

SERFF Tracking Number: AFLC-126293976 State: Arkansas
 Filing Company: Americo Financial Life and Annuity Insurance Company State Tracking Number: 43432
 Company Tracking Number: 1214
 TOI: L07I Individual Life - Whole Sub-TOI: L07I.101 Fixed/Indeterminate Premium - Single Life
 Product Name: Whole Life Application (AAR5099 09/09)
 Project Name/Number: AR Regulation & Rule 97/1214

Filing at a Glance

Company: Americo Financial Life and Annuity Insurance Company

Product Name: Whole Life Application (AAR5099 09/09) SERFF Tr Num: AFLC-126293976 State: Arkansas

TOI: L07I Individual Life - Whole SERFF Status: Closed-Approved-Closed State Tr Num: 43432

Sub-TOI: L07I.101 Fixed/Indeterminate Premium - Single Life Co Tr Num: 1214 State Status: Approved-Closed

Filing Type: Form Reviewer(s): Linda Bird

Authors: Ronni Jones, Rebecca Aguirre Disposition Date: 09/09/2009

Date Submitted: 09/04/2009 Disposition Status: Approved-Closed

Implementation Date Requested: Implementation Date:

State Filing Description:

General Information

Project Name: AR Regulation & Rule 97
 Project Number: 1214
 Requested Filing Mode: Review & Approval

Status of Filing in Domicile:
 Date Approved in Domicile:
 Domicile Status Comments: The purpose of this filing is to comply with regulatory changes in Arkansas only.

Explanation for Combination/Other:
 Submission Type: New Submission
 Overall Rate Impact:
 Filing Status Changed: 09/09/2009

Market Type: Individual
 Group Market Size:
 Group Market Type:
 Explanation for Other Group Market Type:
 State Status Changed: 09/09/2009

Deemer Date:
 Submitted By: Rebecca Aguirre

Created By: Rebecca Aguirre
 Corresponding Filing Tracking Number: AFLC-125385961

SERFF Tracking Number: AFLC-126293976 State: Arkansas
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 Product Name: Whole Life Application (AAR5099 09/09)
 Project Name/Number: AR Regulation & Rule 97/1214

Filing Description:

The purpose of this filing is to submit for approval application form AAR5099 (09/09). This form was originally approved as form number AAR5099 on 12/26/2007 under Arkansas tracking number 37640. This form has been revised in order to comply with Regulation and Rule 97 effective January 1, 2010.

A redline version of this form is provided to demonstrate the changes made to the form.

Company and Contact

Filing Contact Information

Rebecca Aguirre, Manager rebecca.Aguirre@americo.com
 300 W. 11th Street 816-391-2768 [Phone]
 Kansas City, MO 64105 816-391-2083 [FAX]

Filing Company Information

Americo Financial Life and Annuity Insurance CoCode: 61999 State of Domicile: Texas
 Company
 300 West 11th Street Group Code: 449 Company Type:
 Kansas City, MO 64105 Group Name: State ID Number:
 (800) 231-0801 ext. [Phone] FEIN Number: 35-0810610

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? Yes
 Fee Explanation: TX Fee \$50.00 X 1 = \$50.00
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Americo Financial Life and Annuity Insurance Company	\$50.00	09/04/2009	30348878

SERFF Tracking Number: AFLC-126293976 State: Arkansas
Filing Company: Americo Financial Life and Annuity Insurance State Tracking Number: 43432
Company
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TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single
Life
Product Name: Whole Life Application (AAR5099 09/09)
Project Name/Number: AR Regulation & Rule 97/1214

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved- Closed	Linda Bird	09/09/2009	09/09/2009

SERFF Tracking Number: AFLC-126293976 *State:* Arkansas
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Life
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Project Name/Number: AR Regulation & Rule 97/1214

Disposition

Disposition Date: 09/09/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: AFLC-126293976 State: Arkansas
 Filing Company: Americo Financial Life and Annuity Insurance State Tracking Number: 43432
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 Company Tracking Number: 1214
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Life & Annuity - Acturial Memo		No
Supporting Document	Redline - AAR5099 (09/09)		Yes
Form	Application for Life Insurance		Yes

SERFF Tracking Number: AFLC-126293976 State: Arkansas
 Filing Company: Americo Financial Life and Annuity Insurance State Tracking Number: 43432
 Company
 Company Tracking Number: 1214
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Form Schedule

Lead Form Number: AAR5099 (09/09)

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	AAR5099 (09/09)	Application/ Enrollment Form Application for Life Insurance	Other	Other Explanation: Revision for state requirement eff. 01/01/2010	52.200	AAR5099_09-09_FILE 2009-09-04.pdf

1. PROPOSED INSURED INFORMATION

Name (Last, First, Middle Initial)	Address (If address is a PO BOX, a street address is also required.)
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Years at current address: _____ If less than 5 years, prior address required. Male Female

Phone Number	SSN or Taxpayer ID	Date of Birth	Age	Place of Birth (City, State, Country)
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2. OWNER INFORMATION (If different from the Proposed Insured.)

Name (Last, First, Middle Initial)	Relationship to Proposed Insured	SSN or Taxpayer ID
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Address (If address is a PO BOX, a street address is also required.)

Years at current address: _____ If less than 5 years, prior address required.

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

<i>If not specified, all beneficiaries will be Primary.</i>	Name	SSN or Taxpayer ID	Relationship	% of Share (Must total 100%)
Primary				
<input type="checkbox"/> Primary <input type="checkbox"/> Contingent				
<input type="checkbox"/> Primary <input type="checkbox"/> Contingent				

4. PRODUCT INFORMATION

<input type="checkbox"/> Ultra Protector I <input type="checkbox"/> Ultra Protector II <input type="checkbox"/> Check here if you are willing to accept any Ultra Protector product for which you qualify based on this application. The insurance for which you qualify may have a face amount less than any indicated on this application and riders may not be available. All premiums will be applied toward the insurance for which you qualify.	Face Amount <input type="checkbox"/> Solve for Face Amount <input type="checkbox"/> Face Amount \$ _____	Premium Mode <input type="checkbox"/> Monthly Bank Draft <input type="checkbox"/> Annually	Modal Premium \$ _____	<input type="checkbox"/> Check here to select Automatic Premium Loan.
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Children's Term Rider: Complete only when applying for the Children's Term Rider. This rider is only available on Ultra Protector I.

- Are you applying for the Children's Term Rider? Yes No *If Yes, complete this section.*
- Amount of Children's Term coverage desired: \$ _____
- Please list below all children and/or dependent grandchildren proposed for coverage. A dependent grandchild means a grandchild who is eligible to be claimed on the federal income tax return of, and resides with, the Proposed Insured.

Full Name of Child or Dependent Grandchild Proposed for Coverage	Date of Birth	Sex	Relationship to Proposed Insured	Height	Weight
		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Child <input type="checkbox"/> Dependent Grandchild		
		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Child <input type="checkbox"/> Dependent Grandchild		
		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Child <input type="checkbox"/> Dependent Grandchild		

- In the past 7 years, has any child to be insured ever been diagnosed or treated by a member of the medical profession for: birth defects or blood disorders, cancer, convulsions or seizures, diabetes, Down's syndrome, digestive disorder, emotional or psychiatric disorder, heart disorder, kidney or liver disorder, lung or respiratory disorder, nervous system disorder, alcohol or drug abuse, Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC), or any immune deficiency related disorder; or tested positive for antibodies to the Human Immunodeficiency Virus (HIV)? *If Yes, circle the condition(s) and provide details below.* Yes No
- Has any child proposed for coverage been diagnosed or treated by a member of the medical profession for any disease or disorder not mentioned above? *If Yes, provide details below.* Yes No

Name of Child or Dependent Grandchild	Reason Treated	Date(s) of Treatment	Name/Address/Phone Number of Doctor/Hospital Where Treated

5. REPLACEMENT INFORMATION

1. Do you have any existing life insurance policies or annuities on the life of any Proposed Insured? *(If Yes, provide information below.)* Yes No
2. Will the life insurance policy applied for replace, or otherwise reduce in value, any existing life insurance policies or annuities now in force? Yes No
(If Yes to either question, submit applicable Replacement Notice. Application and Replacement Notice form must be dated on the same date.)

Insured's Name	Company	Owner	Life Amount	Accidental Death Benefit	Policy Date

6. HEALTH INFORMATION *(Provide details of all Yes answers in the Health Question Details/Remarks section.)*

Has the Proposed Insured smoked cigarettes within the last 12 months? Yes No

	Proposed Insured's Height	Proposed Insured's Weight

PART 1 Yes No

1. Is the Proposed Insured currently: hospitalized, bedridden, confined to a nursing facility, receiving hospice or home health care, using oxygen to assist in breathing, confined to a wheelchair, using a walker, waiting for an organ transplant, diagnosed with a terminal illness, paralyzed, or has the Proposed Insured been declined for life insurance within the last 6 months? Yes No
2. Has the Proposed Insured ever:
 - a. Had, been told they have, been treated for, or been prescribed medication for: Alzheimer's disease, dementia, memory loss, muscular dystrophy, or ALS (Lou Gehrig's Disease)? Yes No
 - b. Been diagnosed as having, been treated by a medical professional for, or tested positive for: Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or the Human Immunodeficiency Virus (HIV)? Yes No
3. a. In the past 5 years, has the Proposed Insured been told they have or been treated by surgery, chemotherapy, radiation, or prescribed medication for: leukemia or lung, colon, bladder, or breast cancer? Yes No
 - b. In the past 3 years, has the Proposed Insured been told they have, or been treated by surgery, chemotherapy, radiation, or prescribed medication for any other internal cancer or malignant melanoma (not basal cell skin cancer)? Yes No
4. In the past 12 months, has the Proposed Insured had, been told they have, been treated for, or been prescribed medication or had surgery for: heart bypass, angioplasty (balloon procedure), stent placement, heart valve disorder, heart attack, or angina (chest pain)? Yes No
5. In the past 2 years, has the Proposed Insured had, been told they have, been treated for, or been prescribed medication or had surgery for:
 - a. Congestive heart failure, stroke, circulation or blood clot problems in the legs or to the heart or brain, systemic lupus, chronic kidney disease, or kidney failure? Yes No
 - b. Drug or alcohol abuse/dependency or addiction? Yes No
6. Has the Proposed Insured been told they have, been treated for, or taken medication for diabetes in combination with stroke or TIA, heart disease, or circulatory disease? Yes No

PART 2 Yes No

1. In the past 2 years, has the Proposed Insured ever been told they have, been treated for, or been prescribed medication for: Parkinson's disease, cirrhosis of the liver, chronic hepatitis, or other liver diseases or disorders? Yes No
2. Does the Proposed Insured have diabetes requiring insulin, diagnosed prior to age 50? Yes No
3. In the past 2 years, has the Proposed Insured:
 - a. Experienced complications of diabetes including: amputation, eye or kidney problems, insulin shock, or diabetic coma? Yes No
 - b. Experienced periods when their blood sugar was not controlled (in excess of 175)? Yes No
4. In the past 2 years, has the Proposed Insured had, been told they have, been treated for, or been prescribed medication or had surgery for: heart bypass, angioplasty (balloon procedure), stent placement, heart valve disorder, heart attack, angina (chest pain), coronary disease, or multiple sclerosis? Yes No
5. In the past 2 years, has the Proposed Insured had, been told they have, been treated for, or been prescribed medication for: emphysema, chronic bronchitis that is not seasonal, or any other chronic respiratory or lung problem excluding allergies or asthma? Yes No

Eligibility is based on answers to the Health Questions and additional underwriting criteria.

7. HEALTH QUESTION DETAILS/REMARKS *(Attach a separate sheet if more space is needed; additional sheet must be signed and dated by Proposed Insured/Owner to avoid amendments.)*

8. AUTHORIZATION AND ACKNOWLEDGMENT

I/We authorize any insurance company, employer, physician, medical professional, hospital, medical facility, consumer reporting agency, the Medical Information Bureau, or any other person or organization that has any record of information about me/us or my/our minor children who are to be insured, to give to Americo Financial Life and Annuity Insurance Company (Americo), its reinsurers or its authorized representatives, information about other insurance coverage, employment, age, general character, finances, participation in hazardous activities, medical care or advice about any physical or mental condition including information about drugs and alcoholism, or other information Americo requires to determine insurability or eligibility for benefits. I/We further authorize the sources listed above except the Medical Information Bureau to give such information to a consumer reporting agency acting on behalf of Americo.

Americo may release information obtained by this Authorization to its reinsurers, to the Medical Information Bureau, to other insurers with whom I/we have policies or to whom I/we may apply or submit a claim, to other persons or organizations performing business or legal services in connection with an insurance transaction for me/us, or as may otherwise be lawfully required.

I/We have received a copy of the Notice of Insurance Information Practices. I/We, or my/our authorized representative, may obtain a copy of this Authorization on request. This Authorization will be valid for 2 years from the date signed. It is Americo's practice to prohibit third parties who lawfully receive nonpublic health information from redisclosing or reusing the disclosed information. A photographic copy shall be as valid as the original. I/We understand that a copy of this authorization will be provided, upon request, to me/us or a person authorized on my/our behalf. I/We understand that disclosure of information to Americo may subject the information to redisclosure in accordance with Americo's privacy policy and MIB, Inc. rules. This authorization may be revoked; however, it may not be revoked during the contestability period of the policy or to the extent Americo has taken action in reliance on this authorization. Notice of revocation may be sent, in writing, to Americo at its Administrative Office address.

IN ACCORDANCE WITH STATE LAW, WE MUST PROVIDE YOU WITH THE FOLLOWING FRAUD NOTICE: 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.

The **USA PATRIOT Act** requires all financial institutions, including insurance companies, to verify the identity of their customers. Providing your name, address, date of birth and taxpayer identification number allows us to verify your identity. Our verification process may include the use of third-party sources to verify the information provided.

REQUEST FOR OWNER'S TAXPAYER IDENTIFICATION NUMBER AND CERTIFICATION: Under penalties of perjury, I as the Owner, certify that the number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me).

Any policy issued on this application will be deemed to be delivered in and governed by the laws of the jurisdiction in which this application was signed.

No agent or medical examiner can waive the answer to any question in this application nor decide on insurability nor waive any of the company's underwriting requirements nor make or change any contract. The company shall have no knowledge of statements made by or to the Agent or medical examiner unless such statements are shown on the application.

I/We represent to Americo that the statements made on this application are true, complete and correctly recorded to the best of my/our knowledge and belief. I/We agree that Americo can rely on these statements. I/We agree that this application and/or any medical exam form and any supplemental application or amendment to the application will be the basis for any policy issued on this application or any amendment to the application. **I/WE AGREE THAT ALL ANSWERS TO THE HEALTH QUESTIONS ON PAGE 2 OF THIS APPLICATION, SIGNED AND DATED BELOW, ARE COMPLETE AND ACCURATE.**

Signed at (City and State) _____ on (Month/Day/Year) _____

Signature of Proposed Insured (required)

Signature of Owner (if different than Proposed Insured)

Signature of Witnessing Agent (required)

AGENT'S REPORT

Proposed Insured's Name: _____

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

Provide details of all No answers in the Agent Comments/Remarks section.

2. How long has the Agent known the Proposed Insured(s)? _____ Yes No

3. At the time this application was taken, were all of the Proposed Insured(s) present and did you witness their signatures?

4. Did the Proposed Insured(s) directly respond to each application question?

5. Was a government-issued picture I.D. requested, reviewed, and confirmed (by reviewing a second document such as a utility bill, tax return, etc.)
for the Proposed Insured, Owner, and Payor (if different than the Proposed Insured)?

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

6. Did the applicant approach you to purchase insurance? (If Yes, list their stated need for the insurance in the Agent Comments/Remarks section.)

7. Does the applicant have any existing life insurance policies or annuities on the life of any Proposed Insured?

8. Will the life insurance policy applied for replace, or otherwise reduce in value, any life insurance policies or annuities now in force?
(If Yes to either question 7 or 8, complete applicable replacement form. Provide copies of replacement forms to the Owner and the Company.)

Agent Comments/Remarks:

I hereby certify that I have personally asked each question on this application to the Proposed Insured(s), that I have truly and accurately recorded on the application the information supplied by him/her, and that I have no reason to believe that any of the information provided is inaccurate or incomplete. If not, I have set forth my reservations in the Agent Comments/Remarks section above.

Agent Signature	Print Agent Name	Agent Phone Number	Agent Email Address	Agent #	%

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 Life
 Product Name: Whole Life Application (AAR5099 09/09)
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Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification		
Comments:		
Attachment: AAR5099 (0909) READ.pdf		

	Item Status:	Status Date:
Bypassed - Item: Application		
Bypass Reason: Not applicable.		
Comments:		

	Item Status:	Status Date:
Satisfied - Item: Redline - AAR5099 (09/09)		
Comments:		
Attachment: AAR5099 _09-09_REDLINE.pdf		

READABILITY CERTIFICATION

Company Name: Americo Financial Life and Annuity Insurance Company

I hereby certify, that the forms listed below have the following readability scores as calculated by the Flesch Reading Ease Test.

Form Number	Score
AAR5099 (09/09)	52.2



Jack L. Fortini
Vice President – Legal and Secretary

September 3, 2009
Date

1. PROPOSED INSURED INFORMATION

Name (Last, First, Middle Initial)	Address (If address is a PO BOX, a street address is also required.)
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Years at current address: _____ If less than 5 years, prior address required. Male Female

Phone Number	SSN or Taxpayer ID	Date of Birth	Age	Place of Birth (City, State, Country)
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2. OWNER INFORMATION (If different from the Proposed Insured.)

Name (Last, First, Middle Initial)	Relationship to Proposed Insured	SSN or Taxpayer ID
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Address (If address is a PO BOX, a street address is also required.)

Years at current address: _____ If less than 5 years, prior address required.

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

If not specified, all beneficiaries will be Primary.	Name	SSN or Taxpayer ID	Relationship	% of Share (Must total 100%)
Primary				
<input type="checkbox"/> Primary <input type="checkbox"/> Contingent				
<input type="checkbox"/> Primary <input type="checkbox"/> Contingent				

4. PRODUCT INFORMATION

<input type="checkbox"/> Ultra Protector I <input type="checkbox"/> Ultra Protector II <input type="checkbox"/> Check here if you are willing to accept any Ultra Protector product for which you qualify based on this application. The insurance for which you qualify may have a face amount less than any indicated on this application and riders may not be available. All premiums will be applied toward the insurance for which you qualify.	Face Amount <input type="checkbox"/> Solve for Face Amount <input type="checkbox"/> Face Amount \$ _____	Premium Mode <input type="checkbox"/> Monthly Bank Draft <input type="checkbox"/> Annually	Modal Premium \$ _____	<input type="checkbox"/> Check here to select Automatic Premium Loan.
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Children's Term Rider: Complete only when applying for the Children's Term Rider. This rider is only available on Ultra Protector I.

- Are you applying for the Children's Term Rider? Yes No *If Yes, complete this section.*
- Amount of Children's Term coverage desired: \$ _____
- Please list below all children and/or dependent grandchildren proposed for coverage. A dependent grandchild means a grandchild who is eligible to be claimed on the federal income tax return of, and resides with, the Proposed Insured.

Full Name of Child or Dependent Grandchild Proposed for Coverage	Date of Birth	Sex	Relationship to Proposed Insured	Height	Weight
		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Child <input type="checkbox"/> Dependent Grandchild		
		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Child <input type="checkbox"/> Dependent Grandchild		
		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Child <input type="checkbox"/> Dependent Grandchild		

4. In the past 7 years, has any child to be insured ever been diagnosed or treated by a member of the medical profession for: birth defects or blood disorders, cancer, convulsions or seizures, diabetes, Down's syndrome, digestive disorder, emotional or psychiatric disorder, heart disorder, kidney or liver disorder, lung or respiratory disorder, nervous system disorder, alcohol or drug abuse, Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC), or any immune deficiency related disorder; or tested positive for antibodies to the Human Immunodeficiency Virus (HIV)? *If Yes, circle the condition(s) and provide details below.* Yes No

5. Has any child proposed for coverage been diagnosed or treated by a member of the medical profession for any disease or disorder not mentioned above? *If Yes, provide details below.* Yes No

Name of Child or Dependent Grandchild	Reason Treated	Date(s) of Treatment	Name/Address/Phone Number of Doctor/Hospital Where Treated

5. REPLACEMENT INFORMATION

1. Do you have any existing life insurance policies or annuities on the life of any Proposed Insured? *(If Yes, provide information below.)* Yes No
 2. Will the life insurance policy applied for replace, or otherwise reduce in value, any existing life insurance policies or annuities now in force? Yes No
- (If Yes to either question, submit applicable Replacement Notice. Application and Replacement Notice form must be dated on the same date.)*

Insured's Name	Company	Owner	Life Amount	Accidental Death Benefit	Policy Date

6. HEALTH INFORMATION *(Provide details of all Yes answers in the Health Question Details/Remarks section.)*

Has the Proposed Insured smoked cigarettes within the last 12 months? Yes No

	Proposed Insured's Height	Proposed Insured's Weight

PART 1 Yes No

1. Is the Proposed Insured currently: hospitalized, bedridden, confined to a nursing facility, receiving hospice or home health care, using oxygen to assist in breathing, confined to a wheelchair, using a walker, waiting for an organ transplant, diagnosed with a terminal illness, paralyzed, or has the Proposed Insured been declined for life insurance within the last 6 months? Yes No
2. Has the Proposed Insured ever:
 - a. Had, been told they have, been treated for, or been prescribed medication for: Alzheimer's disease, dementia, memory loss, muscular dystrophy, or ALS (Lou Gehrig's Disease)? Yes No
 - b. Been diagnosed as having, been treated by a medical professional for, or tested positive for: Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or the Human Immunodeficiency Virus (HIV)? Yes No
3. a. In the past 5 years, has the Proposed Insured been told they have or been treated by surgery, chemotherapy, radiation, or prescribed medication for: leukemia or lung, colon, bladder, or breast cancer? Yes No
 - b. In the past 3 years, has the Proposed Insured been told they have, or been treated by surgery, chemotherapy, radiation, or prescribed medication for any other internal cancer or malignant melanoma (not basal cell skin cancer)? Yes No
4. In the past 12 months, has the Proposed Insured had, been told they have, been treated for, or been prescribed medication or had surgery for: heart bypass, angioplasty (balloon procedure), stent placement, heart valve disorder, heart attack, or angina (chest pain)? Yes No
5. In the past 2 years, has the Proposed Insured had, been told they have, been treated for, or been prescribed medication or had surgery for:
 - a. Congestive heart failure, stroke, circulation or blood clot problems in the legs or to the heart or brain, systemic lupus, chronic kidney disease, or kidney failure? Yes No
 - b. Drug or alcohol abuse/dependency or addiction? Yes No
6. Has the Proposed Insured been told they have, been treated for, or taken medication for diabetes in combination with stroke or TIA, heart disease, or circulatory disease? Yes No

PART 2 Yes No

1. In the past 2 years, has the Proposed Insured ever been told they have, been treated for, or been prescribed medication for: Parkinson's disease, cirrhosis of the liver, chronic hepatitis, or other liver diseases or disorders? Yes No
2. Does the Proposed Insured have diabetes requiring insulin, diagnosed prior to age 50? Yes No
3. In the past 2 years, has the Proposed Insured:
 - a. Experienced complications of diabetes including: amputation, eye or kidney problems, insulin shock, or diabetic coma? Yes No
 - b. Experienced periods when their blood sugar was not controlled (in excess of 175)? Yes No
4. In the past 2 years, has the Proposed Insured had, been told they have, been treated for, or been prescribed medication or had surgery for: heart bypass, angioplasty (balloon procedure), stent placement, heart valve disorder, heart attack, angina (chest pain), coronary disease, or multiple sclerosis? Yes No
5. In the past 2 years, has the Proposed Insured had, been told they have, been treated for, or been prescribed medication for: emphysema, chronic bronchitis that is not seasonal, or any other chronic respiratory or lung problem excluding allergies or asthma? Yes No

Eligibility is based on answers to the Health Questions and additional underwriting criteria.

7. HEALTH QUESTION DETAILS/REMARKS *(Attach a separate sheet if more space is needed; additional sheet must be signed and dated by Proposed Insured/Owner to avoid amendments.)*

8. AUTHORIZATION AND ACKNOWLEDGMENT

I/We authorize any insurance company, employer, physician, medical professional, hospital, medical facility, consumer reporting agency, the Medical Information Bureau, or any other person or organization that has any record of information about me/us or my/our minor children who are to be insured, to give to Americo Financial Life and Annuity Insurance Company (Americo), its reinsurers or its authorized representatives, information about other insurance coverage, employment, age, general character, finances, participation in hazardous activities, medical care or advice about any physical or mental condition including information about drugs and alcoholism, or other information Americo requires to determine insurability or eligibility for benefits. I/We further authorize the sources listed above except the Medical Information Bureau to give such information to a consumer reporting agency acting on behalf of Americo.

Americo may release information obtained by this Authorization to its reinsurers, to the Medical Information Bureau, to other insurers with whom I/we have policies or to whom I/we may apply or submit a claim, to other persons or organizations performing business or legal services in connection with an insurance transaction for me/us, or as may otherwise be lawfully required.

I/We have received a copy of the Notice of Insurance Information Practices. I/We, or my/our authorized representative, may obtain a copy of this Authorization on request. This Authorization will be valid for 2 years from the date signed. It is Americo's practice to prohibit third parties who lawfully receive nonpublic health information from redisclosing or reusing the disclosed information. A photographic copy shall be as valid as the original. I/We understand that a copy of this authorization will be provided, upon request, to me/us or a person authorized on my/our behalf. I/We understand that disclosure of information to Americo may subject the information to redisclosure in accordance with Americo's privacy policy and MIB, Inc. rules. This authorization may be revoked; however, it may not be revoked during the contestability period of the policy or to the extent Americo has taken action in reliance on this authorization. Notice of revocation may be sent, in writing, to Americo at its Administrative Office address.

IN ACCORDANCE WITH STATE LAW, WE MUST PROVIDE YOU WITH THE FOLLOWING FRAUD NOTICE: 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.

The **USA PATRIOT Act** requires all financial institutions, including insurance companies, to verify the identity of their customers. Providing your name, address, date of birth and taxpayer identification number allows us to verify your identity. Our verification process may include the use of third-party sources to verify the information provided.

REQUEST FOR OWNER'S TAXPAYER IDENTIFICATION NUMBER AND CERTIFICATION: Under penalties of perjury, I as the Owner, certify that the number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me).

Any policy issued on this application will be deemed to be delivered in and governed by the laws of the jurisdiction in which this application was signed.

No agent or medical examiner can waive the answer to any question in this application nor decide on insurability nor waive any of the company's underwriting requirements nor make or change any contract. The company shall have no knowledge of statements made by or to the Agent or medical examiner unless such statements are shown on the application.

I/We represent to Americo that the statements made on this application are true, complete and correctly recorded to the best of my/our knowledge and belief. I/We agree that Americo can rely on these statements. I/We agree that this application and/or any medical exam form and any supplemental application or amendment to the application will be the basis for any policy issued on this application or any amendment to the application. **I/WE AGREE THAT ALL ANSWERS TO THE HEALTH QUESTIONS ON PAGE 2 OF THIS APPLICATION, SIGNED AND DATED BELOW, ARE COMPLETE AND ACCURATE.**

Signed at (City and State) _____ on (Month/Day/Year) _____

Signature of Proposed Insured (required)

Signature of Owner (if different than Proposed Insured)

Signature of Witnessing Agent (required)

AGENT'S REPORT

Proposed Insured's Name: _____

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

Provide details of all No answers in the Agent Comments/Remarks section.

2. How long has the Agent known the Proposed Insured(s)? _____ Yes No

3. At the time this application was taken, were all of the Proposed Insured(s) present and did you witness their signatures?

4. Did the Proposed Insured(s) directly respond to each application question?

5. Was a government-issued picture I.D. requested, reviewed, and confirmed (by reviewing a second document such as a utility bill, tax return, etc.) for the Proposed Insured, Owner, and Payor (if different than the Proposed Insured)?

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

6. Did the applicant approach you to purchase insurance? (If Yes, list their stated need for the insurance in the Agent Comments/Remarks section.)

7. Does the applicant have any existing life insurance policies or annuities on the life of any Proposed Insured?

8. Will the life insurance policy applied for replace, or otherwise reduce in value, any life insurance policies or annuities now in force?
 (If Yes to either question 7 or 8, complete applicable replacement form. Provide copies of replacement forms to the Owner and the Company.)

Agent Comments/Remarks:

I hereby certify that I have personally asked each question on this application to the Proposed Insured(s), that I have truly and accurately recorded on the application the information supplied by him/her, and that I have no reason to believe that any of the information provided is inaccurate or incomplete. If not, I have set forth my reservations in the Agent Comments/Remarks section above.

Agent Signature	Print Agent Name	Agent Phone Number	Agent Email Address	Agent #	%