s) or do they have life coverage in-force? __yes __no
If yes, indicate the amount of coverage for each sibling:

Name/ Coverage Amount	Name/ Coverage Amount
1. ________________________________	4. ________________________________
2. ________________________________	5. ________________________________
3. ________________________________	6. ________________________________

Do the parent(s) or guardian(s) have coverage in-force or has insurance been requested on the parent(s) or guardian(s)? __yes __no
If yes, indicate the amount of coverage for each parent or guardian:
Father's/Guardian's amount of life coverage in-force and company name:
____
Mother's/Guardian's amount of life coverage in-force and company name:
____

Provide the annual income for the household for which the juvenile resides: _______________________

Medical information for child:
List child's current physician's name and address: ____
____
Date last seen and reason: ____
____
List current treatment and all medications: ____

____ ____
Parent/Guardian (Owner) Signature Date

AA9825(1/22)

☐ American-Amicable Life Insurance Company of Texas
☐ IA American Life Insurance Company
☐ Occidental Life Insurance Company of North Carolina
☐ Pioneer Security Life Insurance Company
☐ Pioneer American Insurance Company

Your Annuity cannot be issued without signature on either the Waiver or the Completed Suitability Questionnaire Below

STATEMENT OF ANNUITY SUITABILITY AND WAIVER OF QUESTIONNAIRE

We appreciate your interest in an annuity contract. We are required to ask for information that will help determine whether an annuity contract is suitable for your investment goals and financial situation. The questions pertain to your personal situation at the time of this application, and to your understanding of the features of the product for which you are applying. This information will not be used for any other purpose and will remain confidential. **You have the right to decline to provide this information. If this is your wish, please read the following statement, sign, date, and return this form with your Application. The company reserves the right to reject any application that has not had the suitability information completed.**

No, I will not answer the questions on the below Questionnaire, and I take full responsibility for determining whether the proposed annuity is suitable for me.

(The Proposed Annuitant must sign in the "Signature" space below if electing to forgo answering the Questionnaire below.)

____________________ Proposed Annuitant's Signature
____________________ Printed Proposed Annuitant's Name
____________________ Date

Annuity Suitability Questionnaire (Must Be Completed if not signing above Waiver)

I agree to answer the questions below and understand that my responses will be used to evaluate the suitability of an annuity contract. I understand the company may elect not to issue the annuity contract being applied for based on a reasonable determination that the product may not be suitable for me.

Proposed Annuitant's Name: ______________________________ Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Occupation: ____ Investment Knowledge: ☐ Limited ☐ Average ☐ Extensive

Primary Financial Objectives: ☐ Immediate Income ☐ Tax Deferral ☐ Wealth Accumulation ☐ Charitable Giving ☐ Future Income ☐ Education Planning ☐ Preservation of Capital ☐ Inheritance

Time Frame for These Above Objectives: ☐ 1 year or less ☐ 1–3 years ☐ 3–7 years ☐ 7–10 years ☐ 10 years or more ☐ Never if for Inheritance or Charity

Annual Household Income: $_____________ Liquid Net Worth, excluding residence and furnishings: $ _____________

Source of Income for the Proposed Annuity (Check all that apply): ☐ Employment ☐ Retirement Plans ☐ Investments ☐ Social Security ☐ Other

Tax Bracket: ☐ 10% ☐ 15% ☐ 25% ☐ 28% ☐ 33% ☐ 35% Proposed Annuity represents what % of your Net Worth: ___%

Do you have funds available to you in case of emergency? ☐ Yes ☐ No Risk Tolerance: ☐ High ☐ Moderate ☐ Low

Please list any other relevant information below (financial constraints, health concerns, long-term care consideration, etc.):

____

Are you considering using funds from existing life insurance policies, annuity contracts or certificates of deposit to purchase this annuity? ☐ Yes ☐ No

If Yes, how many years has that policy(ies), contracts(s) or certificate(s) of deposit been in force? ___Years

If Yes, are there any surrender charges associated with the above-mentioned existing policy(ies), contract(s) or certificate(s) of deposit and what is/are those charge(s)? ____

I have adequate income or available liquid assets to meet my financial obligations and emergency expenses without using the money I am investing in this annuity. By signing this form, I have agreed that the information on this form was obtained prior to purchase of the annuity and that the information is correct. I also understand the company encourages me to discuss this proposed investment with my personal financial advisor(s).

____________________ Proposed Annuitant's Signature
____________________ Printed Proposed Annuitant's Name
____________________ Date

Agent's Statement

☐ **I DO recommend** the purchase of this annuity policy, which I believe is suitable based on the information provided by the proposed annuitant regarding his or her insurance needs and financial objectives.

☐ **I DO NOT recommend** the purchase of this annuity contract (Form No. 3704 must be completed and sent with the annuity application).

____________________ Agent's Signature
____________________ Agent's Printed Name and Agent Number
____________________ Date

COMPLETE AND RETURN WITH ANNUITY APPLICATION

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 12 months**, have you been advised by a medical professional to be quarantined, for any period of time for the novel coronavirus (COVID-19)?.. ☐ Yes ☐ No

2. **Within the past 12 months**, have you been treated for, examined for, diagnosed with, or tested positive for the novel coronavirus (COVID-19) by a medical professional?... ☐ Yes ☐ No

3. **Within the past 30 days**, have you been advised by a medical professional to get specified medical care (such as any diagnostic testing or hospitalization) which was not completed; as result of fever, cough, shortness of breath, fatigue (excluding HIV/AIDS)? .... ☐ 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)____