

<i>SERFF Tracking Number:</i>	<i>APLE-126100780</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>IA American Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>42870</i>
<i>Company Tracking Number:</i>	<i>GL201</i>		
<i>TOI:</i>	<i>L08 Life - Other</i>	<i>Sub-TOI:</i>	<i>L08.000 Life - Other</i>
<i>Product Name:</i>	<i>LIFE APPLICATIONS</i>		
<i>Project Name/Number:</i>	<i>LIFE APPLICATIONS/GL201</i>		

Filing at a Glance

Company: IA American Life Insurance Company

Product Name: LIFE APPLICATIONS

TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Filing Type: Form

SERFF Tr Num: APLE-126100780 State: Arkansas

SERFF Status: Closed-Approved-
Closed State Tr Num: 42870

Co Tr Num: GL201

Author: Laci Hunter

Date Submitted: 07/01/2009

State Status: Approved-Closed

Reviewer(s): Linda Bird

Disposition Date: 07/20/2009

Disposition Status: Approved-
Closed

Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

General Information

Project Name: LIFE APPLICATIONS

Project Number: GL201

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 07/20/2009

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Individual

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 07/20/2009

Created By: Lucille McGowan

Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Lucille McGowan

Filing Description:

This filing includes general life applications and other related forms, that do not replace any existing policy forms currently in use. The forms contain no unusual or controversial features or language that deviates from normal insurance industry standards. The forms will be used by individuals in the general public through licensed agents.

These forms are to be used with all life insurance policies. Currently, we have a life insurance policy pending approval by your department under SERFF filing number APLE-126212522.

Form GL201 will be used when applying for any life insurance policy. Form GL202 will be used if a paramedical exam is required, which is determined by age and face amount on a per product basis. Form GL203 will be used when certain

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questions on the general application are answered "yes", as indicated in form GL201. Form GL 204 will be used when requesting coverage on additional persons. Form GL 205 will be used in cases of reinstatement of a change to the policy as issued. Form GL206 will be used when requesting coverage on a child. Form GL 207 will be used when requesting a face amount of coverage for \$1,000,000 or more. GL208 will be used to update an applicant's health information since the initial application was submitted. Form GL209 will be used whenever the applicant needs to change their response to a question on the initial application. It will not amend or change any policy provision. Form GL501 will be used whenever an illustration on the base policy is not provided at application.

Company and Contact

Filing Contact Information

Lucille McGowan, Compliance Assistant lucille.mcgown@iaplife.com
 17550 N Perimeter Drive 888-473-5540 [Phone] 2232 [Ext]
 Suite 210 480-502-5088 [FAX]
 Scottsdale, AZ 85255

Filing Company Information

IA American Life Insurance Company CoCode: 91693 State of Domicile: Georgia
 17550 N. Perimeter Dr. Group Code: 315 Company Type: LAH
 Suite 210 Group Name: Industrial Alliance State ID Number:
 Group
 Scottsdale, AZ 85255-0131 FEIN Number: 13-3036472
 (480) 473-5540 ext. [Phone]

Filing Fees

Fee Required? Yes
 Fee Amount: \$200.00
 Retaliatory? Yes
 Fee Explanation: 10 forms x 20 each = \$250.00
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
IA American Life Insurance Company	\$200.00	07/01/2009	28933863

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	07/20/2009	07/20/2009

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Disposition

Disposition Date: 07/20/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Form	Application for Life Insurance		Yes
Form	Part 2 of Application		Yes
Form	Supplemental Application		Yes
Form	Additional Insured Application		Yes
Form	Application for Reinstatement/Change		Yes
Form	Application for Child Rider		Yes
Form	Confidential Financial Questionnaire		Yes
Form	Declaration of Good Health		Yes
Form	Amendment Page		Yes
Form	Certificate in Lieu of Life Insurance Illustration		Yes

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Form Schedule

Lead Form Number:

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	GL201	Application/ Application for Life Enrollment Insurance Form	Initial		46.900	GL201 App P1.pdf
	GL202	Application/ Part 2 of Application Enrollment Form	Initial		50.700	GL202 AppP2.pdf
	GL203	Application/ Supplemental Enrollment Application Form	Initial		56.600	GL203 Supp.pdf
	GL204	Application/ Additional Insured Enrollment Application Form	Initial		47.000	GL204 Addl Insrdr.pdf
	GL205	Application/ Application for Enrollment Reinstatement/Change Form	Initial		45.700	GL205 AppRnstmt.pdf
	GL206	Application/ Application for Child Enrollment Rider Form	Initial		45.200	GL206 App Chld Rdr.pdf
	GL207	Application/ Confidential Financial Enrollment Questionnaire Form	Initial		46.400	GL207 ConfFin.pdf
	GL208	Application/ Declaration of Good Enrollment Health Form	Initial		48.600	GL208 DeclGdHlth.pdf
	GL209	Application/ Amendment Page Enrollment Form	Initial		47.200	GL209 Amdt Pg.pdf
	GL501	Application/ Certificate in Lieu of Enrollment Life Insurance Form Illustration	Initial		51.200	GL501 CertIll.pdf



IA American Life Insurance Company
 17550 N. Perimeter Dr., Suite 210
 Scottsdale, AZ 85255-7833
 Tel: (888) 473-5540 FAX: (480) 502-5088

Application for Life Insurance

Part 1: General Information

Please print using dark ink

www.iaamerican.com

Section 1 – Proposed Insured

First name _____ Middle initial _____ Last name _____
 Sex: Male Female Date of birth _____ / _____ / _____ Age _____ Place of birth _____
MM DD YYYY
 Home address _____ City _____
 State _____ ZIP _____ How long _____ Home telephone (_____) _____ - _____
 Social Security No. _____ Occupation _____
 Employer _____ How long _____ Annual income _____
 Employer's address _____ Telephone (_____) _____ - _____
 City _____ State _____ ZIP _____

Section 2 – Policyowner Same as the Proposed Insured

Full name _____ Tax ID or SSN _____
 Relationship to Proposed Insured _____ Date of birth _____ / _____ / _____
MM DD YYYY
 Address _____ Telephone (_____) _____ - _____
 City _____ State _____ ZIP _____

Section 3 – Payor Same as the Proposed Insured

Full name _____ Tax ID or SSN _____
 Relationship to Proposed Insured _____ Date of birth _____ / _____ / _____
MM DD YYYY
 Address _____ Telephone (_____) _____ - _____
 City _____ State _____ ZIP _____

Section 4 – Beneficiary

If the beneficiary section is left blank, benefits will be paid to the Policyowner's estate. If the beneficiary is a minor, consult your advisor. If the beneficiary is a trust, provide the trustee name, the trust name, and the date of trust.

Primary _____ % (Total of all Primary Beneficiaries must equal 100%)

Full name _____ Tax ID or SSN _____
 Relationship to Proposed Insured _____ Date of birth _____ / _____ / _____
MM DD YYYY
 Address _____ Telephone (_____) _____ - _____
 City _____ State _____ ZIP _____

Primary _____ % or **Contingent** _____ % (Total of all Contingent Beneficiaries must equal 100%)

Full name _____ Tax ID or SSN _____
 Relationship to Proposed Insured _____ Date of birth _____ / _____ / _____
MM DD YYYY
 Address _____ Telephone (_____) _____ - _____
 City _____ State _____ ZIP _____

Primary _____ % or **Contingent** _____ %

Full name _____ Tax ID or SSN _____
 Relationship to Proposed Insured _____ Date of birth _____ / _____ / _____
MM DD YYYY
 Address _____ Telephone (_____) _____ - _____
 City _____ State _____ ZIP _____



Section 5 – Policy Details

Policy _____ **Face Amount** _____

Rating Class: Preferred (where available) Standard Non-Tobacco Tobacco Preferred Tobacco (where available)
 Universal Life: Option 1 Option 2
 Term: Level Decreasing for _____ years Premium Guarantee:(where applicable) 5 Year Rolling Fully Limited

Additional Benefits: (not available with all policies)

- Waiver of Monthly Deduction
- Waiver of Specified Premium for \$ _____
- Accidental Death Benefit for \$ _____ (maximum \$150,000)
- Term 10 or Term 20 for \$ _____ (not to exceed 3X face amount)
- Child Rider for _____ units (1 unit = \$1,000) (maximum 25 units, complete Application for Child Rider)
- Waiver of Premium
- Premium Refund Rider
- Disability Income Rider \$ _____/mo.
- Accident Only Disability Income Rider \$ _____/mo.
- Additional Insured Rider (not to exceed 3X face amount) (complete Additional Insured Application)
- Other Rider _____

Premium Payment Mode: Annual Semi-annual Quarterly Pre-authorized check: Monthly Quarterly
 List bill Employer _____ Pay frequency: 12 pay 10 pay Other _____
 Modal Premium \$ _____ Paid with application \$ _____

Section 6 – General Questions

For “Yes” answers, provide details and/or complete the applicable section on the Supplemental Questionnaire.

- A. Proposed Insured:** Height _____ft. _____in. Weight _____lbs. Weight change in past 12 months? Yes No
 Lost _____lbs. Gained _____lbs. Reason? _____
- B.** Have you used tobacco or nicotine products: in the past 36 months? Yes No
 in the past 12 months? Yes No
- C.** Within the past 5 years, have you flown as a student, private, commercial, military, or test pilot; or do you have plans for such flights in the future? (If “Yes,” complete the Aviation section of the Supplemental Questionnaire) Yes No
- D.** Within the past 5 years, have you participated in motorized racing, scuba or skin diving, rock or mountain climbing, sky diving, hang gliding, or rodeos? (If “Yes,” complete the Hazardous Sports section of the Supplemental Questionnaire) Yes No
- E.** Within the past 5 years, have you been convicted of, or pled guilty to, motor vehicle violations, driving under the influence, or reckless driving? (**Provide your driver’s license number regardless of your answer**) Yes No
 Driver’s license number _____ State _____
- F.** Within the past 5 years, have you been convicted of a felony or misdemeanor? (If “Yes,” provide details) Yes No
- G.** In the next year, do you intend to live or travel outside the U.S. or Canada for more than one month? (If “Yes,” complete the Foreign Residence section of the Supplemental Questionnaire) Yes No
- H.** Do you have an application for life or health insurance pending, or have you applied for such insurance within the past 6 months? (If “Yes,” provide insurance amounts and whether policies will be accepted) Yes No
- I.** Within the past 5 years, have you had an application (including a reinstatement application) for life or health insurance declined, rated, modified, or postponed? Yes No
- J.** Do you currently have any life insurance or annuity contracts in force? (If “Yes,” list all policies below) Yes No
- K.** Is this policy to replace any existing life insurance or annuity contract? (If “Yes,” indicate which policy). Yes No

COMPANY	AMOUNT	A.D.B.	YEAR ISSUED	REPLACEMENT
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

- L.** Are you financing the premium for, or do you intend to assign, this policy? (If “Yes,” provide details) . . . Yes No
- M. Complete only if the Proposed Insured is a minor**
 - 1. Are all siblings being insured? Yes No
 - 2. Sum of existing life insurance on each parent: \$ _____ \$ _____ None
 - 3. If 1 is “No” or 2 is “None,” provide reason: _____

N. Name, address, and phone number of the physician or medical facility that will have your medical records:
(Please provide the medical record number, if available.)

O. Date, reason for, and results of the last visit made to the above physician or medical facility.

Date _____ Reason _____

Results _____

P. Do you currently take any medication regularly or as needed? (If "Yes," provide the medication name and the condition treated). Yes No

Details and additional instructions:

Part 2: Medical Questionnaire

You may skip questions 1 and 2 of this section if a paramedical exam is required.

- 1.** In the past 10 years, have you had, been tested for, received treatment or counseling for, or been told by a medical professional that you have: (If "Yes," circle the appropriate item in each question and provide details.)
- a. Dizziness, fainting, convulsions, epilepsy, seizures, paralysis, stroke, or severe headaches? Yes No
 - b. Depression, anxiety, stress, bipolar, mental, or nervous disorder? Yes No
 - c. Shortness of breath, bronchitis, emphysema, asthma, sleep apnea, pleurisy, or tuberculosis? Yes No
 - d. Chest pain, angina, palpitations, irregular heartbeat, high blood pressure, elevated cholesterol, cardiac insufficiency, heart attack, or coronary artery disease? Yes No
 - e. Heart murmur, heart valve disorder, edema, aneurysm, or disorder of the heart or blood vessels? Yes No
 - f. Ulcer, intestinal bleeding, colitis, ulcerative colitis, Crohn's disease, jaundice, hernia, diarrhea, hepatitis, or any disorder of the stomach, esophagus, intestines, spleen, pancreas, liver, or rectum? Yes No
 - g. Diabetes, high blood sugar, or sugar in your urine? Yes No
 - h. Blood or protein in your urine, or any disorder of the kidneys, bladder, prostate, or urinary system? Yes No
 - i. Any disease or disorder of the breasts or reproductive system? Yes No
 - j. Thyroid, thymus, pituitary, adrenal, or lymph gland disorder? Yes No
 - k. Cancer, sarcoidosis, tumor, polyp, or any abnormal growth? Yes No
 - l. Back pain, arthritis, muscular dystrophy, or any disorder of the muscles, bones, or joints? Yes No
 - m. Multiple sclerosis or any disorder of the brain or nervous system? Yes No
 - n. Anemia, bleeding or clotting disorder, or any disorder of the blood (other than HIV-related)? Yes No
 - o. Alcoholism, drug addiction, or excessive use of alcohol or drugs? Yes No
- 2.** In the past 10 years, have you:
- a. been diagnosed or treated by a physician or other health care professional as having acquired immunodeficiency syndrome (AIDS), AIDS-related complex (ARC), or positive test results indicating the presence of the AIDS virus? Yes No
 - b. used marijuana, cocaine, heroin, or narcotics not prescribed to you by a physician? Yes No

Details to "Yes" answers (include dates, physicians or medical facilities, and addresses):

Agreement

Each of the undersigned declares that the statements and answers contained in this application and provided by such individuals are complete and true to the best of his/her knowledge and belief, that the statements and answers were correctly recorded before he/she signed below, and that they shall form the basis of any insurance policy that may be issued. A copy of this application shall be attached to, and made a part of, the policy. No change in amount, classification, plan of insurance, or benefits shall be effective unless agreed to in writing by the Proposed Insured and/or the Policyowner.

All information that I (we) have given to the Agent is contained in this application. A misrepresentation in response to any question may result in policy rejection or rescission subject to the incontestability provision in the policy.

It is also agreed that IA American Life Insurance Company (the Company) will incur no liability under this application until:

- a. the application has been received and approved;
- b. a policy has been issued and delivered; and
- c. the full modal premium has been paid to, and accepted by, the Company at its Home Office.

The policy must be issued, delivered, and the full Modal Premium paid while the health, habits, avocations, and occupation of the lives to be insured are as stated in this application. The policy will then be deemed effective on its issue date.

If the full Modal Premium specified in the application is paid on the date of this application, the liability of the Company shall be as stated on the Conditional Premium Receipt, which then becomes part of this application.

The Company will notify the Policyowner of its decision regarding the insurability of the lives to be insured, as stated in this application, within 60 days of receipt of the application. Otherwise, it will notify the Policyowner of the reason for any further delay.

No Agent has the authority to waive the answers to any of the questions in this application or to make or alter any contract for the Company.

The Agent and Policyowner agree that no insurance, other than those policies for the indicated life or lives to be insured indicated as replacements in Section 6(K), will be replaced by a policy issued in connection with this application.

Authorization to Obtain Information

The undersigned authorizes any or all of the following to give to IA American Life Insurance Company, or its reinsurers, any information from their records pertaining to my, or my minor children's, employment, health, alcohol, drug, and psychiatric information: a. any physician or medical practitioner; b. hospital, clinic, medical or medically-related facility; c. insurance or reinsurance company; d. MIB, Inc. (formerly known as the Medical Information Bureau); e. consumer reporting agencies; or f. employers.

Information obtained with this Authorization may only be: a. used to determine insurability; b. released to reinsurance companies; c. sent to MIB, Inc.; d. sent to persons or organizations performing business or legal services in connection with my application, except for information received from MIB, Inc., which must not be disclosed; e. used as lawfully required; or f. used as I may further authorize in writing.

The undersigned acknowledges receipt of the Notice of Insurance Information Practices, the Fair Credit Reporting Act Notice, and the MIB Notice and agrees that a photographic copy of this Authorization shall be as valid as the original. The undersigned agrees that this Authorization shall be valid for two years from the date shown below.

Each of the undersigned requests that any examination findings relating to such undersigned resulting in a rating, postponement, or declination of any, or of all, coverage requested on this application be forwarded directly to:

- Such undersigned's regular physician Yes No
- Such undersigned's attention at his/her home address Yes No
- Each of the undersigned elects to be interviewed if an investigative consumer report is prepared in connection with this application Yes No

I acknowledge that I have read the Fraud Warning applicable to my state on page 6 of this application.

Signed at _____ this _____ day of _____ 20____
City, State Month Year

Signature of Proposed Insured
(Parent or legal guardian if Proposed Insured is under 16)

Signature of Policyowner
(If other than Proposed Insured)

Fraud Warning

Arkansas, Louisiana, and Texas Residents Only: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance, is guilty of a crime and may be subject to fines and confinement in prison.

Colorado Residents Only: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

District of Columbia Residents Only: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida Residents Only: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Kentucky Residents Only: Any person who knowingly and with intent to defraud, any insurance company or other person files an application for insurance 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.

Maine, Tennessee, and Washington Residents Only: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Maryland Residents Only: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey Residents Only: Any person, who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

New Mexico Residents Only: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

North Dakota and South Dakota Residents Only: Any person, who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, commits insurance fraud, which may be a crime and may subject the person to civil and criminal penalties.

Ohio Residents Only: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma Residents Only: WARNING: Any person who knowingly and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon Residents Only: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Pennsylvania Residents Only: 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.

Virginia Residents Only: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer makes any claim for the proceeds of an insurance policy containing false, incomplete, or misleading information may be guilty of a felony.

In All Other States: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Disclosure Statement

One of the prime objectives of IA American Life Insurance Company is to provide insurance at low cost. The underwriting process (evaluation of risk) is necessary not only to ensure this low cost, but also to ensure that each policyholder contributes his/her fair share of the cost. In considering an application, information from various sources must be considered for insurance on your life. This includes the results of a physical examination, if required, and any reports received from doctors and hospitals who have attended the individuals whose lives are to be insured.

Notice of Insurance Information Practices

IA American Life Insurance Company, as part of its evaluation of your application for insurance, will obtain personal information about you. Personal information may include such information as your name, address, date of birth, Social Security number, occupation, physical condition, health history, habits, general reputation, credit, and avocation. It may be necessary to obtain some of the information from sources other than you. The information obtained may vary depending on the type of policy applied for by you.

Personal information provided to us will be treated as strictly confidential. It will only be shared with our affiliates and third parties to provide the insurance products and services you expect. All personal information will be treated in accordance with applicable law. You have the right to request a copy of the personal information kept in our files. You also have the right to seek correction of information you believe to be inaccurate.

The preceding paragraphs are a general description of our privacy practices. We will provide you with a more detailed explanation of our personal information practices upon your request.

Fair Credit Reporting Act Notice

As part of our evaluation of the application for insurance on your life, an investigative consumer report may be prepared whereby information is obtained through personal interviews with agencies, friends, neighbors, or others with whom you are acquainted or who may have information about you. This report, among other things, may include information as to your character, general reputation, personal characteristics, health, and mode of living, except as may be related, directly or indirectly, to your sexual orientation.

You have the right to request, and be granted, an interview in connection with the preparation of such an investigative consumer report. Upon your written request, and within a reasonable period of time, you have the right to receive additional detailed information about the nature and scope of the investigation and to receive a copy of the report at your expense.

MIB, Inc. (Medical Information Bureau)

Information regarding your insurability will be treated as confidential. IA American Life Insurance Company 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 insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866 346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is [50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734].

IA American Life Insurance Company, 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 may be obtained on its website www.mib.com.

This page must be given to the individual whose life is to be insured, and where any such individual is a minor, to the parent or legal guardian of such individual.

Authorization for Pre-Authorized Check Plan for Payment of Insurance Premiums

Print the name(s) of the depositor(s) exactly as shown on the bank's records. If a business account, include the name of the firm.

Print the name of the bank and branch.

Print the address of the bank or branch where the account is maintained.

Routing Number

Checking Account Number _____ PAC Withdrawal Date _____ (1-28 of the month only)

Subject to the following conditions:

1. A check shall be drawn on, or about, the PAC Withdrawal Date as specified above.
2. If any check is not paid upon presentation and the premium is not paid within the grace period, the policy will lapse according to its terms.
3. The payment of premiums under this plan may be discontinued by the bank, the Company, or the undersigned upon a thirty (30) day written notice.
4. If the plan is terminated, any premium then past due, and premiums due thereafter, shall be payable directly to the Company in accordance with the premium rate and mode of payment provided in the policy.

IMPORTANT – PLEASE NOTE:

I am paying other premiums to you in this manner and desire to have one check drawn each month on the PAC Withdrawal Date, as specified above, for all premiums.

Policy numbers _____

I hereby request and authorize the above bank to pay and charge to my account checks drawn on my account by, and payable to the order of, IA American Life Insurance Company, 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 each check shall be the same as if it were a check drawn on the bank and signed personally by me. This authority is to remain in effect until revoked by me in writing, and, until the bank actually receives such notice, I agree that the bank shall be fully protected in honoring any such check.

I further agree that if any such check be dishonored, whether with or without cause, whether intentionally or inadvertently, the bank shall be under no liability whatsoever, even though such dishonor results in the forfeiture of insurance.

Date _____

Bank Signature of Premium Payor _____
(If this is a business account, include the name of the firm)

Joint Account Signature _____
(If this is a joint account, include both signatures)

ATTACH VOID CHECK HERE

Name on Account

Bank Branch Address

Mary G. Citizen 1234 Main Street Anytown, USA 12345-6789	10101 Date _____
Pay to the order of _____	\$ _____ DOLLARS
YOUR BANK NAME Center & Main Street Your Town, USA 12345-6789	
Memo _____	
⑆034993435⑆	22 11 123456
⑆10101⑆	

Routing Number
034993435

Account Number
22 11 123456

Check Number
10101

Conditional Premium Receipt

(Do not detach this receipt unless the full Modal Premium is paid with the application.)

Received from the undersigned _____ the sum of (\$_____) dollars as the full Modal Premium specified in the application to IA American Life Insurance Company (the Company), dated the same day as this receipt.

1. NO COVERAGE WILL BECOME EFFECTIVE PRIOR TO ISSUANCE OF THE POLICY APPLIED FOR UNLESS, AND UNTIL, ALL THE BELOW CONDITIONS OF THIS RECEIPT HAVE BEEN FULFILLED EXACTLY:
 - (a) The amount of payment taken with the application must be at least equal to the amount of the full first premium for the mode of payment selected in the application and for the amount of insurance that may become effective prior to issuance of the policy.
 - (b) All medical examinations, tests, and questionnaires required by the Company must be completed and received at its Home Office within 60 days of the date of completion of Parts 1 and 2 of this application.
 - (c) As of the Conditional Effective Date, as defined below, each person proposed for insurance in this application must be a risk insurable in accordance with the Company's rules, limits, and standards for the plan and the amount applied for without any modification of plan, amount, riders, supplemental agreements, and/or the rate of premium paid. "Conditional Effective Date," as used herein, is the later of: (a) the date of completion of Parts 1 and 2 of the application; (b) the date of completion of all medical examinations, tests, and questionnaires required by the Company; or (c) the date of issue, if any, requested in the application.
 - (d) As of the Conditional Effective Date, the state of health and all factors affecting the insurability of each person proposed for insurance must be as stated in the application.
2. Subject to the conditions of paragraph 1, insurance, as provided by the terms and conditions of the policy applied for, but for an amount not exceeding that specified in paragraph 3, will become effective as of the Conditional Effective Date.
3. The total amount of insurance that may become effective on all persons proposed for insurance prior to policy issuance shall not exceed **\$250,000** of life insurance, including any accidental death insurance benefits.
4. If one or more of the conditions of paragraph 1 have not been fulfilled exactly, there shall be no liability on the part of the Company except to return the applicable payment in exchange for this Receipt.
5. NO AGENT OR ANY OTHER PERSON IS AUTHORIZED BY THE COMPANY TO WAIVE OR MODIFY, IN ANY WAY, THE PROVISIONS OF THIS CONDITIONAL RECEIPT.

If any of the conditions listed above are not fulfilled exactly, the insurance will not take effect until the policy is issued to the Policyowner stated in the application, and only if at the time of such issuance there has been no change in insurability as represented in the application.

I acknowledge possession of this Conditional Premium Receipt, and I certify that I have read it and the Agreement in the application. I agree that the terms and conditions of this receipt and the Agreement in this application have been fully explained to me by the Agent, and I understand them.

Signed at _____ this _____ day of _____ 20____
City, State Month Year

Signature of Proposed Insured
(Parent or legal guardian if Proposed Insured is under 16)

Signature of Policyowner (If other than Proposed Insured)

Signature of Licensed Agent (Witness)

Please forward a copy of the completed and signed Conditional Premium Receipt to the Company with the application.



IA American Life Insurance Company
 17550 N. Perimeter Dr., Suite 210
 Scottsdale, AZ 85255-7833
 Tel: (888) 473-5540 FAX: (480) 502-5088

Part 2 of Application

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Please print using dark ink

Section 1 – Proposed Insured

- Name of Proposed Insured _____
 Sex: Male Female Date of birth ____/____/____
MM DD YYYY
- Name and address of your usual physician or medical facility _____

 Date and reason last consulted ____/____/____

 Results, diagnosis, and/or treatment prescribed _____

Section 2 – Medical Questionnaire

- In the past 10 years, have you had, been tested for, received treatment or counseling for, or been told by a medical professional that you have: *(If "Yes," circle the appropriate item in each question and provide details.)*

	Yes	No
a. Dizziness, fainting, convulsions, epilepsy, seizures, paralysis, stroke, or severe headaches? .	<input type="checkbox"/>	<input type="checkbox"/>
b. Depression, anxiety, stress, bipolar, mental, or nervous disorder?	<input type="checkbox"/>	<input type="checkbox"/>
c. Shortness of breath, bronchitis, emphysema, asthma, sleep apnea, pleurisy, or tuberculosis . . .	<input type="checkbox"/>	<input type="checkbox"/>
d. Chest pain, angina, palpitations, irregular heartbeat, high blood pressure, elevated cholesterol, cardiac insufficiency, heart attack, or coronary artery disease?	<input type="checkbox"/>	<input type="checkbox"/>
e. Heart murmur, heart valve disorder, edema, aneurysm, or disorder of the heart or blood vessels?	<input type="checkbox"/>	<input type="checkbox"/>
f. Ulcer, intestinal bleeding, colitis, ulcerative colitis, Crohn's disease, jaundice, hernia, diarrhea, hepatitis, or any disorder of the stomach, esophagus, intestines, spleen, pancreas, liver, or rectum?	<input type="checkbox"/>	<input type="checkbox"/>
g. Diabetes, high blood sugar, or sugar in your urine?	<input type="checkbox"/>	<input type="checkbox"/>
h. Blood or protein in your urine, or any disorder of the kidneys, bladder, prostate, or urinary system? .	<input type="checkbox"/>	<input type="checkbox"/>
i. Any disease or disorder of the breasts or reproductive system?	<input type="checkbox"/>	<input type="checkbox"/>
j. Thyroid, thymus, pituitary, adrenal, or lymph gland disorder?	<input type="checkbox"/>	<input type="checkbox"/>
k. Cancer, sarcoidosis, tumor, polyp, or any abnormal growth?	<input type="checkbox"/>	<input type="checkbox"/>
l. Back pain, arthritis, muscular dystrophy, or any disorder of the muscles, bones, or joints?	<input type="checkbox"/>	<input type="checkbox"/>
m. Multiple sclerosis or any disorder of the brain or nervous system?	<input type="checkbox"/>	<input type="checkbox"/>
n. Anemia, bleeding or clotting disorder, or any disorder of the blood (other than HIV-related)? . . .	<input type="checkbox"/>	<input type="checkbox"/>
o. Alcoholism, drug addiction, or excessive use of alcohol or drugs?	<input type="checkbox"/>	<input type="checkbox"/>

Details of "Yes" Answers
 Please identify the applicable question and include the dates, diagnosis, duration, and treatment, as well as the full name and address of all physicians and medical facilities.



	Yes	No
2. In the past 10 years, have you:		
a. Been diagnosed or treated by a physician or other health care professional as having acquired immunodeficiency syndrome (AIDS), AIDS-related complex (ARC), or positive test results indicating the presence of the AIDS virus?	<input type="checkbox"/>	<input type="checkbox"/>
b. Used marijuana, cocaine, heroin, or narcotics not prescribed to you by a physician?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you used tobacco or nicotine products:		
a. In the past 36 months?	<input type="checkbox"/>	<input type="checkbox"/>
b. In the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
4. Other than above, in the past 5 years, have you had:		
a. An examination or treatment by a doctor or medical practitioner?	<input type="checkbox"/>	<input type="checkbox"/>
b. Observation or treatment at a clinic, hospital, or other facility?	<input type="checkbox"/>	<input type="checkbox"/>
c. An EKG, stress test, x-ray, blood test, or any other diagnostic test?	<input type="checkbox"/>	<input type="checkbox"/>
d. A surgical operation or been advised to have a surgical operation?	<input type="checkbox"/>	<input type="checkbox"/>
e. A change of weight, anorexia nervosa, or bulimia?	<input type="checkbox"/>	<input type="checkbox"/>
5. a. If female, are you currently pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
b. Have you ever had any complications with this or previous pregnancies?	<input type="checkbox"/>	<input type="checkbox"/>
6. a. Do you have a family history of diabetes, cancer, stroke, kidney disease, high blood pressure, coronary artery disease, Huntington's chorea, alcoholism, drug abuse, or mental illness?	<input type="checkbox"/>	<input type="checkbox"/>
b. Has any member of your immediate family (father, mother, brother, or sister) died before age 60 from cancer (breast, colon, intestinal, or prostate) or from a cardiovascular disease (heart attack, myocardial infarct, angina, cardiac insufficiency, cerebral thrombosis, or coronary artery disease)?	<input type="checkbox"/>	<input type="checkbox"/>
c. Have you ever received disability benefits from any source?	<input type="checkbox"/>	<input type="checkbox"/>

Details of "Yes" Answers
Please identify the applicable question and include the dates, diagnosis, duration, and treatment, as well as the full name and address of all physicians and medical facilities.

I declare that the statements and answers contained in this Part 2 of Application are full, complete, and true to the best of my knowledge and belief and that the answers were correctly recorded before I signed below. I understand and agree that this Part 2 of Application shall be part of my application for insurance and will form part of the policy contract.

Signed at _____ this _____ day of _____ 20____
City, State Month Year

Signature of Examiner (*Witness*)

Signature of Proposed Insured

Medical Examiner's Report

This section is to be completed by all examiners.

This section is to be completed by physician only.

All Proposed Insureds must be weighed and measured.

1. a. Height _____ft. _____in.
b. Weight _____lbs.
Weight change in past 12 months? Yes No
Lost _____ lbs. Gained _____ lbs.
Reason? _____

2. Blood Pressure:
Systolic 1) _____ 2) _____ 3) _____
Diastolic 1) _____ 2) _____ 3) _____
*Take 2 readings at least 5 minutes apart.
If blood pressure is over 140/90, take a third reading.*

3. Pulse _____
Rhythm _____
Irregularities? _____
If pulse is over 90, repeat in 5–10 minutes.

4. Urinalysis:
*Please indicate test results in the space provided.
This section is to be completed on all examinations.*
Albumin _____
Glucose _____
Blood _____
Please forward urine sample to LabOne for urinalysis.

5. Does the Proposed Insured appear older than the stated age? Yes No

6. Is there any evidence of alcohol, drug, or nicotine addiction? Yes No

7. Any evidence of past or present disease of:
- a. The brain or nervous system? *(Test reflexes and coordination)* Yes No
 - b. Head or neck? *(Include ears, eyes, and mouth)* Yes No
 - c. Endocrine system, breasts, or glands? Yes No
 - d. Chest and lungs? *(Examine on bare chest with expiratory cough)* Yes No
 - e. Heart and blood vessels? Yes No
 - f. Abdomen? *(Include liver, spleen, abnormal masses, tenderness, and surgical scars)* Yes No
 - g. Genitourinary system? *(Include prostate)* Yes No
 - h. Musculoskeletal system? *(Include spine/joint deformities)* Yes No
 - i. Skin *(Include xanthomas, nevi, etc.)* or lymph nodes? Yes No

8. Is there:
- a. Evident arteriosclerosis? Yes No
 - b. Cardiac hypertrophy? Yes No
 - c. Cyanosis, dyspnea, or edema? Yes No
 - d. Cardiovascular impairment? Yes No
 - e. Any hernias or varicosities? Yes No
 - f. A heart murmur? *(Complete heart chart)* Yes No

9. Heart Chart
- Murmur
- Location: Apical Aortic
 Mitral Pulmonic
- Timing: Systolic Diastolic Pre-systolic
- Intensity: Soft Moderate Loud
- Grade: I II III IV V VI
- Is murmur constant? Yes No
- Transmitted? Yes No
- If transmitted, indicate to where _____
- Effect of exercise: Unchanged Decreased
 Increased Disappears
- Your impression of murmur _____

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Section 1 – General Information

First name _____ Middle initial _____ Last name _____

 Date of birth ____/____/____ Policy number (if known) _____
MM DD YYYY
Section 2 – Alcohol
Do you use or have you ever used alcohol? Yes No

Give details for all "Yes" answers.

If "Yes," answer the following questions:

(1 unit = 1 glass of wine = 1 bottle of beer = 1 ounce of alcohol)

- Current number of units and frequency _____ / day _____ / week
- If there has been a reduction in alcohol consumption, enter the number of units and frequency before the reduction.
 (Specify date and reason for reduction/decrease) _____ / day _____ / week
- Have you ever been treated for, or advised to seek treatment for alcohol use? Yes No
 (Specify dates and names of physicians or institutions)
- Have you ever been convicted of driving while under the influence of alcohol? (Specify date) Yes No
- Are you a member of a support group? Yes No
 (Specify name of group- e.g., Alcoholics Anonymous)

Section 3 – Drugs
In the past 10 years, have you been treated for drug abuse, or used drugs other than as prescribed to you by a physician? Yes No

If "Yes," answer the following questions:

- When did you start using drugs? Date ____/____/____
- Why did you start using drugs? (Give reasons) _____

c. Indicate in the table below the specific drugs you have used in the past or are using at present. (Circle the specific drug category or drugs, if listed)

	Yes No		Dosage or Amount Used	How Often Used	Dates Used From To	
	<input type="checkbox"/>	<input type="checkbox"/>				
1. Narcotics such as Opium, Heroin, Morphine, Codeine, Demerol, Methadone, Oxycodone, Hydrocodone or Vicodin	<input type="checkbox"/>	<input type="checkbox"/>				
2. Depressants such as Barbiturates, Benzodiazepines, Xanax, Valium, Ativan, or Halcion	<input type="checkbox"/>	<input type="checkbox"/>				
3. Stimulants such as Cocaine, Amphetamines, Methamphetamines, or Ritalin	<input type="checkbox"/>	<input type="checkbox"/>				
4. Hallucinogens such as Mescaline, LSD, Peyote, Psilocybin, Ecstasy, or Phencyclidine (PSP)	<input type="checkbox"/>	<input type="checkbox"/>				
5. Marijuana, Hashish, or THC	<input type="checkbox"/>	<input type="checkbox"/>				
6. Inhalants such as Amyl Nitrite, Nitrous Oxide, Adhesives, Paint Products, Cleaning Fluids, Solvents, or Glue	<input type="checkbox"/>	<input type="checkbox"/>				
7. Anabolic Steroids	<input type="checkbox"/>	<input type="checkbox"/>				
8. Others						

 d. Have you ever been treated for drug use? Yes No
 If "Yes," give the dates, names, and addresses of physicians or institutions: _____

e. If you are no longer using drugs, why did you stop? _____

 f. Do you intend to use drugs in the future? Yes No


Section 4 – Foreign Residence

In the next year, do you intend to travel or live outside of the United States or Canada for more than a month? Yes No

If "Yes," answer the following questions:

- a. Citizenship _____ b. Departure date ____/____/____
- c. Foreign residence location (Country, city) _____ d. Total duration of stay _____
- e. Reasons _____
- f. Type of employment _____
- g. Name of employer or organization in charge _____
- h. Have you ever lived abroad? Yes No
Specify location, duration, and date _____
- i. Over the next 5 years, will you likely live/travel abroad? Yes No
Specify location, duration, and date _____
- j. Beyond the next 5 years, will you likely live/travel abroad? Yes No
Specify location, duration, and date _____

Section 5 – Driving Record

Within the past three years, have you had your driver's license suspended or revoked or been convicted of, or pled guilty or *nolo contendere* (no contest) to, five or more traffic violations? Yes No

If "Yes," complete the table and answer the following questions:

a.

Violation	Number of Violations	Dates of Violations	Point Change on License
Unbuckled seat belt			
Speeding			
Failing to obey traffic lights			
Failing to stop or yield			
Illegal passing			
Accident – at fault			
Following too closely			
Others (Specify)			

- b. Has your driver's license ever been suspended or revoked as a result of the above violation(s)? Yes No
 Details _____ Due to accumulated points? Yes No
 Due to unpaid fines? Yes No Amount _____
 Other reason? (Give specifics) _____
 Date you lost your license ____/____/____ Duration _____
 Did you drive while your license was suspended? Yes No Dates _____
 When was your license returned, or when do you expect its return? Date ____/____/____
- c. Have you ever been convicted of, or entered a plea of guilty or of *nolo contendere* (no contest) to, driving under the influence of alcohol (DUI), driving while intoxicated (DWI), or driving while ability impaired (DWAI)? Yes No
 If "Yes," give the date of conviction/plea ____/____/____
 Did you drive while your license was suspended? Yes No Dates _____
 When was your license returned, or when do you expect its return? Date ____/____/____
- d. Have you ever been convicted of, or entered a plea of guilty or of *nolo contendere* (no contest) to: hit-and-run, reckless driving, vehicular homicide, vehicular manslaughter, negligent homicide, or negligent manslaughter? Yes No
 If "Yes," specify: Date ____/____/____ Violation _____
 Circumstances _____
 Did you drive while your license was suspended? Yes No Dates _____
 When was your license returned, or when do you expect its return? Date ____/____/____

Section 6 – Aviation

Have you ever made, or do you intend to make, aerial flights other than as a passenger? Yes No

If “Yes,” answer the following questions:

a. Statement of hours flown and expected number of flight hours:

	Solo	With IFR or ATR	Number of Flight Hours			Expected hours in the next 12 months
			Total hours accumulated	During the past 12 to 24 months	During the past 12 months	
UNPAID FLIGHTS as a pilot, co-pilot, or unpaid student						
PAID FLIGHTS as a member of the crew or an employee paid for duties performed during the flight. (Give details)						
MILITARY OR OTHER FLIGHTS as a member of the crew or in any other capacity. (Give details)						

b. What kind of license do you have?

- Student Private Pilot Commercial Pilot Airline Pilot (ATR) Instructor
 Flight Instruments (IFR) None Date of Issue ____/____/____

Has your license ever been suspended?

Yes No If “Yes,” give details _____

c. What type of flights do you make?

- Pleasure Instructor Taxi: passenger Taxi: goods
 Crop-dusting With aircraft designed for crop-dusting Night flight
 Business Specify _____ Other _____

Over what areas are most of your flights made? _____

Who is the owner of the aircraft? _____

Who does the maintenance? _____

Type of aircraft: Single engine: # of passengers _____ Multi-engine # of passengers: _____

Pounds of payload _____ Pounds of payload _____

- Helicopter Glider Ultralight motorized
 Hot air balloon Motorized hang glider Amateur built/homebuilt
 Freeflight
 Tethered
 Record attempts

Have you ever had an accident during a flight? Yes No

If “Yes,” give details _____

d. When did you last fly? ____/____/____

Do you intend to continue flying? Yes No

Do you expect future flights to differ from those done in the past? Yes No

If “Yes,” give details _____

Section 7 – Hazardous Sports

Complete questions a. and b. for all hazardous sports. Then complete the appropriate section for each applicable sport.

a. In the last two years, have you taken part in any hazardous sports, such as:

- | | |
|--|--|
| <input type="checkbox"/> Skin or scuba diving | <input type="checkbox"/> Mountain climbing |
| <input type="checkbox"/> Parachuting, skydiving, and/or bungee jumping | <input type="checkbox"/> Hang gliding |
| <input type="checkbox"/> Automotive sports | <input type="checkbox"/> Rodeos |

How long have you been practicing it (*Frequency / month / year*)? _____

When did you last practice this sport? ____/____/____

Are you a member of a club? Yes No *If "Yes," specify name of club* _____

- Do you practice this sport as: An amateur A professional
- If professional, is it: Full-time Part-time
- Do you intend to continue practicing this sport? Yes No
- Do you expect any changes in the participation in this sport? Yes No *If "Yes," specify* _____

b. Extra premium or restriction

If you do not qualify for full coverage at standard rates, do you wish:

- To be covered for the hazardous sport you practice for an extra premium?
- Not to be covered for the hazardous sport you practice?

Skin or Scuba Diving

- a. Give a brief description of the equipment you use _____
- b. Give a brief description of your diving habits (*location, security measures, etc.*) _____
- c. Do you dive alone? Yes No *If "Yes," specify* _____
- d. Have you ever suffered any ill effects due to diving? Yes No *If "Yes," specify* _____
- e. Please give details of dives made during the past 3 years and an estimate of dives expected in the next 12 months by completing the following table:

PERIOD	DEPTH							
	50 feet or less		51 feet to 100 feet		101 feet to 150 feet		151 feet to _____ feet	
	Number of dives	Number of hours	Number of dives	Number of hours	Number of dives	Number of hours	Number of dives	Number of hours
24 to 36 months ago								
12 to 24 months ago								
Last 12 months								
Next 12 months								

Parachuting , Skydiving and/or Bungee Jumping

- a. Check the type of parachuting you practice:
- | | |
|--|---|
| <input type="checkbox"/> Sport parachuting | <input type="checkbox"/> Parachuting with respiratory equipment |
| <input type="checkbox"/> Para-kiting | <input type="checkbox"/> Para-skiing |
| <input type="checkbox"/> Para-sailing | <input type="checkbox"/> Bungee jumping |
- b. Number of jumps since you began participating in this sport _____
- c. Are you making record attempts? Yes No *If "Yes," specify* _____

Hang Gliding

- a. Maximum altitude less than 50 feet? Yes No
- b. Are you using any equipment that is not professionally manufactured, that is of an experimental nature, or represents any other particular risks? Yes No *If "Yes," specify* _____
- c. Are you making record attempts? Yes No *If "Yes," specify* _____

Mountain Climbing

Check all appropriate boxes:

- Rock climbing
- Trail climbing
- In North America
- Elsewhere (*Specify*) _____

Automotive Sports

Check all appropriate boxes:

- a. Type of automobile races:
 - Championship
 - Sprinting/drag
 - Sports car
 - Other (*Specify*) _____
 - Stock car
 - Demolition
 - Midget
- b. Type of motorcycle races:
 - Hill climbing
 - Cross-country
 - Other (*Specify*) _____
 - Sprinting/drag
 - Moto-cross
- c. Track:
 - Oval
 - Other (*Specify*) _____
- d. Surface:
 - Paved
 - Dirt road
 - Unpaved
 - Other (*Specify*) _____
- e. Modified vehicle?
 - Yes No *If "Yes,"... for safety?* Yes No
 - ...for performance?* Yes No
 - Make _____ Model _____
 - Cylinders _____ Horsepower _____
- f. Do you participate in races outside of the U.S. or Canada? Yes No *If "Yes," specify* _____
- g. Specify the names of tracks where you race: _____
- h. Maximum speed _____ mph
Average speed _____ mph
- i. Reason for participating in race (*pleasure, cash prizes, etc.*)

Signature

I acknowledge that I have read the Fraud Warning applicable to my state on page 6 of this application.

I declare that the above statements and answers form an integral part of my application to IA American Life Insurance Company; that they are full, complete, and true to the best of my knowledge and belief.

Signed at _____ this _____ day of _____ 20____
City, State Month Year

Signature of Proposed Insured

Fraud Warning

Arkansas, Louisiana, and Texas Residents Only: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance, is guilty of a crime and may be subject to fines and confinement in prison.

Colorado Residents Only: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

District of Columbia Residents Only: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida Residents Only: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Kentucky Residents Only: Any person who knowingly and with intent to defraud, any insurance company or other person files an application for insurance 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.

Maine, Tennessee, and Washington Residents Only: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Maryland Residents Only: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey Residents Only: Any person, who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

New Mexico Residents Only: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

North Dakota and South Dakota Residents Only: Any person, who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, commits insurance fraud, which may be a crime and may subject the person to civil and criminal penalties.

Ohio Residents Only: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma Residents Only: WARNING: Any person who knowingly and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon Residents Only: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Pennsylvania Residents Only: 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.

Virginia Residents Only: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer makes any claim for the proceeds of an insurance policy containing false, incomplete, or misleading information may be guilty of a felony.

In All Other States: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.



IA American Life Insurance Company
 17550 N. Perimeter Dr., Suite 210
 Scottsdale, AZ 85255-7833
 Tel: (888) 473-5540 FAX: (480) 502-5088

Additional Insured Application

Part 1: General Information

Please print using dark ink

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Section 1 – Proposed Additional Insured

First name _____ Middle initial _____ Last name _____
 Sex: Male Female Date of birth ____/____/____ Age ____ Place of birth _____
MM DD YYYY
 Home address _____ City _____
 State _____ ZIP _____ How long _____ Home telephone (____) ____-____
 Social Security No. _____ Occupation _____
 Employer _____ How long _____ Annual income _____
 Employer's address _____ Telephone (____) ____-____
 City _____ State _____ ZIP _____

Section 2 – Beneficiary

If the beneficiary section is left blank, benefits will be paid to the Policyowner's estate. If the beneficiary is a minor, consult your advisor. If the beneficiary is a trust, provide the trustee name, the trust name, and the date of trust.

Primary _____ % (Total of all Primary Beneficiaries must equal 100%)

Full name _____ Tax ID or SSN _____
 Relationship to Proposed Additional Insured _____ Date of birth ____/____/____
MM DD YYYY
 Address _____ Telephone (____) ____-____
 City _____ State _____ ZIP _____

Primary _____ % or **Contingent** _____ % (Total of all Contingent Beneficiaries must equal 100%)

Full name _____ Tax ID or SSN _____
 Relationship to Proposed Additional Insured _____ Date of birth ____/____/____
MM DD YYYY
 Address _____ Telephone (____) ____-____
 City _____ State _____ ZIP _____

Primary _____ % or **Contingent** _____ %

Full name _____ Tax ID or SSN _____
 Relationship to Proposed Additional Insured _____ Date of birth ____/____/____
MM DD YYYY
 Address _____ Telephone (____) ____-____
 City _____ State _____ ZIP _____

Section 3 – Policy Details

Policy _____ **Face Amount** _____

*(Not to exceed 3X the face amount of the base policy)
 (Minimum \$10,000)*

- Rating Class: Preferred (where available)
 Standard Non-Tobacco
 Tobacco
 Other _____



Section 4 – General Questions

For “Yes” answers, provide details and/or complete the applicable section on the Supplemental Questionnaire.

- A. Proposed Additional Insured:** Height ___ft. ___in. Weight _____lbs. Weight change past 12 months? Yes No
Lost _____lbs. Gained _____lbs. Reason? _____
- B.** Have you used tobacco or nicotine products: in the past 36 months? Yes No
in the past 12 months? Yes No
- C.** Within the past 5 years, have you flown as a student, private, commercial, military, or test pilot; or do you have plans for such flights in the future? (If “Yes,” complete the Aviation section of the Supplemental Questionnaire) Yes No
- D.** Within the past 5 years, have you participated in motorized racing, scuba or skin diving, rock or mountain climbing, sky diving, hang gliding, or rodeos? (If “Yes,” complete the Hazardous Sports section of the Supplemental Questionnaire)..... Yes No
- E.** Within the past 5 years, have you been convicted of, or pled guilty to, motor vehicle violations, driving under the influence, or reckless driving? (**Provide your driver’s license number regardless of your answer**) Yes No
Driver’s license number _____ State _____
- F.** Within the past 5 years, have you been convicted of a felony or misdemeanor? (If “Yes,” provide details) Yes No
- G.** In the next year, do you intend to live or travel outside the U.S. or Canada for more than one month? (If “Yes,” complete the Foreign Residence section of the Supplemental Questionnaire) Yes No
- H.** Do you have an application for life or health insurance pending, or have you applied for such insurance within the past 6 months? (If “Yes,” provide insurance amounts and whether policies will be accepted) Yes No
- I.** Within the past 5 years, have you had an application (including a reinstatement application) for life or health insurance declined, rated, modified, or postponed? Yes No
- J.** Do you currently have any life insurance or annuity contracts in force? (If “Yes,” list all policies below) . Yes No
- K.** Is this policy to replace any existing life insurance or annuity contract? (If “Yes,” indicate which policy) Yes No

COMPANY	AMOUNT	A.D.B.	YEAR ISSUED	REPLACEMENT
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

- L.** Are you financing the premium for, or do you intend to assign, this policy? (If “Yes,” provide details) Yes No
- M. Complete only if the Proposed Additional Insured is a minor**
 - 1. Are all siblings being insured? Yes No
 - 2. Sum of existing life insurance on each parent: \$ _____ \$ _____ None
 - 3. If 1 is “No” or 2 is “None,” provide reason: _____

N. Name, address, and phone number of the physician or medical facility that will have your medical records: (Please provide the medical record number, if available.)

O. Date, reason for, and results of the last visit made to the above physician or medical facility.
Date _____ Reason _____
Results _____

P. Do you currently take any medication regularly or as needed? (If “Yes,” provide the medication name and the condition treated). Yes No

Details and additional instructions:

Agreement

Each of the undersigned declares that the statements and answers contained in this application and provided by such individuals are complete and true to the best of his/her knowledge and belief, that the statements and answers were correctly recorded before he/she signed below, and that they shall form the basis of any insurance policy that may be issued. A copy of this application shall be attached to, and made a part of, the policy. No change in amount, classification, plan of insurance, or benefits shall be effective unless agreed to in writing by the Proposed Additional Insured and/or the Policyowner.

All information that I (we) have given to the Agent is contained in this application. A misrepresentation in response to any question may result in policy rejection or rescission subject to the incontestability provision in the policy.

It is also agreed that IA American Life Insurance Company (the Company) will incur no liability under this application until:

- a. the application has been received and approved;
- b. a policy has been issued and delivered; and
- c. the full Modal Premium has been paid to, and accepted by, the Company at its Home Office.

The policy must be issued, delivered, and the full Modal Premium paid while the health, habits, avocations, and occupation of the lives to be insured are as stated in this application. The policy will then be deemed effective on its issue date.

The Company will notify the Policyowner of its decision regarding the insurability of the lives to be insured, as stated in this application, within 60 days of receipt of the application. Otherwise, it will notify the Policyowner of the reason for any further delay.

No Agent has the authority to waive the answers to any of the questions in this application or to make or alter any contract for the Company.

The Agent and Policyowner agree that no insurance, other than those policies for the indicated life or lives to be insured indicated as replacements in Section 4(K), will be replaced by a policy issued in connection with this application.

Authorization to Obtain Information

The undersigned authorizes any or all of the following to give to IA American Life Insurance Company, or its reinsurers, any information from their records pertaining to my, or my minor children's, employment, health, alcohol, drug, and psychiatric information: a. any physician or medical practitioner; b. hospital, clinic, medical or medically-related facility; c. insurance or reinsurance company; d. MIB, Inc. (formerly known as the Medical Information Bureau); e. consumer reporting agencies; or f. employers.

Information obtained with this Authorization may only be: a. used to determine insurability; b. released to reinsurance companies; c. sent to MIB, Inc.; d. sent to persons or organizations performing business or legal services in connection with my application, except for information received from MIB, Inc., which must not be disclosed; e. used as lawfully required; or f. used as I may further authorize in writing.

The undersigned acknowledges receipt of the Notice of Insurance Information Practices, the Fair Credit Reporting Act Notice, and the MIB Notice and agrees that a photographic copy of this Authorization shall be as valid as the original. The undersigned agrees that this Authorization shall be valid for two years from the date shown below.

Each of the undersigned requests that any examination findings relating to such undersigned resulting in a rating, postponement, or declination of any, or of all, coverage requested on this application be forwarded directly to:

- Such undersigned's regular physician Yes No
- Such undersigned's attention at his/her home address Yes No
- Each of the undersigned elects to be interviewed if an investigative consumer report is prepared in connection with this application Yes No

I acknowledge that I have read the Fraud Warning applicable to my state on page 6 of this application.

Signed at _____ this _____ day of _____ 20____
City, State Month Year

Signature of Proposed Additional Insured
(Parent or legal guardian if Proposed Additional Insured is under 16)

Signature of Policyowner

Fraud Warning

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Colorado Residents Only: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

District of Columbia Residents Only: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

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Maryland Residents Only: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey Residents Only: Any person, who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

New Mexico Residents Only: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

North Dakota and South Dakota Residents Only: Any person, who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, commits insurance fraud, which may be a crime and may subject the person to civil and criminal penalties.

Ohio Residents Only: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma Residents Only: WARNING: Any person who knowingly and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon Residents Only: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Pennsylvania Residents Only: 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.

Virginia Residents Only: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer makes any claim for the proceeds of an insurance policy containing false, incomplete, or misleading information may be guilty of a felony.

In All Other States: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Disclosure Statement

One of the prime objectives of IA American Life Insurance Company is to provide insurance at low cost. The underwriting process (evaluation of risk) is necessary not only to ensure this low cost, but also to ensure that each policyholder contributes his/her fair share of the cost. In considering an application, information from various sources must be considered for insurance on your life. This includes the results of a physical examination, if required, and any reports received from doctors and hospitals who have attended the individuals whose lives are to be insured.

Notice of Insurance Information Practices

IA American Life Insurance Company, as part of its evaluation of your application for insurance, will obtain personal information about you. Personal information may include such information as your name, address, date of birth, Social Security number, occupation, physical condition, health history, habits, general reputation, credit, and avocation. It may be necessary to obtain some of the information from sources other than you. The information obtained may vary depending on the type of policy applied for by you.

Personal information provided to us will be treated as strictly confidential. It will only be shared with our affiliates and third parties to provide the insurance products and services you expect. All personal information will be treated in accordance with applicable law. You have the right to request a copy of the personal information kept in our files. You also have the right to seek correction of information you believe to be inaccurate.

The preceding paragraphs are a general description of our privacy practices. We will provide you with a more detailed explanation of our personal information practices upon your request.

Fair Credit Reporting Act Notice

As part of our evaluation of the application for insurance on your life, an investigative consumer report may be prepared whereby information is obtained through personal interviews with agencies, friends, neighbors, or others with whom you are acquainted or who may have information about you. This report, among other things, may include information as to your character, general reputation, personal characteristics, health, and mode of living, except as may be related, directly or indirectly, to your sexual orientation.

You have the right to request, and be granted, an interview in connection with the preparation of such an investigative consumer report. Upon your written request, and within a reasonable period of time, you have the right to receive additional detailed information about the nature and scope of the investigation and to receive a copy of the report at your expense.

MIB, Inc. (Medical Information Bureau)

Information regarding your insurability will be treated as confidential. IA American Life Insurance Company 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 insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866 346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is [50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734].

IA American Life Insurance Company, 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 may be obtained on its website www.mib.com.

This page must be given to the individual whose life is to be insured, and where any such individual is a minor, to the parent or legal guardian of such individual.



IA American Life Insurance Company
 17550 N. Perimeter Dr., Suite 210
 Scottsdale, AZ 85255-7833
 Tel: (888) 473-5540 FAX: (480) 502-5088

Application for Reinstatement/Change

Please print using dark ink

www.iaamerican.com

Section 1 – Policy Information

Policy number _____

Policyowner:

First name _____ Middle initial _____ Last name _____

Home address _____ City _____

State _____ ZIP _____ Home telephone (_____) _____ - _____ Fax (_____) _____ - _____

Insured:

First name _____ Middle initial _____ Last name _____

Date of birth / / Social Security No. _____ Place of birth _____
MM DD YYYY

A SEPARATE APPLICATION FOR REINSTATEMENT/CHANGE IS REQUIRED FOR EACH INSURED

Section 2 – Reason for Application

Change Death Benefit Option from 2 to 1 Decrease face amount to: \$ _____

Conversion to _____

When requesting any of the following: Complete Section 3 – General Questions, Section 4 – Medical Questionnaire, and the Agreement and Authorization on page 3. Remove, read, and retain the notices on page 5.

Reinstatement Change rating

Change Death Benefit Option from 1 to 2 Change to Non-Smoker / Non-Tobacco rates

Increase face amount to \$ _____ Other _____

Change plan of insurance to _____

Section 3 – General Questions

For "Yes" answers, provide details and/or complete the applicable section on the Supplemental Questionnaire.

A. Insured: Height _____ft. _____in. Weight _____lbs. Weight change in past 12 months? Yes No
 Lost _____lbs. Gained _____lbs. Reason? _____

B. Have you used tobacco or nicotine products: in the past 36 months? Yes No
 in the past 12 months? Yes No

C. Since the application or medical exam for the policy identified in Section 1 above:
1. Have you flown as a student, private, commercial, military, or test pilot; or do you have plans for such flights in the future? (If "Yes," complete the Aviation section of the Supplemental Questionnaire). . . . Yes No

2. Have you participated in motorized racing, scuba or skin diving, rock or mountain climbing, sky diving, hang gliding, or rodeos? (If "Yes," complete the Hazardous Sports section of the Supplemental Questionnaire) Yes No

3. Have you been convicted of, or pled guilty to, motor vehicle violations, driving under the influence, or reckless driving? (**Provide your driver's license number regardless of your answer**) Yes No
 Driver's license number _____ State _____

4. Have you been convicted of a felony or misdemeanor? (If "Yes," provide details) Yes No

5. Have you had an application (including a reinstatement application) for life or health insurance declined, rated, modified, or postponed? Yes No

D. In the next year, do you intend to live or travel outside the U.S. or Canada for more than one month? (If "Yes," complete the Foreign Residence section of the Supplemental Questionnaire) Yes No

E. Do you have an application for life or health insurance pending, or have you applied for such insurance within the past 6 months? (If "Yes," provide insurance amounts and whether policies will be accepted) Yes No



F. Do you currently have any life insurance or annuity contracts in force? (If "Yes," list all policies below) Yes No

COMPANY	AMOUNT	A.D.B.	YEAR ISSUED

G. Name, address, and phone number of the physician or medical facility that will have your medical records:
(Please provide the medical record number, if available.)

H. Date, reason for, and results of the last visit made to the above physician or medical facility.

Date _____ Reason _____

Results _____

I. Do you currently take any medication regularly or as needed? (If "Yes," provide the medication name and the condition treated) Yes No

Details and additional instructions:

Section 4 – Medical Questionnaire

You may skip questions 1 and 2 of this section if a paramedical exam is required.

1. Since the application or medical exam for the policy identified in Section 1 above, have you had, been tested for, received treatment or counseling for, or been told by a medical professional that you have: (If "Yes," circle the appropriate item in each question and provide details.)
 - a. Dizziness, fainting, convulsions, epilepsy, seizures, paralysis, stroke, or severe headaches? Yes No
 - b. Depression, anxiety, stress, bipolar, mental, or nervous disorder? Yes No
 - c. Shortness of breath, bronchitis, emphysema, asthma, sleep apnea, pleurisy, or tuberculosis? Yes No
 - d. Chest pain, angina, palpitations, irregular heartbeat, high blood pressure, elevated cholesterol, cardiac insufficiency, heart attack, or coronary artery disease? Yes No
 - e. Heart murmur, heart valve disorder, edema, aneurysm, or disorder of the heart or blood vessels? . . Yes No
 - f. Ulcer, intestinal bleeding, colitis, ulcerative colitis, Crohn's disease, jaundice, hernia, diarrhea, hepatitis, or any disorder of the stomach, esophagus, intestines, spleen, pancreas, liver, or rectum? . Yes No
 - g. Diabetes, high blood sugar, or sugar in your urine? Yes No
 - h. Blood or protein in your urine, or any disorder of the kidneys, bladder, prostate, or urinary system? . . Yes No
 - i. Any disease or disorder of the breasts or reproductive system? Yes No
 - j. Thyroid, thymus, pituitary, adrenal, or lymph gland disorder? Yes No
 - k. Cancer, sarcoidosis, tumor, polyp, or any abnormal growth? Yes No
 - l. Back pain, arthritis, muscular dystrophy, or any disorder of the muscles, bones, or joints? Yes No
 - m. Multiple sclerosis or any disorder of the brain or nervous system? Yes No
 - n. Anemia, bleeding or clotting disorder, or any disorder of the blood (other than HIV-related)? Yes No
 - o. Alcoholism, drug addiction, or excessive use of alcohol or drugs? Yes No
2. Since the application or medical exam for the policy identified in Section 1 above, have you:
 - a. been diagnosed or treated by a physician or other health care professional as having acquired immunodeficiency syndrome (AIDS), AIDS-related complex (ARC), or positive test results indicating the presence of the AIDS virus? Yes No
 - b. used marijuana, cocaine, heroin, or narcotics not prescribed to you by a physician? Yes No

Details to "Yes" answers (include dates, physicians or medical facilities, and addresses):

Agreement

Each of the undersigned declares that the statements and answers contained in this application and provided by such individuals are complete and true to the best of his/her knowledge and belief, that the statements and answers were correctly recorded before he/she signed below, and that they shall form the basis of any insurance policy that may be issued. Upon approval of reinstatement or change, a copy of this application shall be provided to become a part of, and be kept with, the policy. No change in amount, classification, plan of insurance, or benefits shall be effective unless agreed to in writing by the Insured and/or the Policyowner. **All information that I (we) have given to the Agent is contained in this application. A misrepresentation in response to any question may result in application rejection or policy rescission subject to the incontestability provision in the policy.**

It is also agreed that IA American Life Insurance Company (the Company) will incur no liability under this application until:
a. the application has been received and approved; and
b. the full Modal Premium amount and, if applicable, additional required premiums as defined by the reinstatement provision of your policy have been paid to, and accepted by, the Company at its Home Office.

The Company will notify the Policyowner of its decision regarding the insurability of the lives to be insured, as stated in this application, within 60 days of receipt of the application. Otherwise, it will notify the Policyowner of the reason for any further delay.

No Agent has the authority to waive the answers to any of the questions in this application or to make or alter any contract for the Company.

Authorization to Obtain Information

The undersigned authorizes any or all of the following to give to IA American Life Insurance Company, or its reinsurers, any information from their records pertaining to my, or my minor children's, employment, health, alcohol, drug, and psychiatric information: a. any physician or medical practitioner; b. hospital, clinic, medical or medically-related facility; c. insurance or reinsurance company; d. MIB, Inc. (formerly known as the Medical Information Bureau); e. consumer reporting agencies; or f. employers.

Information obtained with this Authorization may only be: a. used to determine insurability; b. released to reinsurance companies; c. sent to MIB, Inc.; d. sent to persons or organizations performing business or legal services in connection with my application, except for information received from MIB, Inc., which must not be disclosed; e. used as lawfully required; or f. used as I may further authorize in writing.

The undersigned acknowledges receipt of the Notice of Insurance Information Practices, the Fair Credit Reporting Act Notice, and the MIB Notice and agrees that a photographic copy of this Authorization shall be as valid as the original. The undersigned agrees that this Authorization shall be valid for two years from the date shown below.

Each of the undersigned requests that any examination findings relating to such undersigned resulting in a rating, postponement, or declination of any, or of all, coverage requested on this application be forwarded directly to:

- Such undersigned's regular physician Yes No
- Such undersigned's attention at his/her home address Yes No
- Each of the undersigned elects to be interviewed if an investigative consumer report is prepared in connection with this application Yes No

I acknowledge that I have read the Fraud Warning applicable to my state on page 4 of this application.

Signed at _____ this _____ day of _____ 20____
City, State Month Year

Signature of Insured
(Parent or legal guardian if Insured is under 16)

Signature of Policyowner
(If other than Insured)

A copy of the Authorization will be made available to the Policyowner or the Policyowner's Authorized Representative on the Company's receipt of written request.

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Personal information provided to us will be treated as strictly confidential. It will only be shared with our affiliates and third parties to provide the insurance products and services you expect. All personal information will be treated in accordance with applicable law. You have the right to request a copy of the personal information kept in our files. You also have the right to seek correction of information you believe to be inaccurate.

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As part of our evaluation of the application for insurance on your life, an investigative consumer report may be prepared whereby information is obtained through personal interviews with agencies, friends, neighbors, or others with whom you are acquainted or who may have information about you. This report, among other things, may include information as to your character, general reputation, personal characteristics, health, and mode of living, except as may be related, directly or indirectly, to your sexual orientation.

You have the right to request, and be granted, an interview in connection with the preparation of such an investigative consumer report. Upon your written request, and within a reasonable period of time, you have the right to receive additional detailed information about the nature and scope of the investigation and to receive a copy of the report at your expense.

MIB, Inc. (Medical Information Bureau)

Information regarding your insurability will be treated as confidential. IA American Life Insurance Company 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 insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866 346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is [50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734].

IA American Life Insurance Company, 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 may be obtained on its website www.mib.com.

This page must be given to the individual whose life is to be insured, and where any such individual is a minor, to the parent or legal guardian of such individual.

Section 1 – Policy Information

 To be included as part of a new application on _____
(Proposed Insured on base policy)

Or added to Policy No. _____

Section 2 – Children to be Insured (ages 15 days to 18 years)

Full name of each child to be insured <i>(children, stepchildren, and legally adopted)</i>	Sex		Insurance now in force in all companies	Date of birth			Height	Weight
	M	F		MM	DD	YYYY		

Section 3 – Medical Questionnaire

- | | | | |
|--|------------|-----------|---|
| <p>1. In the past 10 years, has any child proposed for insurance had, been tested for, received treatment or counseling for, or been told by a medical professional that they have:</p> <p>a. Muscular dystrophy, cerebral palsy, or any other disease or disorder of the brain or nervous system? <input type="checkbox"/> <input type="checkbox"/></p> <p>b. Cystic fibrosis or any other disease or disorder of the lungs or respiratory system? <input type="checkbox"/> <input type="checkbox"/></p> <p>c. Tetralogy of Fallot, transportation of the great vessels, truncus arteriosus, total anomalous pulmonary venous drainage, atresias of the heart, or any other disease or disorder of the heart or blood vessels? <input type="checkbox"/> <input type="checkbox"/></p> <p>d. Any disease or disorder of the stomach, intestines, or bowels? <input type="checkbox"/> <input type="checkbox"/></p> <p>e. Any disease or disorder of the kidneys, liver, or bladder? <input type="checkbox"/> <input type="checkbox"/></p> <p>f. Any disease or disorder of the glands or blood (other than HIV-related)? <input type="checkbox"/> <input type="checkbox"/></p> <p>g. Any disease or disorder of the skin, muscles, bones, or joints? <input type="checkbox"/> <input type="checkbox"/></p> <p>h. Any disease or disorder of the eyes, ears, nose, or throat? <input type="checkbox"/> <input type="checkbox"/></p> <p>i. Diabetes or sugar in the urine? <input type="checkbox"/> <input type="checkbox"/></p> <p>j. Cancer or tumor or any other growth? <input type="checkbox"/> <input type="checkbox"/></p> <p>k. Down syndrome, paralysis, spina bifida, or any other abnormality, deformity disease or disorder? <input type="checkbox"/> <input type="checkbox"/></p> | Yes | No | <i>If "Yes," give the name of the child, specify the disease or disorder, and give history, dates, details, and names of doctors.</i> |
|--|------------|-----------|---|
2. Is any child proposed for insurance currently receiving treatment or taking medication of any kind? *(If "Yes," give the name of the child and details of the treatment or medication.)*
3. Have any physicians or practitioners not mentioned above been consulted regarding any of the children for any reason not mentioned above?
4. Within the past 10 years, have either parent or any of the children been diagnosed or treated by a physician or other health care professional as having acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC), or positive test results indicating the presence of the AIDS virus? . .
5. Have any of the child's natural parents, brothers, or sisters ever been diagnosed with any of the following conditions: heart disease, stroke, high blood pressure, diabetes, multiple sclerosis, mental illness, kidney disease, cancer, tumors, Huntington's chorea, cystic fibrosis, muscular dystrophy, or any other hereditary disease?

Section 4 – General Questions

1. With respect to any child proposed for insurance:
- | | | |
|---|--------------------------|--------------------------|
| | Yes | No |
| a. Is this insurance intended to replace or change any insurance now or recently held in any company? . . . | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Has any application for insurance ever been declined, postponed, rated, or modified | <input type="checkbox"/> | <input type="checkbox"/> |

If "Yes," on either 1(a) or (b), give the name of the child and full details.


Yes No

2. Does every child proposed for insurance under this Rider reside with you?
If "No," give the name of the child and full details. _____

3. If any child proposed for insurance is adopted, please indicate the name of the child and provide any medical conditions known about the natural parents: _____

Agreement

Each of the undersigned declares that the statements and answers contained in this application and provided by such individuals are complete and true to the best of his/her knowledge and belief, that the statements and answers were correctly recorded before he/she signed below, and that they shall form the basis of any insurance policy that may be issued. A copy of this application shall be attached to, and made a part of, the policy. No change in amount, classification, plan of insurance, or benefits shall be effective unless agreed to in writing by the Proposed Insured and/or the Policyowner.

All information that I (we) have given to the Agent is contained in this application. A misrepresentation in response to any question may result in policy rejection or rescission subject to the incontestability provision in the policy.

It is also agreed that IA American Life Insurance Company (the Company) will incur no liability under this application until:

- a. the application has been received and approved;
- b. a policy has been issued and delivered; and
- c. the full Modal Premium has been paid to, and accepted by, the Company at its Home Office.

The policy must be issued, delivered, and the full Modal Premium paid while the health, habits, avocations, and occupation of the lives to be insured are as stated in this application. The policy will then be deemed effective on its issue date.

The Company will notify the Policyowner of its decision regarding the insurability of the lives to be insured, as stated in this application, within 60 days of receipt of the application. Otherwise, it will notify the Policyowner of the reason for any further delay.

No Agent has the authority to waive the answers to any of the questions in this application or to make or alter any contract for the Company.

The Agent and Policyowner agree that no insurance, other than those policies for the indicated life or lives to be insured indicated as replacements in Section 4(1a), will be replaced by a policy issued in connection with this application.

Authorization to Obtain Information

The undersigned Policyowner and/or parent authorizes any or all of the following to give to IA American Life Insurance Company, or its reinsurers, any information from their records pertaining to the undersigned or identified minor children's employment, health, alcohol, drug, and psychiatric information: a. any physician or medical practitioner; b. hospital, clinic, medical or medically-related facility; c. insurance or reinsurance company; d. MIB, Inc. (formerly known as the Medical Information Bureau); e. consumer reporting agencies; or f. employers.

Information obtained with this Authorization may only be: a. used to determine insurability; b. released to reinsurance companies; c. sent to MIB, Inc.; d. sent to persons or organizations performing business or legal services in connection with my application, except for information received from MIB, Inc., which must not be disclosed; e. used as lawfully required; or f. used as I may further authorize in writing.

The undersigned Policyowner and/or parent acknowledges receipt of the Notice of Insurance Information Practices, the Fair Credit Reporting Act Notice, and the MIB Notice and agrees that a photographic copy of this Authorization shall be as valid as the original. The undersigned Policyowner and/or parent agrees that this Authorization shall be valid for two years from the date shown below.

Each of the undersigned requests that any examination findings relating to such undersigned resulting in a rating, postponement, or declination of any, or of all, coverage requested on this application be forwarded directly to:

- Such minor children's regular physician. Yes No
- Such undersigned Policyowner and/or parent's attention at his/her home address Yes No

Each of the undersigned Policyowner and/or parent and minor children elects to be interviewed if an investigative consumer report is prepared in connection with this application Yes No

I acknowledge that I have read the Fraud Warning applicable to my state on page 3 of this application.

Signed at _____ this _____ day of _____ 20____
City, State Month Year

Signatures of minor children age 15 and above

Signature of Policyowner

Signature of Parent where child does not reside with Policyowner

Witness/Agent Signature

A copy of the Authorization will be made available to the Policyowner or the Policyowner's Authorized Representative on the Company's receipt of written request.

Fraud Warning

Arkansas, Louisiana, and Texas Residents Only: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance, is guilty of a crime and may be subject to fines and confinement in prison.

Colorado Residents Only: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

District of Columbia Residents Only: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida Residents Only: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Kentucky Residents Only: Any person who knowingly and with intent to defraud, any insurance company or other person files an application for insurance 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.

Maine, Tennessee, and Washington Residents Only: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Maryland Residents Only: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey Residents Only: Any person, who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

New Mexico Residents Only: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

North Dakota and South Dakota Residents Only: Any person, who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, commits insurance fraud, which may be a crime and may subject the person to civil and criminal penalties.

Ohio Residents Only: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma Residents Only: WARNING: Any person who knowingly and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon Residents Only: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Pennsylvania Residents Only: 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.

Virginia Residents Only: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer makes any claim for the proceeds of an insurance policy containing false, incomplete, or misleading information may be guilty of a felony.

In All Other States: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.



IA American Life Insurance Company
 17550 N. Perimeter Dr., Suite 210
 Scottsdale, AZ 85255-7833
 Tel: (888) 473-5540 FAX: (480) 502-5088

Confidential Financial Questionnaire

Please print using dark ink

www.iaamerican.com

Instructions

This questionnaire is to be submitted with applications for \$1,000,000 and greater or may be requested at the underwriter's discretion.

- Section 1 is to be completed in all instances
- Section 2 is to be completed for personal insurance
- Section 3 is to be completed for business insurance

For amounts over \$2 million, please submit audited financial statements. (For personal insurance, a year-end review by a personal accountant; for business insurance, such audited documents as income statements, profit & loss statements, balance sheets, and year-end financial reviews).

Proposed Insured _____ Policy Number _____

Section 1 – General

Life Insurance

In Force	Personal	Business	Purpose of Business Insurance
Life	\$ _____	\$ _____	_____
Accidental Death	\$ _____	\$ _____	_____
Annual Premium	\$ _____	\$ _____	_____

Pending or Contemplated

Amount	Name of Insurance Company(s)	Purpose
\$ _____	_____	_____
\$ _____	_____	_____
\$ _____	_____	_____

Is it the intention to place IA American Life Insurance Company coverage in place of pending or contemplated coverages?

- Yes (explain) _____
- No

Is it the intention to place IA American Life Insurance Company coverage in addition to pending or contemplated coverages?

- Yes (explain) _____
- No

Personal Income

Current Year	Last Year	
\$ _____	_____	Annual earned income (salary, wages, bonus, commissions, etc.)
\$ _____	_____	Other income (dividends, interest, rent, etc.)
\$ _____	_____	Total income

Bankruptcy: Have you undergone bankruptcy in the past 7 years?

- Yes (Give full details, including dates) _____
- No

Are you subject to any pending lawsuits, judgments or liens?

- Yes (Give full details, including dates) _____
- No



Section 2 – Personal Insurance

Purpose of Coverage

- Income replacement/family protection
- Estate conservation/wealth transfer
- Debt repayment (*give full details*) _____
- Other (*give full details*) _____

Personal Worth

Assets

\$ _____ Cash in bank

\$ _____ Stocks and bonds

\$ _____ Notes and accounts receivable

\$ _____ Real estate (*residence*)

\$ _____ Real estate (*other*)

\$ _____ Value of business
(*complete Business Section 3*)

\$ _____ Retirement plan assets

\$ _____ Other (*specify*)

\$ _____ Total assets

Liabilities

\$ _____ Bank loans

\$ _____ Notes and accounts payable

\$ _____ Insurance policy loans

\$ _____ Taxes and interest due

\$ _____ Mortgages due

\$ _____ Other (*specify*)

\$ _____ Total liabilities

Net Worth

\$ _____ Total assets

(minus) \$ _____ Total liabilities

(equals) \$ _____ Net worth

Section 3 – Business Insurance

Details of Business

Name _____

Address _____

Nature of business _____

How long has the company been in existence? _____

When did this individual join the company? _____

Type of organization: Corporation LLC Partnership Sole Proprietorship Other _____

Year established _____

Has this business undergone bankruptcy in the past 7 years?

Yes (Give full details, including dates) _____

No

Value of the Business

Current business: \$ _____ Book value

\$ _____ Market value

Proposed Insured's % of ownership of business _____%

Proposed Insured's annual income from business \$ _____

Profits of Business (before taxes and bonuses)

\$ _____ Year-before-last

\$ _____ Last year

\$ _____ This year (estimated)

Purpose of Coverage

Key person Buy-sell/stock redemption Business loan Other (explain fully on back of form)

If key person, how is the Proposed Insured important to the business (special skills, knowledge, or abilities)?

If business loan, provide the following information:

Name of lender _____

Address _____

Amount of loan \$ _____ Date of loan _____

Repayment terms _____

Purpose of the loan _____

Is the lender requiring this insurance? Yes No

What other persons are being insured in favor of the business?

_____	_____	_____	_____	_____	_____
Name	Amount	Insurance Company	Name	Amount	Insurance Company

_____	_____	_____	_____	_____	_____
Name	Amount	Insurance Company	Name	Amount	Insurance Company

The undersigned declares that the statements and answers made in this questionnaire are made for the purpose of establishing the value of insurability. These statements and answers are an accurate statement of current financial conditions, and are complete and true to the best of his/her knowledge and belief.

Signature of Proposed Insured

Date

SERFF Tracking Number: APLE-126100780 State: Arkansas
Filing Company: IA American Life Insurance Company State Tracking Number: 42870
Company Tracking Number: GL201
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: LIFE APPLICATIONS
Project Name/Number: LIFE APPLICATIONS/GL201

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: Attachment: readcert.pdf		

	Item Status:	Status Date:
Satisfied - Item: Application Comments: This filing is an "application" filing.		

CERTIFICATION OF READABILITY

IA American Life Insurance Company hereby certifies that the following forms comply with state requirements for readability as follows:

GL201	Application for Life Insurance	46.9
GL202	Part 2 of Application	50.7
GL203	Supplemental Application	56.6
GL204	Additional Insured Application	47.0
GL205	Application for Reinstatement/Change	45.7
GL206	Application for Child Rider	45.2
GL207	Confidential Financial Questionnaire	46.4
GL208	Declaration of Good Health	48.6
GL209	Amendment Page	47.2
GL501	Certificate in Lieu of Life Insurance Illustration	51.2



Michael L. Stickney
President

April 2, 2009