

SERFF Tracking Number: AFLC-126961275 State: Arkansas  
Filing Company: Americo Financial Life and Annuity Insurance Company State Tracking Number: 47594  
Company Tracking Number: 1273  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: 1273: 5120 application  
Project Name/Number: 1273: 5120 application/1273

## Filing at a Glance

Company: Americo Financial Life and Annuity Insurance Company

Product Name: 1273: 5120 application

TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Filing Type: Form

SERFF Tr Num: AFLC-126961275 State: Arkansas

SERFF Status: Closed-Approved-Closed  
State Tr Num: 47594

Co Tr Num: 1273

Author: Rebecca Aguirre

Date Submitted: 12/27/2010

State Status: Approved-Closed

Reviewer(s): Linda Bird

Disposition Date: 01/05/2011

Disposition Status: Approved-Closed

Implementation Date:

Implementation Date Requested:

State Filing Description:

## General Information

Project Name: 1273: 5120 application

Project Number: 1273

Requested Filing Mode: Review & Approval

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments: Our Domicile State is Texas. Based upon Texas statutes, this life application is exempt and is being filed as such simultaneously with this filing.

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Market Type: Individual

Individual Market Type:

Filing Status Changed: 01/05/2011

State Status Changed: 01/05/2011

Deemer Date:

Submitted By: Rebecca Aguirre

Filing Description:

Enclosed, for review and approval, is life insurance application ABB5120.

Created By: Rebecca Aguirre

Corresponding Filing Tracking Number:

This form:

- is new and does not replace any previously approved form;
- contains no unusual or controversial elements;
- will be used in the individual life insurance market; and,

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- will be used by licensed independent agents doing business with our company.

#### Application ABB5120 description

This application is an Application for Simplified Issue Individual Life Insurance that will be used to apply for individual life insurance forms approved by your jurisdiction. An Associated Forms List is provided, under the Supporting Documentation tab, for your reference.

In addition to traditional use as a paper application, this application will accommodate our electronic initiatives by accepting the applicant's application for life insurance in one of two electronic application processing methods:

#### METHOD 1

The agent meets with the client in person. The applicant's responses will be entered electronically, by the agent, through the Company's secure website and populated to applicable blanks on the captured application form.

Once the application data has been entered, the agent uses an e-mail delivery system to send the completed application to the appropriate parties for signature. Each party (Owner, Insured, Payor, Agent) responds to the received e-mail by logging into a secure website where they will review the completed application in PDF form and electronically apply their signatures while in the presence of the agent or at a later time using any internet service.

Once the Owner, Insured, and Payor have electronically signed the application, the agent completes the process by applying his/her signature.

#### METHOD 2

The agent will contact the applicant by telephone, and the agent completes the application interview over the telephone. The call is not recorded. The applicant's responses will be entered electronically by the agent through the Company's secure website and populated to applicable blanks on the captioned application form.

Once the application data has been entered, the agent uses a secure e-mail delivery system to send the completed application to the appropriate parties for signature. Each party (Owner, Insured, Payor, Agent) responds to the received e-mail by logging into a secure website where they will review the completed application in PDF form and electronically apply their signatures.

Once the Owner, Insured, and Payor have electronically signed the application, the agent completes the process by applying his/her signature.

The following is true for both electronic methods:

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The respective name of the Proposed Insured, the Owner, the Payor, and the Agent, as applicable, followed by the words "Signed by Electronic Signature" will print on the signature lines of the application. The completed application will be attached to the policy at issue. Applicable signatures on all application documents will be affixed by electronic signature.

The security measures in place to protect customer privacy are: agents will be required to authenticate with Americo's extranet by entering a unique user name and password. The extranet site uses a Secured Socket Layer (SSL) encryption certificate. All data collected and transferred to Americo will be SSL encrypted and stored in database files on the Company's main data repository. A Corporate firewall protects these files from external threats and the files are secured by access groups. Only the employees who have a valid business need, as approved by management, have access to these files.

Upon receipt of the policy, the Owner has a 30-day free look period, pursuant to the terms of the policy, to review coverage and return the policy for a full refund of premium if he/she decides not to accept the policy.

The applicant can reject the application at any time during the process prior to returning his/her electronically signed approval.

To the best of our knowledge and belief, this filing is complete and complies with the insurance laws and regulations of your jurisdiction.

## 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

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## Filing Fees

SERFF Tracking Number: AFLC-126961275 State: Arkansas  
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Fee Required? Yes  
Fee Amount: \$50.00  
Retaliatory? Yes  
Fee Explanation: TX 1 exempt form = \$50.00  
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Americo Financial Life and Annuity Insurance Company	\$50.00	12/27/2010	43238019

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	01/05/2011	01/05/2011

### Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Application for Simplified Issue Individual Life Insurance	Rebecca Aguirre	12/28/2010	12/28/2010

*SERFF Tracking Number:* AFLC-126961275      *State:* Arkansas  
*Filing Company:* Americo Financial Life and Annuity Insurance      *State Tracking Number:* 47594  
*Company*  
*Company Tracking Number:* 1273  
*TOI:* L08 Life - Other      *Sub-TOI:* L08.000 Life - Other  
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## **Disposition**

Disposition Date: 01/05/2011

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		No
Supporting Document	Associated Forms Document		Yes
Supporting Document	Agent Statement		Yes
Form (revised)	Application for Simplified Issue Individual Life Insurance		Yes
Form	Application for Simplified Issue Individual Life Insurance	Replaced	Yes

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**Amendment Letter**

Submitted Date: 12/28/2010

**Comments:**

Form ABB5120 has been replaced to correct a drafting error.

**Changed Items:**

**Form Schedule Item Changes:**

**Form Schedule Item Changes:**

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
ABB5120	Application/EApplication nrollment Form	Application for Simplified Issue Individual Life Insurance	Initial				52.200	ABB5120 [Filing Form 12-28- 2010].pdf

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## Form Schedule

Lead Form Number: ABB5120

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	ABB5120	Application/ Enrollment Form Application for Simplified Issue Individual Life Insurance	Initial		52.200	ABB5120 [Filing Form 12-28-2010].pdf

**1. PROPOSED INSURED INFORMATION**

a. Proposed Insured's Name (Last, First, MI)		b. <input type="checkbox"/> Single <input type="checkbox"/> Married
		c. <input type="checkbox"/> Male <input type="checkbox"/> Female
d. Address (Include City, State, and ZIP. If mailing address is a PO Box, a street address is also required.)		
e. Home Phone	f. Work Phone	g. Email Address
h. How long at current address? _____ If less than 5 years at current address, prior address is required.		
i. Social Security Number	j. Date of Birth (MM/DD/YYYY)	k. Age
l. Place of Birth (City, State, Country)		
m. Is the Proposed Insured currently employed? <input type="checkbox"/> Yes <input type="checkbox"/> No		n. Occupation
o. Annual Salary		
p. Provide description of job duties:		

**2. PRODUCT INFORMATION** (Verify that the product is available in the state where the application is being signed.)

a. <input type="checkbox"/> HMS 150 Term	<input type="checkbox"/> HMS 150 UL	<input type="checkbox"/> Other Term	<input type="checkbox"/> HMS Term with ADB (if selected, skip sections 2b & 2c.)
<input type="checkbox"/> HMS 125 Term	<input type="checkbox"/> HMS 125 UL	<input type="checkbox"/> Other: _____	Base Face Amount: [\$ _____]
<input type="checkbox"/> HMS 100 Term	<input type="checkbox"/> HMS 100 UL		ADB Rider: [\$ _____]
b. Guarantee Periods (Level Period/Guarantee Period)		c. Payment Information	
<input type="checkbox"/> 15/15 <input type="checkbox"/> 20/20 <input type="checkbox"/> 25/25 <input type="checkbox"/> 30/30		Face Amount \$ _____	
<input type="checkbox"/> 15/5 <input type="checkbox"/> 20/5 <input type="checkbox"/> 25/5 <input type="checkbox"/> 30/5		d. Mode Premium \$ _____	
<input type="checkbox"/> Other: _____		Mode: <input type="checkbox"/> Monthly Bank Draft	
[Additional Guarantee Periods for [HMS First to Die]:		<input type="checkbox"/> Quarterly	
<input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> /		<input type="checkbox"/> Semi-Annually	
<b>IMPORTANT NOTE:</b> 5-Year Guarantee Periods are NOT available with [the HMS UL] [and HMS First to Die] Term product[s].		<input type="checkbox"/> Annually	
		e. Effective Date (If not checked, will be "Issue Date". Date cannot be the 29 <sup>th</sup> , 30 <sup>th</sup> , or 31 <sup>st</sup> of the month.)	
		<input type="checkbox"/> Issue Date	
		<input type="checkbox"/> Save Age of _____	
		<input type="checkbox"/> Specific Date _____	

**3. RIDERS** (Verify rider availability.)

a. <input type="checkbox"/> Additional Insured Term Insurance* .....\$ _____	d. <input type="checkbox"/> Disability Income†
Additional Insured's Occupation .....	<input type="checkbox"/> Primary Insured <input type="checkbox"/> 1 Year <input type="checkbox"/> 2 Years \$ _____
Additional Insured's Annual Salary .....\$ _____	<input type="checkbox"/> Additional Insured <input type="checkbox"/> 1 Year <input type="checkbox"/> 2 Years \$ _____
b. <input type="checkbox"/> Children's Term* .....\$ _____	e. <input type="checkbox"/> Waiver of Premium‡
c. <input type="checkbox"/> Critical Illness Accelerated Benefit†+ .....\$ _____	f. <input type="checkbox"/> Other _____

\*Complete section 4 of this application. †Supplemental application required. ‡Critical Illness Accelerated Benefit and Waiver of Premium riders cannot be issued on the same policy.

**4. ADDITIONAL PROPOSED INSURED(S)** (To include [First To Die policy,], [Additional Insured,] and [Children's Term] rider.)

Name of Other Proposed Insured (Last, First, MI)	Date of Birth (MM/DD/YYYY)	State of Birth	Sex	Height	Weight (lbs.)	Social Security Number	Relationship to Proposed Insured
			<input type="checkbox"/> M <input type="checkbox"/> F	' "			
			<input type="checkbox"/> M <input type="checkbox"/> F	' "			
			<input type="checkbox"/> M <input type="checkbox"/> F	' "			
			<input type="checkbox"/> M <input type="checkbox"/> F	' "			
			<input type="checkbox"/> M <input type="checkbox"/> F	' "			

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

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

**6. LIFE INSURANCE IN FORCE AND REPLACEMENT INFORMATION**

**Yes No**

- a. Does any Proposed Insured have life insurance or annuity applications pending with other companies?
- b. Is there any existing life insurance or annuity coverage on the life of any Proposed Insured? (If Yes, provide information below.)
- c. Will the life insurance applied for replace or otherwise reduce in value any existing life insurance or annuities now in force?    
(If Yes, complete applicable replacement form(s) and submit with application. Application and replacement form(s) must be dated on the same date.)
- d. Is this an internal replacement? (If Yes, include a Surrender form or Absolute Assignment form for the life insurance or annuity being replaced.) ...
- e. If current life insurance or annuity is being replaced, indicate the amount of surrender charges that will be assessed. .... \$ \_\_\_\_\_

Insured's Name (Last, First, MI)	Company	Owner	Amount	Accidental Death Benefit	Policy Date (MM/DD/YYYY)

**7. OWNER INFORMATION (If different from the Proposed Insured.)**

a. Owner's Name (Last, First, MI)		b. Relationship to Proposed Insured	c. SSN or Taxpayer ID
d. Address (Include City, State, and ZIP. If mailing address is a PO Box, a street address is also required.)			
e. How long at current address? _____ If less than 5 years at current address, prior address is required.			
f. Home Phone	g. Work Phone	h. Date of Birth (MM/DD/YYYY)	i. Place of Birth (City, State, Country)

**8. PAYOR INFORMATION (If different from the Proposed Insured and Owner.)**

a. Payor's Name (Last, First, MI)		b. Relationship to Proposed Insured	c. SSN or Taxpayer ID
d. Address (Include City, State, and ZIP. If mailing address is a PO Box, a street address is also required.)			
e. How long at current address? _____ If less than 5 years at current address, prior address is required.			

**9. SPECIAL REQUESTS**

**PERSONAL HISTORY (Provide details of all "Yes" answers in the Personal History Details section below.)**

**Proposed Insured**  
Yes No  
**Additional Proposed Insured**  
Yes No

- 10. Has any Proposed Insured ever been declined, rated, or modified for life or health insurance?
- 11. Within the past two (2) years, has any Proposed Insured:
  - a. made any flights as a pilot, student pilot, or member of a flight crew? (If Yes, complete aviation questionnaire.)
  - b. engaged in the following hazardous sports: bungee or base jumping, parachuting, hang gliding; competitive skiing/snowboarding (such as heli-skiing or ski jumping); diving activities (such as scuba, cave diving, or underwater photography); canyoning, kayaking, or white water rafting; organized racing (such as automobiles, drag racers, or motorcycles); rock or mountain climbing, rodeo riding, or any other hazardous sport/activity? (If Yes, complete sports questionnaire.)
- 12. Within the past seven (7) years, has any Proposed Insured been convicted of, pleaded guilty to, or entered a plea of no contest to any felony?
- 13. Is any Proposed Insured currently on probation or been placed on probation within the last twelve (12) months?
- 14. Within the next two (2) years, does any Proposed Insured intend to work, travel, or reside outside of the United States for more than thirty (30) days? (If Yes, where? Provide details below.)
- 15. Within the past five (5) years, has any Proposed Insured:
  - a. pleaded guilty to or been convicted of three (3) or more moving violations?
  - b. had a driver's license suspended or revoked, or are you currently under license suspension or revocation?
  - c. been convicted of reckless driving or driving under the influence of alcohol or drugs?
- 16. Driver's License Number(s) during the past five (5) years:

Name of Proposed Insured(s) on Driver's License	Driver's License Number	State Issued

**PERSONAL HISTORY DETAILS**

Question #	Proposed Insured's Name	Dates	Details

**MEDICAL HISTORY** (Provide details of all "Yes" answers in the Medical History Details section below.)

17. a. Proposed Insured's Height ..... [ ] ' [ ] " b. Proposed Insured's Weight ..... [ ] lbs.

[NOTE: Questions 18-26 are NOT required when applying for HMS Term with ADB.]

18. Has any Proposed Insured used cigarettes, cigars, pipes, chewing tobacco, nicotine patches, snuff, nicotine chewing gum, or other products containing nicotine within the last twelve (12) months? ..... [ ] [ ] [ ] [ ]

19. Within the past seven (7) years, has any Proposed Insured:

a. been treated for or been advised or diagnosed by a medical professional to seek treatment for the use of alcohol or prescription drugs? ..... [ ] [ ] [ ] [ ]

b. been advised to reduce or discontinue the intake of alcohol or prescription drugs? ..... [ ] [ ] [ ] [ ]

(If Yes, complete the alcohol usage and/or prescription medication and drug use questionnaire.)

20. Within the past seven (7) years, has any Proposed Insured used, except as prescribed by a physician: heroin, morphine, other narcotics, ecstasy, opium derivatives, marijuana, cocaine, crack, barbiturates, amphetamines, methamphetamines, hallucinogens, any other illegal, restricted or controlled substances, been treated for or been advised by a medical professional to seek treatment for the intake of any drug? (If Yes, complete the prescription medication and drug use questionnaire.) ..... [ ] [ ] [ ] [ ]

21. Within the past five (5) years, has any Proposed Insured been diagnosed with or been advised to have or had treatment for:

a. hypertension, heart disease or disorder, valve disorders, angina, cardiac arrhythmia, heart surgery including bypass, angioplasty or stent placement, circulatory disorder, blood vessel or blood disorders? ..... [ ] [ ] [ ] [ ]

b. lung or respiratory disorder, COPD, emphysema, current use of oxygen, shortness of breath, or sleep apnea? ..... [ ] [ ] [ ] [ ]

c. cancer in any form? ..... [ ] [ ] [ ] [ ]

d. diabetes or pancreatic disorders? ..... [ ] [ ] [ ] [ ]

e. digestive disorder, kidney or liver disease to include hepatitis, Crohn's disease or ulcerative colitis, gastrointestinal bleeding, bladder disorders, or unexplained weight loss? ..... [ ] [ ] [ ] [ ]

f. Alzheimer's disease, dementia, nervous system disorder, emotional or psychiatric disorder, paralysis, sexually transmitted disease, systemic lupus, any blood disorders, or birth defects? ..... [ ] [ ] [ ] [ ]

g. rheumatoid arthritis, any disease or disorder of the bones or muscles? ..... [ ] [ ] [ ] [ ]

22. Within the last five (5) years, has any Proposed Insured consulted a physician, had tests performed (such as an EKG, echocardiogram, X-ray, or blood tests) or been hospitalized or had surgery for any reason? ..... [ ] [ ] [ ] [ ]

23. Has any Proposed Insured ever been diagnosed as having, been told by a medical professional that you have, or been treated by a medical professional for Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or any immune deficiency related disorder or tested positive for antibodies to the Human Immunodeficiency Virus (HIV)? ..... [ ] [ ] [ ] [ ]

24. Within the last twelve (12) months, has any Proposed Insured had tests, surgery, treatment or hospitalization recommended but not completed? ..... [ ] [ ] [ ] [ ]

25. Do any of the Proposed Insured(s):

a. currently use prescription medicines? (If Yes, list each medication and describe the reason for its use.) ..... [ ] [ ] [ ] [ ]

b. currently have a personal physician? (If Yes, list name, address, and telephone number along with date, reason, and results of last consultation.) ..... [ ] [ ] [ ] [ ]

**ANSWER QUESTION #26 BELOW ONLY IF ANY PROPOSED INSURED IS AGE 65 OR OLDER:**

26. Within the past five (5) years, has any Proposed Insured been diagnosed with or been advised to have or had treatment for: stroke, TIA, prostate disorders, any disease or disorders of the back or joints, memory loss, or taking any prescription medication for Alzheimer's disease or dementia? ..... [ ] [ ] [ ] [ ]

**MEDICAL HISTORY DETAILS**

Please provide details of all "Yes" answers in the area below. (Attach a separate sheet if more space is needed; additional sheet MUST be signed and dated by applicable Proposed Insured/Owner to avoid amendments.)

Question #	Proposed Insured's Name	Date of Onset/Treatment	Details/Results	Name, Address, and Telephone Number of Attending Physician

**AUTHORIZATION AND ACKNOWLEDGMENT**

I/We authorize any insurance or reinsurance company, employer, licensed medical physician, medical professional, hospital, medical facility, pharmacy or pharmacy benefit manager, records custodians, other medical or medically related facility, clearing house, consumer reporting agency, and/or the Medical Information Bureau that has any record of information about me/us or my/our minor children who are to be insured, to give Americo Financial Life and Annuity Insurance Company (Americo), its reinsurers or its authorized representatives, information about other insurance coverage, employment, age, general character, motor vehicle records, habits, court records, foreign travel, finances, participation in hazardous activities, medical care or advice about any physical or mental condition, including information about drugs and alcoholism Americo requires to determine insurability if used for determining claims eligibility, no longer than the duration of the claim.

Americo may release information obtained by this Authorization to its reinsurers, to the Medical Information Bureau, to other insurers with whom I/we have life insurance 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 two (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.

**DC 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.

**TN 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 may include imprisonment, fines or denial of insurance benefits.

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. Notwithstanding the foregoing, if this application is not solicited face to face and/or is effected through any electronic means, any policy issued on this application will be deemed to be delivered in and governed by the laws of the jurisdiction of the Owner, and said jurisdiction will also be the "Signed at (City and State)" inserted below.

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 have read this application and 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 PERSONAL HISTORY QUESTIONS ON PAGE 2 AND TO MEDICAL HISTORY QUESTIONS ON PAGE 3 OF THIS APPLICATION, WHICH IS SIGNED AND DATED BELOW, ARE COMPLETE AND ACCURATE.**

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

\_\_\_\_\_  
Signature of Proposed Insured

\_\_\_\_\_  
Signature of Owner (If different from the Proposed Insured)

\_\_\_\_\_  
Signature of Additional Proposed Insured

\_\_\_\_\_  
Signature of Witnessing Agent (Required)

SERFF Tracking Number: AFLC-126961275 State: Arkansas  
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## Supporting Document Schedules

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

**Satisfied - Item:** Flesch Certification

**Comments:**

**Attachment:**

Readability Certification [ABB5120].pdf

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

**Satisfied - Item:** Associated Forms Document

**Comments:**

**Attachment:**

Associated Forms List - AR.pdf

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

**Satisfied - Item:** Agent Statement

**Comments:**

The agent statement is provided for your information to demonstrate compliance with replacement requirements in your state.

**Attachment:**

ABB5120-AS [FILING FORM 12-23-2010].pdf

AMERICO FINANCIAL LIFE AND ANNUITY INSURANCE COMPANY

NAIC number: 0449-61999

FEIN number: 35-0810610

Readability Certification

I, Eric H. Petersen – FSA, MAAA hereby certify that the form listed below has the following readability score as calculated by the Flesch Reading Ease Test.

<u>Form Number</u>	<u>Form Description</u>	<u>Readability Score</u>
ABB5120	Application for Simplified Issue Individual Life Insurance	52.2



\_\_\_\_\_  
Eric H. Petersen – FSA, MAAA

Assistant Vice President – Product Development  
Title

December 27, 2010

Date

Americo Financial Life and Annuity Insurance Company

NAIC: 0049-61999

FEIN: 25-0810610

**ASSOCIATED FORMS LIST**

Description(s)	Form Number(s)	SERFF Tr. #	State Tr. #	Status	Status Date
Term to 105 and Data Pages; Term to 100 and Data Pages; Term to 95 and Data Pages	AAR300, AAR301, AAR302, AAR300 (15), AAR300 (15/5), AAR300 (20), AAR300 (20/5), AAR300 (25), AAR300 (25/5), AAR300 (30), AAR300 (30/5), AAR301 (15), AAR301 (15/5), AAR301 (20), AAR301 (20/5), AAR301(25), AAR301 (25/5), AAR301 (30), AAR301 (30/5), AAR302 (15), AAR302 (15/5), AAR302 (20), AAR302 (20/5), AAR302 (25), AAR302 (25/5), AAR302 (30), AAR302 (30/5)	AFLC-126748984	46398	Approved	9/28/2010
Flexible Premium Adjustable Life Insurance w/ End. at 105 & data pages. Flexible Premium Adjustable Life Insurance w/ End at 100 & data pages. Flexible Premium Adjustable Life Insurance w/ End at 95 & data pages.	ABB295, ABB295 (15), ABB295 (20), ABB295(25), ABB295 (30), ABB296, ABB296 (15), ABB296 (20), ABB296 (25), ABB296 (30), ABB297, ABB297 (15), ABB297 (20), ABB297 (25), ABB297 (30),	AFLC-126775221	46597	Approved	9/3/2010
Additional Insured Riders	AAR2160-105, AAR2160-100, AAR2160-95	AFLC-126748984	46398	Approved	9/28/2010
Accidental Death Benefit Rider	AAA2165	AFLC-126748984	46398	Approved	9/28/2010
Children's Term Insurance Rider	AAA2162	AFLC-126775221	46597	Approved	9/3/2010
Disability Income Rider & Supp. Application	ABB2145; ABB5083	USPH-5HETMM694		Approved	1/7/2003
Critical Illness Accelerated Benefit Rider & Supp. Application	AAA2139; ABB5082	USPH-5EBNJJ585		Approved	12/5/2002
Involuntary Unemployment Waiver of Premium Rider	AAA2140	USPH-5hus59864		Approved	1/21/2003
Waiver of Premium Rider	AAA2158	AFLC-125988249	41359	Approved	1/22/2009
Waiver of Monthly Specified Premium Rider	AAA2158-UL	AFLC-126775221	46597	Approved	9/3/2010
Questionnaires: Alcohol Usage, Arthritis, Aviation, Back Disorders, Chest Pain, Diabetic, Epilepsy/Seizure, High Blood Pressure, Military, Nervous Disorders, Prescription Medication & Drug Use, Respiratory Disorders, Sports Activities, Tumor	AAA5101, AAA5102, AAA5103, AAA5104, AAA5105, AAA5106, AAA5107, AAA5108, AAA5109, AAA5110, AAA5111, AAA5112, AAA5113, AAA5114	AFLC-126007301	41692	Approved	3/4/2009

**AGENT'S REPORT**

**Important Note: Agent's Report must be completed and submitted with all applications**

Proposed Insured's Name: \_\_\_\_\_

- |  |                          |                          |
|--|--------------------------|--------------------------|
|  | <b>Yes</b>               | <b>No</b>                |
| 1. Are you related to the Proposed Insured(s)? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| If Yes, provide relationship: .....  |                          |                          |
| 2. How long have you known the Proposed Insured(s)?.....   |                          |                          |
| 3. Did the applicant approach you to purchase insurance? (If Yes, list their stated need for the insurance in the Agent Comments/Remarks section below.) .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. At the time this application was taken, were all of the Proposed Insureds present and did you witness their signatures? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Did the Proposed Insured(s) directly respond to you regarding each application question? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Was a government-issued picture ID 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)?..... | <input type="checkbox"/> | <input type="checkbox"/> |

**Provide details of all NO answers to questions 4-6 in the Agent Comments/Remarks section below.**

**Replacement Information**

- |  |                          |                          |
|--|--------------------------|--------------------------|
|  | <b>Yes</b>               | <b>No</b>                |
| 7. Does the applicant have any existing life insurance or annuities on the life of any Proposed Insured? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Will the life insurance applied for replace, or otherwise reduce in value, any life insurance or annuity now in force? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>(If Yes, complete applicable replacement form(s). Provide copies of replacement form(s) to the Owner and the Company. Leave copies of sales materials with Owner. If you used an electronic sales presentation, you must mail a copy to the Owner.)</i> |                          |                          |

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.

Print Agent's Name	Agent's Signature	Americo Agent Number	% Split

Writing Agent's Phone Number	Writing Agent's Fax Number	Writing Agent's Email Address

**Does Americo have your current contact information? If not, email: [licensing@americo.com](mailto:licensing@americo.com).**



**1. PROPOSED INSURED INFORMATION**

a. Proposed Insured's Name <i>(Last, First, MI)</i>		b. <input type="checkbox"/> Single <input type="checkbox"/> Married
		c. <input type="checkbox"/> Male <input type="checkbox"/> Female
d. Address <i>(Include City, State, and ZIP. If mailing address is a PO Box, a street address is also required.)</i>		
e. Home Phone	f. Work Phone	g. Email Address
h. How long at current address? _____ <i>If less than 5 years at current address, prior address is required.</i>		
i. Social Security Number	j. Date of Birth <i>(MM/DD/YYYY)</i>	k. Age
l. Place of Birth <i>(City, State, Country)</i>		
m. Is the Proposed Insured currently employed? <input type="checkbox"/> Yes <input type="checkbox"/> No		n. Occupation
o. Annual Salary		
p. Provide description of job duties:		

**2. PRODUCT INFORMATION** *(Verify that the product is available in the state where the application is being signed.)*

a. <input type="checkbox"/> HMS 150 Term	[ <input type="checkbox"/> HMS 150 UL	[ <input type="checkbox"/> Other Term	[ <input type="checkbox"/> HMS Term with ADB <i>(if selected, skip sections 2b &amp; 2c.)</i>
<input type="checkbox"/> HMS 125 Term	[ <input type="checkbox"/> HMS 125 UL	[ <input type="checkbox"/> Other: _____	Base Face Amount: [\$ _____]
<input type="checkbox"/> HMS 100 Term	[ <input type="checkbox"/> HMS 100 UL		ADB Rider: [\$ _____]
b. Guarantee Periods <i>(Level Period/Guarantee Period)</i>		c. Payment Information	
<input type="checkbox"/> 15/15 <input type="checkbox"/> 20/20 <input type="checkbox"/> 25/25 <input type="checkbox"/> 30/30 <input type="checkbox"/> 15/5 <input type="checkbox"/> 20/5 <input type="checkbox"/> 25/5 <input type="checkbox"/> 30/5 <input type="checkbox"/> Other: _____ [Additional Guarantee Periods for [HMS First to Die]: <input type="checkbox"/> / <input type="checkbox"/> / <input type="checkbox"/> / <input type="checkbox"/> / <b>[IMPORTANT NOTE: 5-Year Guarantee Periods are NOT available with [the HMS UL] [and HMS First to Die] Term product[s].]</b>		Face Amount \$ _____ d. Mode Premium \$ _____ Mode: <input type="checkbox"/> Monthly Bank Draft <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Annually	
		e. Effective Date <i>(If not checked, will be "Issue Date". Date cannot be the 29<sup>th</sup>, 30<sup>th</sup>, or 31<sup>st</sup> of the month.)</i>	
		<input type="checkbox"/> Issue Date	
		<input type="checkbox"/> Save Age of _____	
		<input type="checkbox"/> Specific Date _____	

**3. RIDERS** *(Verify rider availability.)*

a. <input type="checkbox"/> Additional Insured Term Insurance* .....\$ _____	d. <input type="checkbox"/> Disability Income <sup>†</sup>
Additional Insured's Occupation .....	<input type="checkbox"/> Primary Insured <input type="checkbox"/> 1 Year <input type="checkbox"/> 2 Years \$ _____
Additional Insured's Annual Salary .....\$ _____	<input type="checkbox"/> Additional Insured <input type="checkbox"/> 1 Year <input type="checkbox"/> 2 Years \$ _____
b. <input type="checkbox"/> Children's Term* .....\$ _____	e. <input type="checkbox"/> Waiver of Premium <sup>‡</sup>
c. <input type="checkbox"/> Critical Illness Accelerated Benefit <sup>†,‡</sup> .....\$ _____	f. <input type="checkbox"/> Other _____

\*Complete section 4 of this application. <sup>†</sup>Supplemental application required. <sup>‡</sup>Critical Illness Accelerated Benefit and Waiver of Premium riders cannot be issued on the same policy.

**4. ADDITIONAL PROPOSED INSURED(S)** *(To include [FTD,] [FTD w/ROP,] [Additional Insured,] and [Children's Term] Rider.)*

Name of Other Proposed Insured <i>(Last, First, MI)</i>	Date of Birth <i>(MM/DD/YYYY)</i>	State of Birth	Sex	Height	Weight <i>(lbs.)</i>	Social Security Number	Relationship to Proposed Insured
			<input type="checkbox"/> M <input type="checkbox"/> F	' "			
			<input type="checkbox"/> M <input type="checkbox"/> F	' "			
			<input type="checkbox"/> M <input type="checkbox"/> F	' "			
			<input type="checkbox"/> M <input type="checkbox"/> F	' "			
			<input type="checkbox"/> M <input type="checkbox"/> F	' "			

**5. 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	Social Security Number or Taxpayer ID	Relationship	Date of Birth	% of Share <i>(Must total 100%)</i>
<input type="checkbox"/> Primary					
<input type="checkbox"/> Primary <input type="checkbox"/> Contingent					
<input type="checkbox"/> Primary <input type="checkbox"/> Contingent					

**6. LIFE INSURANCE IN FORCE AND REPLACEMENT INFORMATION**

Yes No

- a. Does any Proposed Insured have life insurance or annuity applications pending with other companies?  Yes  No
- b. Is there any existing life insurance or annuity coverage on the life of any Proposed Insured? (If Yes, provide information below.)  Yes  No
- c. Will the life insurance applied for replace or otherwise reduce in value any existing life insurance or annuities now in force?  Yes  No  
(If Yes, complete applicable replacement form(s) and submit with application. Application and replacement form(s) must be dated on the same date.)
- d. Is this an internal replacement? (If Yes, include a Surrender form or Absolute Assignment form for the life insurance or annuity being replaced.)  Yes  No
- e. If current life insurance or annuity is being replaced, indicate the amount of surrender charges that will be assessed. \$ \_\_\_\_\_

Insured's Name (Last, First, MI)	Company	Owner	Amount	Accidental Death Benefit	Policy Date (MM/DD/YYYY)

**7. OWNER INFORMATION (If different from the Proposed Insured.)**

a. Owner's Name (Last, First, MI)		b. Relationship to Proposed Insured	c. SSN or Taxpayer ID
d. Address (Include City, State, and ZIP. If mailing address is a PO Box, a street address is also required.)			
e. How long at current address? _____ If less than 5 years at current address, prior address is required.			
f. Home Phone	g. Work Phone	h. Date of Birth (MM/DD/YYYY)	i. Place of Birth (City, State, Country)

**8. PAYOR INFORMATION (If different from the Proposed Insured and Owner.)**

a. Payor's Name (Last, First, MI)		b. Relationship to Proposed Insured	c. SSN or Taxpayer ID
d. Address (Include City, State, and ZIP. If mailing address is a PO Box, a street address is also required.)			
e. How long at current address? _____ If less than 5 years at current address, prior address is required.			

**9. SPECIAL REQUESTS**

**PERSONAL HISTORY (Provide details of all "Yes" answers in the Personal History Details section below.)**

Proposed Insured  
Yes No  
Additional Proposed Insured  
Yes No

- 10. Has any Proposed Insured ever been declined, rated, or modified for life or health insurance?  Yes  No  Yes  No
- 11. Within the past two (2) years, has any Proposed Insured:
  - a. made any flights as a pilot, student pilot, or member of a flight crew? (If Yes, complete aviation questionnaire.)  Yes  No  Yes  No
  - b. engaged in the following hazardous sports: bungee or base jumping, parachuting, hang gliding; competitive skiing/snowboarding (such as heli-skiing or ski jumping); diving activities (such as scuba, cave diving, or underwater photography); canyoning, kayaking, or white water rafting; organized racing (such as automobiles, drag racers, or motorcycles); rock or mountain climbing, rodeo riding, or any other hazardous sport/activity? (If Yes, complete sports questionnaire.)  Yes  No  Yes  No
- 12. Within the past seven (7) years, has any Proposed Insured been convicted of, pleaded guilty to, or entered a plea of no contest to any felony?  Yes  No  Yes  No
- 13. Is any Proposed Insured currently on probation or been placed on probation within the last twelve (12) months?  Yes  No  Yes  No
- 14. Within the next two (2) years, does any Proposed Insured intend to work, travel, or reside outside of the United States for more than thirty (30) days? (If Yes, where? Provide details below.)  Yes  No  Yes  No
- 15. Within the past five (5) years, has any Proposed Insured:
  - a. pleaded guilty to or been convicted of three (3) or more moving violations?  Yes  No  Yes  No
  - b. had a driver's license suspended or revoked, or are you currently under license suspension or revocation?  Yes  No  Yes  No
  - c. been convicted of reckless driving or driving under the influence of alcohol or drugs?  Yes  No  Yes  No
- 16. Driver's License Number(s) during the past five (5) years:

Name of Proposed Insured(s) on Driver's License	Driver's License Number	State Issued

**PERSONAL HISTORY DETAILS**

Question #	Proposed Insured's Name	Dates	Details

**MEDICAL HISTORY** (Provide details of all "Yes" answers in the Medical History Details section below.)

17. a. Proposed Insured's Height ..... [ ] ' [ ] " b. Proposed Insured's Weight ..... [ ] lbs.

[NOTE: Questions 18-26 are NOT required when applying for Accidental Death Benefit Policy.]

18. Has any Proposed Insured used cigarettes, cigars, pipes, chewing tobacco, nicotine patches, snuff, nicotine chewing gum, or other products containing nicotine within the last twelve (12) months? ..... [ ] Yes [ ] No [ ] Additional Yes [ ] No

19. Within the past seven (7) years, has any Proposed Insured:
a. been treated for or been advised or diagnosed by a medical professional to seek treatment for the use of alcohol or prescription drugs? ..... [ ] Yes [ ] No [ ] Additional Yes [ ] No
b. been advised to reduce or discontinue the intake of alcohol or prescription drugs? ..... [ ] Yes [ ] No [ ] Additional Yes [ ] No
(If Yes, complete the alcohol usage and/or prescription medication and drug use questionnaire.)

20. Within the past seven (7) years, has any Proposed Insured used, except as prescribed by a physician: heroin, morphine, other narcotics, ecstasy, opium derivatives, marijuana, cocaine, crack, barbiturates, amphetamines, methamphetamines, hallucinogens, any other illegal, restricted or controlled substances, been treated for or been advised by a medical professional to seek treatment for the intake of any drug? (If Yes, complete the prescription medication and drug use questionnaire.) ..... [ ] Yes [ ] No [ ] Additional Yes [ ] No

21. Within the past five (5) years, has any Proposed Insured been diagnosed with or been advised to have or had treatment for:
a. hypertension, heart disease or disorder, valve disorders, angina, cardiac arrhythmia, heart surgery including bypass, angioplasty or stent placement, circulatory disorder, blood vessel or blood disorders? ..... [ ] Yes [ ] No [ ] Additional Yes [ ] No
b. lung or respiratory disorder, COPD, emphysema, current use of oxygen, shortness of breath, or sleep apnea? ..... [ ] Yes [ ] No [ ] Additional Yes [ ] No
c. cancer in any form? ..... [ ] Yes [ ] No [ ] Additional Yes [ ] No
d. diabetes or pancreatic disorders? ..... [ ] Yes [ ] No [ ] Additional Yes [ ] No
e. digestive disorder, kidney or liver disease to include hepatitis, Crohn's disease or ulcerative colitis, gastrointestinal bleeding, bladder disorders, or unexplained weight loss? ..... [ ] Yes [ ] No [ ] Additional Yes [ ] No
f. Alzheimer's disease, dementia, nervous system disorder, emotional or psychiatric disorder, paralysis, sexually transmitted disease, systemic lupus, any blood disorders, or birth defects? ..... [ ] Yes [ ] No [ ] Additional Yes [ ] No
g. rheumatoid arthritis, any disease or disorder of the bones or muscles? ..... [ ] Yes [ ] No [ ] Additional Yes [ ] No

22. Within the last five (5) years, has any Proposed Insured consulted a physician, had tests performed (such as an EKG, echocardiogram, X-ray, or blood tests) or been hospitalized or had surgery for any reason? ..... [ ] Yes [ ] No [ ] Additional Yes [ ] No

23. Has any Proposed Insured ever been diagnosed as having, been told by a medical professional that you have, or been treated by a medical professional for Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or any immune deficiency related disorder or tested positive for antibodies to the Human Immunodeficiency Virus (HIV)? ..... [ ] Yes [ ] No [ ] Additional Yes [ ] No

24. Within the last twelve (12) months, has any Proposed Insured had tests, surgery, treatment or hospitalization recommended but not completed? ..... [ ] Yes [ ] No [ ] Additional Yes [ ] No

25. Do any of the Proposed Insured(s):
a. currently use prescription medicines? (If Yes, list each medication and describe the reason for its use.) ..... [ ] Yes [ ] No [ ] Additional Yes [ ] No
b. currently have a personal physician? (If Yes, list name, address, and telephone number along with date, reason, and results of last consultation.) ..... [ ] Yes [ ] No [ ] Additional Yes [ ] No

**ANSWER QUESTION #26 BELOW ONLY IF ANY PROPOSED INSURED IS AGE 65 OR OLDER:**

26. Within the past five (5) years, has any Proposed Insured been diagnosed with or been advised to have or had treatment for: stroke, TIA, prostate disorders, any disease or disorders of the back or joints, memory loss, or taking any prescription medication for Alzheimer's disease or dementia? ..... [ ] Yes [ ] No [ ] Additional Yes [ ] No

**MEDICAL HISTORY DETAILS**

Please provide details of all "Yes" answers in the area below. (Attach a separate sheet if more space is needed; additional sheet MUST be signed and dated by applicable Proposed Insured/Owner to avoid amendments.)

Question #	Proposed Insured's Name	Date of Onset/Treatment	Details/Results	Name, Address, and Telephone Number of Attending Physician

**AUTHORIZATION AND ACKNOWLEDGMENT**

I/We authorize any insurance or reinsurance company, employer, licensed medical physician, medical professional, hospital, medical facility, pharmacy or pharmacy benefit manager, records custodians, other medical or medically related facility, clearing house, consumer reporting agency, and/or the Medical Information Bureau that has any record of information about me/us or my/our minor children who are to be insured, to give Americo Financial Life and Annuity Insurance Company (Americo), its reinsurers or its authorized representatives, information about other insurance coverage, employment, age, general character, motor vehicle records, habits, court records, foreign travel, finances, participation in hazardous activities, medical care or advice about any physical or mental condition, including information about drugs and alcoholism Americo requires to determine insurability if used for determining claims eligibility, no longer than the duration of the claim.

Americo may release information obtained by this Authorization to its reinsurers, to the Medical Information Bureau, to other insurers with whom I/we have life insurance 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 two (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.

**DC 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.

**TN 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 may include imprisonment, fines or denial of insurance benefits.

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. Notwithstanding the foregoing, if this application is not solicited face to face and/or is effected through any electronic means, any policy issued on this application will be deemed to be delivered in and governed by the laws of the jurisdiction of the Owner, and said jurisdiction will also be the "Signed at (City and State)" inserted below.

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 have read this application and 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 PERSONAL HISTORY QUESTIONS ON PAGE 2 AND TO MEDICAL HISTORY QUESTIONS ON PAGE 3 OF THIS APPLICATION, WHICH IS SIGNED AND DATED BELOW, ARE COMPLETE AND ACCURATE.**

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

\_\_\_\_\_  
Signature of Proposed Insured

\_\_\_\_\_  
Signature of Owner (If different from the Proposed Insured)

\_\_\_\_\_  
Signature of Additional Proposed Insured

\_\_\_\_\_  
Signature of Witnessing Agent (Required)