

SERFF Tracking Number: AHLI-126549774 State: Arkansas  
 Filing Company: The American Home Life Insurance Company State Tracking Number: 45213  
 Company Tracking Number:  
 TOI: L07I Individual Life - Whole Sub-TOI: L07I.101 Fixed/Indeterminate Premium - Single Life  
 Product Name: Guidestar Insurance Telephone Script  
 Project Name/Number: 2010 FEITS/

## Filing at a Glance

Company: The American Home Life Insurance Company

Product Name: Guidestar Insurance Telephone SERFF Tr Num: AHLI-126549774 State: Arkansas  
 Script

TOI: L07I Individual Life - Whole SERFF Status: Closed-Accepted State Tr Num: 45213  
 For Informational Purposes

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

Filing Type: Form Reviewer(s): Linda Bird  
 Author: Juell Moulden Disposition Date: 03/22/2010  
 Date Submitted: 03/19/2010 Disposition Status: Accepted For Informational Purposes  
 Implementation Date: Implementation Date:

Implementation Date Requested: On Approval  
 State Filing Description:

## General Information

Project Name: 2010 FEITS  
 Project Number:  
 Requested Filing Mode: Informational  
 Explanation for Combination/Other:  
 Submission Type: New Submission  
 Overall Rate Impact:  
 Filing Status Changed: 03/22/2010

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: 03/22/2010  
 Created By: Juell Moulden  
 Corresponding Filing Tracking Number:

Deemer Date:  
 Submitted By: Juell Moulden  
 Filing Description:

American Home Life is filing 2010 FEITS for informational purposes. American Home Life uses the Guidestar® Insurance Telephone Script as a part of the underwriting process. The proposed insured is asked the medical questions over the telephone as set forth in the script. It was previously approved by your state as 2007 FEITS. It has since been updated for clarity purposes. It is used exclusively with the form 2007 FEPA-AR that was previously approved by your state on February 19, 2008.

SERFF Tracking Number: AHLL-126549774 State: Arkansas  
 Filing Company: The American Home Life Insurance Company State Tracking Number: 45213  
 Company Tracking Number:  
 TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life  
 Product Name: Guidestar Insurance Telephone Script  
 Project Name/Number: 2010 FEITS/

## Company and Contact

### Filing Contact Information

Juell Nebergall, Legal Correspondent jnebergall@amhomelife.com  
 400 S Kansas Ave 785-235-6276 [Phone] 344 [Ext]  
 P.O. Box 1497 785-235-1037 [FAX]  
 Topeka, KS 66601

### Filing Company Information

The American Home Life Insurance Company CoCode: 60542 State of Domicile: Kansas  
 400 S Kansas Ave Group Code: Company Type: Life Insurance & Annuities  
 P.O. Box 1497 Group Name: State ID Number:  
 Topeka, KS 66601 FEIN Number: 48-0119710  
 (785) 235-6276 ext. [Phone]  
 -----

## Filing Fees

Fee Required? Yes  
 Fee Amount: \$20.00  
 Retaliatory? No  
 Fee Explanation: 1 form at \$20.00  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The American Home Life Insurance Company	\$20.00	03/19/2010	35021408

SERFF Tracking Number: AHLL-126549774 State: Arkansas  
Filing Company: The American Home Life Insurance Company State Tracking Number: 45213  
Company Tracking Number:  
TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life  
Product Name: Guidestar Insurance Telephone Script  
Project Name/Number: 2010 FEITS/

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Accepted For Informational Purposes	Linda Bird	03/22/2010	03/22/2010

*SERFF Tracking Number:* AHLL-126549774      *State:* Arkansas  
*Filing Company:* The American Home Life Insurance Company      *State Tracking Number:* 45213  
*Company Tracking Number:*  
*TOI:* L071 Individual Life - Whole      *Sub-TOI:* L071.101 Fixed/Indeterminate Premium - Single Life  
*Product Name:* Guidestar Insurance Telephone Script  
*Project Name/Number:* 2010 FEITS/

## **Disposition**

Disposition Date: 03/22/2010

Implementation Date:

Status: Accepted For Informational Purposes

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: AHLL-126549774 State: Arkansas  
 Filing Company: The American Home Life Insurance Company State Tracking Number: 45213  
 Company Tracking Number:  
 TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life  
 Product Name: Guidestar Insurance Telephone Script  
 Project Name/Number: 2010 FEITS/

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Life & Annuity - Acturial Memo		No
Form	Guidestar Insurance Telephone Script		Yes

SERFF Tracking Number: AHLL-126549774 State: Arkansas  
 Filing Company: The American Home Life Insurance Company State Tracking Number: 45213  
 Company Tracking Number:  
 TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life  
 Product Name: Guidestar Insurance Telephone Script  
 Project Name/Number: 2010 FEITS/

## Form Schedule

### Lead Form Number: 2010 FEITS

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	2010 FEITS	Application/Guidestar Insurance Enrollment Telephone Script Form	Initial		63.400	2010 FEITS.pdf

# Guidestar® Insurance Telephone Script

## INFO FROM AGENT:

Client Name: \_\_\_\_\_ Amount: \_\_\_\_\_  
Agent Name: \_\_\_\_\_ Level: \_\_\_\_\_ Graded: \_\_\_\_\_  
Address, City, St, Zip: \_\_\_\_\_ Telephone #: \_\_\_\_\_  
SS#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ State of Birth: \_\_\_\_\_  
Any prescription medications? (name and what for): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Current Family Doctor or Clinic: \_\_\_\_\_

Phone Number or City/State: \_\_\_\_\_

Did you read the Declarations and Authorizations related to the GuideStar Product to the Proposed Insured? YES NO

## INFO FROM CLIENT:

1. This conversation is being recorded for accuracy. Do I have your permission to proceed with this recorded interview? YES NO

### Verify social security number and date of birth.

Please be sure to answer all of my questions truthfully to the best of your knowledge. It is important for you to understand that no agent of American Home Life is authorized to advise you that an inaccurate answer to a question is acceptable. In fact, your failure to answer these questions accurately to the best of your knowledge could affect the future payments of death benefits. Do you understand the importance of answering all of my questions accurately to the best of your knowledge? YES NO

Do you affirm that you have been read the Declarations and Authorizations containing the MIB notice and the authorization allowing the MIB or any other person or organization to release records regarding your medical treatment and history of prescription drug usage? YES NO

By stating yes, you understand you are signing the notice and authorizations electronically and are thereby authorizing American Home Life to immediately obtain this information regarding your medical treatment and history of prescription drug usage. YES NO

### RUN MIB AND SCRIPT CHECK

Place electronic signature below:

## Guidestar® Insurance Telephone Script

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Please verify that the medications your agent provided are correct. YES NO

**\* For Indiana residents only, questions #2-6 must be limited to the last 10 years and thus must begin...  
“In the last 10 years...”**

2. Have you been diagnosed by or received treatment from a licensed medical professional for a terminal illness, ALS, Alzheimer’s or dementia? YES NO

3. Have you tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection? YES NO

**\*\* Read for residents of Wisconsin only: Tests received at anonymous counseling and testing sites and the results of home test kits need not be revealed.**

4. Have you been diagnosed by or received treatment from a licensed medical professional for heart disease including a heart attack, congestive heart failure, aneurysm or stroke in the last two years? \_\_\_\_\_ YES NO

Have you had heart surgery or chest pain diagnosed or treated by a licensed medical professional in the last two years? \_\_\_\_\_ YES NO

Have you been diagnosed by or received treatment from a licensed medical professional for cirrhosis, liver failure, or Hepatitis C? \_\_\_\_\_ YES NO

5. Have you been diagnosed by or received treatment from a licensed medical professional for diabetes? YES NO

If yes, when diagnosed? \_\_\_\_\_

Is it presently controlled by medication prescribed by a licensed medical professional? YES NO

Have you had any complications of diabetes, including heart disease, kidney disease, amputations, retinopathy, neuropathy, any skin sores that are not healing or diabetic coma, diagnosed or treated by a licensed medical professional after the diabetes? YES NO

6. Have you had an organ transplant or been diagnosed by or received treatment from a licensed medical professional for kidney disease? \_\_\_\_\_ YES NO

7. Have you been diagnosed by or received treatment from a licensed medical professional for any psychiatric illness or disease or have you received treatment for alcohol or drugs in the last two years? \_\_\_\_\_ YES NO

8. Have you been diagnosed by or received treatment from a licensed medical professional for any disease of your lungs other than asthma, such as emphysema, chronic obstructive pulmonary disease or chronic bronchitis in the last two years? YES NO

Have you been treated with an inhaler or medication to improve your breathing? YES NO

## Guidestar® Insurance Telephone Script

- |   |     |    |
|---|-----|----|
| 9. Have you received oxygen treatment prescribed by a licensed medical professional in the last two years? _____  | YES | NO |
| 10. Have you been diagnosed by or received treatment from a licensed medical professional for internal cancer, leukemia, melanoma or a disease of the blood in the last two years? _____      | YES | NO |
| 11. Have you been admitted into a nursing home in the past year? _____  | YES | NO |
| 12. Have you been told by a licensed medical professional that you need surgery or been advised by a licensed medical professional to enter a nursing home? _____                             | YES | NO |
| 13. Have you been advised by a licensed medical professional to receive assistance with activities of daily living, such as help with medication or are you receiving home health care? _____ | YES | NO |
| 14. Have you been diagnosed by or received treatment from a licensed medical professional for Parkinson's disease in the last two years? _____  | YES | NO |
| 15. Have you smoked cigarettes in the last 12 months?   | YES | NO |
| 16. Have you answered each question accurately to the best of your knowledge?   | YES | NO |

If a policy will be issued, read the following statement:

**For all states except Kansas and Minnesota:**

Any policy issued upon receipt of your application shall not go into force until the application is complete, the first premium is paid in full and the application is approved by the company while the proposed insured's condition of health is unchanged from the date of the application.

**For the states of Kansas and Minnesota:**

Any policy issued upon receipt of your application shall not go into force until the application is complete and the first premium is paid in full.

\_\_\_ Application will be referred to underwriting for additional information.

\_\_\_ Application is declined.

Interviewer: \_\_\_\_\_ Date and Time of Call: \_\_\_\_\_

Comments: \_\_\_\_\_

---

---

---

---

---

---

---

SERFF Tracking Number: AHLL-126549774 State: Arkansas  
Filing Company: The American Home Life Insurance Company State Tracking Number: 45213  
Company Tracking Number:  
TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life  
Product Name: Guidestar Insurance Telephone Script  
Project Name/Number: 2010 FEITS/

## Supporting Document Schedules

**Item Status:** **Status Date:**

**Satisfied - Item:** Flesch Certification

**Comments:**

**Attachment:**

Flesch Cert.pdf

**Item Status:** **Status Date:**

**Satisfied - Item:** Application

**Comments:**

Approved on February 19, 2008.

**Attachment:**

2007 FEPA-AR.pdf

**CERTIFICATION**

This is to certify that the following form has achieved the Flesch readability score required in your state.

<b><u>Form Number</u></b>	<b><u>Description</u></b>	<b><u>Flesch Readability Score</u></b>
2010 FEITS	Guidestar® Insurance Telephone Script	63.4



---

Les E. Diehl  
Vice President - General Counsel

March 18, 2010

Date

**APPLICATION FOR FINAL EXPENSE INSURANCE**  
**The American Home Life Insurance Company of Kansas**  
**400 Kansas Avenue • P.O. Box 1497 • Topeka, KS 66601**

<b>Plan</b>		<b>Face Amount</b>	<input type="checkbox"/> ADB	<b>Premium Submitted</b>	<b>Mode of Payment</b>			<b>Automatic Premium Loan</b>	
<input type="checkbox"/> Whole Life	<input type="checkbox"/> Single Pay	\$ _____	\$ _____	\$ _____ If COD, Premium Quoted	<input type="checkbox"/> Annual	<input type="checkbox"/> Semi Annual	Yes <input type="checkbox"/> No <input type="checkbox"/>		
<input type="checkbox"/> Graded	<input type="checkbox"/> 5 Pay <input type="checkbox"/> 10 Pay				<input type="checkbox"/> Quarterly	<input type="checkbox"/> Bank Draft			
Proposed Insured				Birthdate ____/____/____	Age	Birthplace	Sex	Height	Weight
Address (Street, City, State, Zip)					Phone ____-____-____		Social Security Number ____/____/____		

Primary Beneficiary	Relationship	Birthdate ____/____/____
Contingent Beneficiary	Relationship	Birthdate ____/____/____

Owner (if other than insured)	Relationship	Birthdate ____/____/____	Social Security Number ____/____/____
-------------------------------	--------------	-----------------------------	--

Address (Street, City, State, Zip)

*Contingent Owner	Relationship	Birthdate ____/____/____	Social Security Number ____/____/____
-------------------	--------------	-----------------------------	--

Address (Street, City, State, Zip)

\*The Owner may designate a Contingent Owner. If the Owner dies while this policy is in force, ownership will belong to the Contingent Owner. If there is no Contingent Owner named or the Contingent Owner dies before the Owner, ownership will belong to the Owner's estate.

<b>If any part of questions #1, #2, or #3 is answered "YES" do not submit the application.</b>	<b>Yes</b>	<b>No</b>
1. Are you hospitalized or confined to a nursing home, hospice or long-term care facility?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you been diagnosed by or received treatment from a medical professional for any of the following:		
A. A terminal illness, ALS, Alzheimer's or dementia?	<input type="checkbox"/>	<input type="checkbox"/>
B. Any complications of diabetes including heart disease, kidney disease, amputations, retinopathy, neuropathy or diabetic coma?	<input type="checkbox"/>	<input type="checkbox"/>
C. Cirrhosis or Liver failure?	<input type="checkbox"/>	<input type="checkbox"/>
D. Kidney failure requiring dialysis?	<input type="checkbox"/>	<input type="checkbox"/>
E. Chronic lung disease requiring oxygen?	<input type="checkbox"/>	<input type="checkbox"/>
F. Leukemia or major organ transplant?	<input type="checkbox"/>	<input type="checkbox"/>
3. To the best of your knowledge, have you been diagnosed or treated by a medical professional, for an immune deficiency disorder, HIV, AIDS or AIDS related complex (ARC), or tested positive on an AIDS related blood test?	<input type="checkbox"/>	<input type="checkbox"/>

<b>If one of the following questions (4-6G) is answered "yes", Plan II (graded) will be issued. If more than one question (4-6G) is answered yes, do not submit the application.</b>	<b>Yes</b>	<b>No</b>
4. Do you have diabetes diagnosed by a medical professional (a) diagnosed before age 35, or (b) diagnosed at any age and that is not presently controlled by medication prescribed by a licensed medical professional?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you need ongoing assistance with activities of daily living or are you receiving home health care?	<input type="checkbox"/>	<input type="checkbox"/>
6. In the last <b>24 months</b> have you been diagnosed by or received treatment from a medical professional for any of the following:		
A. Heart disease (excluding prescription of medication for high blood pressure) or any procedure to improve circulation, including implantation of pacemaker or defibrillator?	<input type="checkbox"/>	<input type="checkbox"/>
B. Stroke or Transient Ischemic Attack (TIA) or a procedure to improve circulation to the brain?	<input type="checkbox"/>	<input type="checkbox"/>
C. Internal cancer, melanoma or disorder of the blood?	<input type="checkbox"/>	<input type="checkbox"/>
D. Alcoholism, drug addiction, kidney disease or liver disease?	<input type="checkbox"/>	<input type="checkbox"/>
E. Any chronic lung disorder excluding asthma?	<input type="checkbox"/>	<input type="checkbox"/>
F. Parkinson's disease, hepatitis C or any psychiatric disorder?	<input type="checkbox"/>	<input type="checkbox"/>
G. Been admitted to a hospital or had a medical procedure performed at any medical facility in the last <b>12 months</b> for any condition listed above.	<input type="checkbox"/>	<input type="checkbox"/>

Have you smoked cigarettes in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
Is there existing life insurance and/or annuity contract(s) on the life of the insured?	<input type="checkbox"/>	<input type="checkbox"/>
Will this policy replace or change any other life insurance or annuity you now carry? If either answered "Yes", give details:	<input type="checkbox"/>	<input type="checkbox"/>
Company _____ Policy Number _____ Effective Date _____ Face Amount _____		
Company _____ Policy Number _____ Effective Date _____ Face Amount _____		

**DECLARATIONS AND AUTHORIZATION DECLARATIONS**

I have read and received the Pre-Notices attached to this application. I agree that: 1) all statements and answers are true and complete; 2) this application will be a part of the policy; 3) temporary insurance coverage starts and remains in effect only as provided in the "Conditional Receipt". I certify, under penalty of perjury that the social security numbers shown on the application are correct. I understand that the agent is not authorized to accept risks or pass on insurability, to make or modify contracts, or waive the Company's rights including the requirement that the adult proposed insured personally sign this application in the agent's presence.

If the Company does not issue a policy from this application, the application will be canceled and a refund will be made. By accepting a policy issued from this application, the owner agrees to any changes made by the Company.

I understand that I may attend any and all meetings of the policyholders of the Company. If I do not attend, the Executive Committee of the Board of Directors will act as my lawful proxy, until that proxy is revoked by me, in writing. The annual meeting of policyholders shall be held at 10:00 a.m. on the second Tuesday in March, each year. I understand that the "secondary addressee" listed in the application will also receive notification of any impending lapse in coverage. I may list a new secondary addressee at any time by written notice to the company.

I permit the Company to give information about me and any proposed insured except HIV test results to the Medical Information Bureau, any reinsurer, and other insurer(s) from which benefits have been claimed or insurance purchased. I acknowledge receipt of the Notice Regarding Medical Information Bureau, Notice Regarding Fair Credit Reporting Act and Notice of Information Practices before signing this form. I understand that I may request in writing to be interviewed. If any investigative consumer report is prepared in connection with this application, upon written request, I am entitled to receive a copy. I understand that there is no benefit paid for suicide for the first two policy years (for residents of Colorado and North Dakota, one policy year).

**AUTHORIZATION TO OBTAIN INFORMATION**

By this form, I authorize any licensed physician, medical practitioner, clinic, hospital, other medical or medically-related facility, the Veterans Administration, the Medical Information Bureau (MIB), an employer, consumer reporting agency, any person, organization, other institution or other insurance companies that have records or knowledge about me or any children to be insured (if applicable) to release this information to The American Home Life Insurance Company of Kansas. This information may be about: (a) employment; (b) occupation; (c) avocations; (d) other insurance coverage; (e) driving record; (f) age; (g) prescription drug usage; (h) any medical history, condition, care or advice relative to the proposed insured's physical or mental health; and (i) other personal characteristics. This AUTHORIZATION extends to information on the use of alcohol, drugs and tobacco; and the diagnosis or treatment of HIV ( the virus that causes AIDS) infection or other sexually transmitted disease. I understand that this information will be used by The American Home Life Insurance Company, its representatives or reinsurers in the evaluation of this application to determine eligibility for insurance and/or to investigate claims. The American Home Life Insurance Company of Kansas or its representatives may release information covered by this AUTHORIZATION to the American Home Agent(s) listed in my application for insurance, to its subsidiaries, reinsurers, the MIB, or other insurance companies. The American Home Life Insurance Company may also release this information to others who I authorize in writing or as allowed by law. This AUTHORIZATION may be used for a period of 24 months from the date signed below unless sooner revoked. I may revoke this AUTHORIZATION at any time by notifying The American Home Life Insurance Company of Kansas in writing at Underwriting Department, The American Home Life Insurance Company, P.O. Box 1497, Topeka, KS 66601. My revocation will not be effective to the extent The American Home Life Insurance Company, its reinsurers, or any other person already has disclosed or collected information or taken other action in reliance on the AUTHORIZATION. I understand that my application for insurance will not be considered unless this AUTHORIZATION is signed and dated. The information The American Home Life Insurance Company or its reinsurers obtains through this AUTHORIZATION may become subject to further disclosure, as required by law. I understand that any information that is disclosed pursuant to this AUTHORIZATION is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be redisclosed except as authorized by me or as required by law. I agree that a photocopy of this AUTHORIZATION is as valid as the original. I understand that I have the right to receive a copy of this AUTHORIZATION upon request.

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.

**NOTICE:** I have reviewed all answers and responses contained in this application. I certify that all answers and responses contained in this application are true and correct to the best of my knowledge. I UNDERSTAND THAT ANY INCORRECT STATEMENTS, OMISSIONS, OR MISREPRESENTATIONS IN THE APPLICATION WHICH AFFECT THE ACCEPTANCE OF THE RISK OR HAZARD ASSUMED BY THE COMPANY MAY RESULT IN THE LOSS OF COVERAGE AND NONPAYMENT OF DEATH BENEFITS SUBJECT TO THE "INCONTESTABILITY" PROVISION OF THE POLICY.

Signed at \_\_\_\_\_

Proposed Insured \_\_\_\_\_

Date \_\_\_\_\_

Applicant/Owner \_\_\_\_\_

Agent \_\_\_\_\_

Agent Name (Printed) \_\_\_\_\_

**Mail Policy To:**    Agent    Insured    Owner

**AGENT'S CERTIFICATION**

I hereby certify that, to the best of my knowledge, there is  is not  existing life insurance and/or annuity contract(s) on the life of the insured. If there is, I have presented and read the applicant a notice regarding replacement, if required by applicable state law. If there is existing coverage, I certify that the insurance hereby applied for will  will not  replace any existing life insurance or annuity contract. I further certify that: 1) the above answers are full, complete and true to the best of my knowledge; 2) that I know of no factors affecting the insurability of any proposed insured except as stated on the application; 3) that the above signatures are those they are represented to be; and 4) that the application was signed by all proposed insureds in my presence.

Signed at \_\_\_\_\_

Licensed Agent \_\_\_\_\_

Date \_\_\_\_\_

Agent Number \_\_\_\_\_

Remarks \_\_\_\_\_

**AGENT'S REMARKS**

Telephone Interview Completed:  Yes  No

Best Time to Call: \_\_\_\_AM \_\_\_\_PM

Premium Notices To:  Insured  Owner

Mail Policy To:  Agent  Insured  Owner

Remarks/Requests: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**AUTHORIZATION AGREEMENT FOR PREAUTHORIZED PAYMENTS**

in favor of The American Home Life Insurance Company of Kansas P.O. Box 1497 • Topeka, Kansas 66601 ID# 48-0119710  
I (we) hereby authorize The American Home Life Insurance Company of Kansas, hereinafter called the COMPANY, to initiate debit entries to my (our)  Checking  Savings account (select one) indicated below and the depository named below, hereinafter called DEPOSITORY, to debit same to such account.

DEPOSITORY NAME \_\_\_\_\_ BRANCH \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

TRANSIT / ABA NO. \_\_\_\_\_ ACCOUNT NO. \_\_\_\_\_

This authority is to remain in full force and effect until COMPANY and DEPOSITORY have received written notification from me (or either of us) of its termination. For any changes to this authority, including termination thereof, please allow Seven (7) business days after COMPANY has received such notification to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

NAME(S) \_\_\_\_\_ SSN \_\_\_\_\_  
(Please Print)

DATE \_\_\_\_\_ SIGNED \_\_\_\_\_

**IMPORTANT: ATTACH VOID CHECK TO CERTIFY ABOVE INFORMATION.**

Preferred Withdrawal Date: \_\_\_\_\_ (of each month)

**CONDITIONAL RECEIPT**

**All Premium Checks Must Be Payable to American Home Life Insurance Company; Do Not Make Checks Payable To The Agent Or Leave The Payee Blank.**

Received \$ \_\_\_\_\_ from \_\_\_\_\_ in connection with the application for life insurance, including any riders for which application has been made.

1. **NO INSURANCE WILL BECOME EFFECTIVE PRIOR TO DELIVERY OF THE POLICY UNLESS AND UNTIL EACH AND EVERYONE OF THE FOLLOWING CONDITIONS HAVE BEEN FULFILLED EXACTLY:**
  - (a) **If the proposed insured(s) is/are a tobacco user**, the amount of payment taken with the application must be at least equal to the amount of the full first premium at tobacco premium rates for the mode of payment selected in the application and for the amount of insurance which may become effective prior to delivery of the policy;
  - (b) **If the proposed insured(s) is/are NOT a tobacco user**, the amount of payment taken with the application must be at least equal to the amount of the full first premium at non-tobacco premium rates for the mode of payment selected in the application and for the amount of insurance which may become effective prior to delivery of the policy;
  - (c) all medical examination, tests, x-rays, and electrocardiograms required by the Company must be completed and received at its Home Office within 60 days from the date of completion of the application;
  - (d) on the Effective Date, as defined below, the Company at its Home Office must be satisfied that each person proposed for insurance in this application is a risk insurable by the company at no greater than standard tobacco or standard non-tobacco premium rates under its rules, limits, and standards for the plan and the amount applied for without any modification either as to plan, amount riders, or supplemental agreements; and
  - (e) on the Effective Date the state of health and all factors, including tobacco usage, 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 and in use on the Effective Date, but for an amount not exceeding that specified in paragraph 2, will become effective as of the Effective Date. "Effective Date", as used herein, is the latest of (a) the date of completion of the application questions, or (b) the date of completion of all medical examinations, prescription checks, tests, x-rays, and electrocardiograms required by the Company, or (c) the date of issue, if any, requested in the application.
3. **The total amount of insurance which may become effective on any person proposed for insurance shall not exceed \$25,000 of life insurance.**
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 ANY OF THE PROVISIONS OF THIS CONDITIONAL RECEIPT.**

Date at \_\_\_\_\_

\_\_\_\_\_  
Signature of Agent

this \_\_\_\_\_ day of \_\_\_\_\_ Year \_\_\_\_\_

I acknowledge possession of this receipt and I certify that I have read it and the agreement in the application. The terms and conditions of this receipt, to which I agree, and the agreement in the application have been explained to me fully by the agent and I understand them.

\_\_\_\_\_  
Signature of the Owner

### **NOTICE REGARDING MEDICAL INFORMATION BUREAU**

Information regarding your insurability will be treated as confidential. The American Home Life Insurance Company of Kansas, or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such company, the Bureau, upon request will supply such company with the information it may have in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, Telephone number (617) 426-3660.

### **NOTICE REGARDING FAIR CREDIT REPORTING ACT**

You are entitled to know that, as a part of our regular procedures, we may request an investigative consumer report concerning the insurability of each person proposed for coverage. This report would include information as to character, general reputation, personal characteristics and mode of living, except as may be related directly or indirectly to your sexual orientation, obtained through personal interviews with friends, neighbors, and associates of the Proposed Insured(s).

Upon receipt of written request to our Home Office, we will inform you whether an investigative consumer report has, in fact, been obtained and the name and address of the consumer reporting agency from whom the report was requested. Copies of the report may be obtained from the consumer reporting agency.

### **NOTICE OF INFORMATION PRACTICES**

To properly underwrite and administer your life insurance coverage, American Home Life must collect certain information. The primary source of information is your application and any supporting amendments, questionnaires, etc. However, it may be necessary to obtain more information from sources such as medical professionals and institutions which have provided care to you or members of your family who have applied for coverage. We may contact your employers, business associates, friends and neighbors, public records, and other insurance companies to which you may have applied. Information from these sources may be obtained by correspondence, phone, or personal contact. In some cases, we may ask an insurance support organization to complete an investigative consumer report for us.

1. To other persons or organizations who perform business, professional or insurance services for us, and whose proper performance for us requires that we disclose certain information to them.
2. To another insurance company to which you have applied for coverage or benefits.
3. To your AHL agent to assist in providing proper service to you.
4. To insurance support organizations formed to prevent or detect fraud in insurance transactions.
5. To our reinsurers if we ask them to accept a portion of the risk under your policy.
6. To a medical care institution or medical professional to verify that you have coverage with us. Also, if a medical examination for insurance purposes reveals a condition or problem unknown to the individual, we may inform the individual's personal medical professional.
7. To state regulatory authorities who conduct examinations and audits of company operations,
8. To law enforcement agencies to assist in the prevention or prosecution of fraud, or to alert them to the possibilities of illegal conduct.

You have certain rights concerning access to information about you that we have collected and retained in our files. To maintain security of that information, access will be permitted only after proper identification has been submitted to us.

If you would like access to this information you must send a signed, written request to the Underwriting Department, The American Home Life Insurance Company of Kansas, P.O. Box 1497, Topeka, Kansas 66601. The request must include full name, address, telephone number and policy number. Within 30 business days after receiving your request we will tell you the nature and substance of the information in our files. If you wish to see and copy the records in person, we will advise you of the location of the records. There may be a charge for each copy made.

Also we will tell you to whom we have disclosed information about you within the last two years or to whom such information normally would have been disclosed.

There are limitations of access. We will identify sources of information which comes from institutions such as hospitals, clinics, doctors or insurance support organizations, but we will not identify sources of information which was obtained from individuals such as friends or neighbors. Also, we are not obligated to provide access to information obtained in connection with or in anticipation of a claim for policy benefits or a civil or criminal proceeding.

Medical information will be provided only through a doctor or some other medical professional, designated by you, who is licensed to provide medical care relevant to the nature of the information.

If you believe, after reviewing information in our files, that it is incorrect, you may request, in writing, that we correct, amend or delete any item of information. Requests should be directed to the Underwriting Department, The American Home Life Insurance of Kansas Company, P.O. Box 1497, Topeka, Kansas 66601. We will respond within thirty business days of receipt of your written request.

If we agree that certain changes should be made, we will notify any person to whom we may have disclosed the original information during the preceding two years. We will also notify any insurance support organization to whom we have disclosed the information or who may have furnished the original information.

If we do not agree to change our records, you may file with us a brief written statement setting forth what you believe to be the correct, relevant or fair information and why you disagree with our decision not to change the original information. Your statement will become a permanent part of our file and will be disclosed in the future with the original information. Also, copies of your statement will be sent to any person or insurance support organization to whom the original information was furnished.

## ACCELERATED BENEFIT RIDER

### Summary and Acknowledgement

**BRIEF DESCRIPTION:** This rider enables the Owner to claim a portion of the policy's death benefit prior to the actual death of the Insured, when the Insured is diagnosed as having a Qualifying Event. The benefit, when paid, is treated as an advance against the death benefit, reducing the policy's death benefit, accordingly. Descriptions of major provisions are given below.

**AVAILABILITY:** Automatically provided in any new American Home Life final expense policy at issue.

**MINIMUM BENEFIT:** \$1,000.

**MAXIMUM BENEFIT:** 100% of the policy's Eligible Proceeds which, in no event shall exceed the lesser of the policy's death benefit or \$25,000. Eligible Proceeds are that portion of the policy's death benefit that can be paid out as an Accelerated Benefit. Additional death benefits provided by rider or endorsement are not a part of the policy's Eligible Proceeds. The Accelerated Benefit amount is subject to the following adjustments and deductions: (1) An actuarial discount, (2) repayment of a portion of any outstanding policy loan, (3) payment of any premium due within the policy's grace period and unpaid at the time the Accelerated Benefit is approved for payment, (4) an Administrative Expense Fee of \$150 for each Accelerated Benefit claim.

**BENEFIT QUALIFICATION:** To make a claim for the Accelerated Benefit, the Insured must be diagnosed as having a Qualifying Event, which means (1) a non-correctable medical condition that, with reasonable medical certainty, will result in the death of the Insured within 24 months from the date on which this benefit is requested or (2) permanent and continuous confinement to a nursing home licensed and operated for nursing home care pursuant to the laws of the state in which it is located, and providing nursing care as its primary function. The Company will require a physician's statement certifying the Insured's life expectancy in the event of a terminal illness or certification of permanent confinement as outlined in the rider.

**BENEFIT PAYMENT:** The Accelerated Benefit may be paid in a lump sum. It may also be paid in installments of not less than \$250. The amount of each installment payment will be based on the following: (1) The lump sum amount; (2) the frequency of payment; (3) the number of installment payments to be made; and (4) a minimum interest rate of 3%.

**BENEFITS AND ADJUSTMENTS:** The following sample illustration shows how the amount available for payment as an Accelerated Benefit is calculated:

Base Policy:	\$10,000	Cash Value:	\$1,000
Eligible Death Benefit:	\$10,000	Policy Loan:	\$ 500
Maximum Gross Accelerated Benefit:			\$10,000
Requested Accelerated Benefit:			\$ 5,000

Adjustments:	Actuarial Discount	Loan Repayment	Premiums Due	Admin Fee	Total Adjustments
	\$5,000	\$500			
	X .05*	.50			
	\$250	+ \$250	+ \$50	+ \$150	= \$700

\*Discount rate is variable; 5% used as example only.

Maximum Net Accelerated Benefit: \$ 4,300 (\$5,000 - \$700 = \$4,300)

**EFFECT ON POLICY VALUES:** This shows how the benefits of the policy are altered after an Accelerated Benefit is paid:

Base Policy:	\$ 5,000	(\$10,000 X .5	= \$5,000)
Benefit at Death:	\$ 5,000		

Cash Value:	\$ 500	(\$1,000 X .5	= \$500)
Policy Loan:	- 250	(\$ 500 X .5	= \$250)
Remaining Cash Value:	\$ 250	(\$ 500 - \$250	= \$250)

Premium Before Benefit:	\$ 600 per year	(\$ 600 X .5	= \$300)
Premium After Benefit:	\$ 300 per year		

**TAX CONSEQUENCES:** Acceleration of life insurance benefits under this rider may or may not qualify for favorable tax treatment under the Internal Revenue Code of 1986, section 101 (g). Qualification for favorable tax treatment will depend on factors such as the Insured's life expectancy at the time benefits are accelerated or use of benefits for necessary long-term care expenses, such as nursing home care. If the acceleration of life insurance benefits qualifies for favorable tax treatment, the benefits will be excludable from the Owner's income and not subject to federal taxation. Tax laws relating to acceleration of life insurance benefits are complex. Consult a qualified tax advisor to assess the tax consequences of accelerated benefits.

**ACCELERATED BENEFITS AND PUBLIC ASSISTANCE PROGRAMS:** Receipt of accelerated benefits may affect eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children (AFDC), supplementary social security income (SSI) and drug assistance programs. Consult a qualified tax advisor and social service agencies concerning how receipt of accelerated benefits will affect eligibility for public assistance.

**I hereby acknowledge receipt of the Summary and Acknowledgement form. I also acknowledge that I have reviewed the "Benefits and Adjustments" and "Effect on Policy Values".**

\_\_\_\_\_  
Signature of Agent

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Owner

\_\_\_\_\_  
Date

## ACCELERATED BENEFIT RIDER

### Summary and Acknowledgement

**BRIEF DESCRIPTION:** This rider enables the Owner to claim a portion of the policy's death benefit prior to the actual death of the Insured, when the Insured is diagnosed as having a Qualifying Event. The benefit, when paid, is treated as an advance against the death benefit, reducing the policy's death benefit, accordingly. Descriptions of major provisions are given below.

**AVAILABILITY:** Automatically provided in any new American Home Life final expense policy at issue.

**MINIMUM BENEFIT:** \$1,000.

**MAXIMUM BENEFIT:** 100% of the policy's Eligible Proceeds which, in no event shall exceed the lesser of the policy's death benefit or \$25,000. Eligible Proceeds are that portion of the policy's death benefit that can be paid out as an Accelerated Benefit. Additional death benefits provided by rider or endorsement are not a part of the policy's Eligible Proceeds. The Accelerated Benefit amount is subject to the following adjustments and deductions: (1) An actuarial discount, (2) repayment of a portion of any outstanding policy loan, (3) payment of any premium due within the policy's grace period and unpaid at the time the Accelerated Benefit is approved for payment, (4) an Administrative Expense Fee of \$150 for each Accelerated Benefit claim.

**BENEFIT QUALIFICATION:** To make a claim for the Accelerated Benefit, the Insured must be diagnosed as having a Qualifying Event, which means (1) a non-correctable medical condition that, with reasonable medical certainty, will result in the death of the Insured within 24 months from the date on which this benefit is requested or (2) permanent and continuous confinement to a nursing home licensed and operated for nursing home care pursuant to the laws of the state in which it is located, and providing nursing care as its primary function. The Company will require a physician's statement certifying the Insured's life expectancy in the event of a terminal illness or certification of permanent confinement as outlined in the rider.

**BENEFIT PAYMENT:** The Accelerated Benefit may be paid in a lump sum. It may also be paid in installments of not less than \$250. The amount of each installment payment will be based on the following: (1) The lump sum amount; (2) the frequency of payment; (3) the number of installment payments to be made; and (4) a minimum interest rate of 3%.

**BENEFITS AND ADJUSTMENTS:** The following sample illustration shows how the amount available for payment as an Accelerated Benefit is calculated:

Base Policy:	\$10,000	Cash Value:	\$1,000
Eligible Death Benefit:	\$10,000	Policy Loan:	\$ 500
Maximum Gross Accelerated Benefit:			\$10,000
Requested Accelerated Benefit:			\$ 5,000

Adjustments:	Actuarial Discount	Loan Repayment	Premiums Due	Admin Fee	Total Adjustments
	\$5,000	\$500			
	X .05*	.50			
	-----	-----	-----	-----	-----
	\$250	+ \$250	+ \$50	+ \$150	= \$700

\*Discount rate is variable; 5% used as example only.

Maximum Net Accelerated Benefit: \$ 4,300 (\$5,000 - \$700 = \$4,300)

**EFFECT ON POLICY VALUES:** This shows how the benefits of the policy are altered after an Accelerated Benefit is paid:

Base Policy:	\$ 5,000	(\$10,000 X .5	= \$5,000)
Benefit at Death:	\$ 5,000		

Cash Value:	\$ 500	(\$1,000 X .5	= \$500)
Policy Loan:	- 250	(\$ 500 X .5	= \$250)
Remaining Cash Value:	\$ 250	(\$ 500 - \$250	= \$250)

Premium Before Benefit:	\$ 600 per year	(\$ 600 X .5	= \$300)
Premium After Benefit:	\$ 300 per year		

**TAX CONSEQUENCES:** Acceleration of life insurance benefits under this rider may or may not qualify for favorable tax treatment under the Internal Revenue Code of 1986, section 101 (g). Qualification for favorable tax treatment will depend on factors such as the Insured's life expectancy at the time benefits are accelerated or use of benefits for necessary long-term care expenses, such as nursing home care. If the acceleration of life insurance benefits qualifies for favorable tax treatment, the benefits will be excludable from the Owner's income and not subject to federal taxation. Tax laws relating to acceleration of life insurance benefits are complex. Consult a qualified tax advisor to assess the tax consequences of accelerated benefits.

**ACCELERATED BENEFITS AND PUBLIC ASSISTANCE PROGRAMS:** Receipt of accelerated benefits may affect eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children (AFDC), supplementary social security income (SSI) and drug assistance programs. Consult a qualified tax advisor and social service agencies concerning how receipt of accelerated benefits will affect eligibility for public assistance.

**I hereby acknowledge receipt of the Summary and Acknowledgement form. I also acknowledge that I have reviewed the "Benefits and Adjustments" and "Effect on Policy Values".**

\_\_\_\_\_  
Signature of Agent

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Owner

\_\_\_\_\_  
Date