Filing at a Glance

Company: American Income Life Insurance Company

Product Name: Application
TOI: L08 Life - Other
Sub-TOI: L08.000 Life - Other
Filing Type: Form

SERFF Tr Num: AMLC-127817292
SERFF Status: Closed-Approved-Closed
Co Tr Num: AG-2649

Author: Angela Fincher
Date Submitted: 11/11/2011

State: Arkansas
State Tr Num: 50252

State Status: Approved-Closed
Reviewer(s): Linda Bird
Disposition Date: 11/16/2011
Disposition Status: Approved-Closed

Implementation Date Requested: On Approval
Implementation Date:
State Filing Description:

General Information

Project Name: AG-2649
Project Number: AG-2649
Requested Filing Mode: Review & Approval

Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:

Deemer Date:
Submitted By: Angela Fincher
Filing Description:
RE: AG-2649 - Bilingual Application
AG-2649C - Bilingual Application Addendum
AG-2592 - Bilingual Conditional Receipt

Status of Filing in Domicile: Pending
Date Approved in Domicile:
Domicile Status Comments: Submitted in Indiana, our state of domicile, as of 11/11/2011.
Market Type: Individual
Individual Market Type:
Filing Status Changed: 11/16/2011
State Status Changed: 11/16/2011
Created By: Angela Fincher
Corresponding Filing Tracking Number:

Enclosed are the above referenced forms, which are not intended to replace any previously approved forms. These forms are the bilingual (English/Spanish) versions of the following forms:

Bilingual Form	English Form	Approval Date	SERFF Tracking #
AG-2649	AG-2549	11/10/2008	AMLC-125892510

AG-2649C	AG-2549C	5/5/2009	AMLC-126119632
AG-2592	AG-2592	5/5/2009	AMLC-126119632

We are enclosing a certification from the Spanish translator that the translations of these forms are complete and accurate.

We wish to thank you for your cooperation in this matter, and trust you will find this filing acceptable for approval. Please contact me if you have any questions.

Company and Contact

Filing Contact Information

Angela Fincher, Senior Compliance Specialist afincher@ailife.com
PO Box 2608 254-761-6761 [Phone]
Waco, TX 76797 254-741-5723 [FAX]

Filing Company Information

American Income Life Insurance Company	CoCode: 60577	State of Domicile: Indiana
P.O. Box 2608	Group Code: 290	Company Type: Life and Health
Waco, TX 76797	Group Name: Liberty National	State ID Number: 498
(254) 761-6761 ext. [Phone]	FEIN Number: 74-1365936	

Filing Fees

Fee Required?	Yes
Fee Amount:	$150.00
Retaliatory?	No
Fee Explanation:	$50/application form * 3
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American Income Life Insurance Company	$150.00	11/11/2011	53694190

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	11/16/2011	11/16/2011

Disposition

Disposition Date: 11/16/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AMLC-127817292*	*State:*	*Arkansas*
Filing Company:	*American Income Life Insurance Company*	*State Tracking Number:*	*50252*
Company Tracking Number:	*AG-2649*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Application*		
Project Name/Number:	*AG-2649/AG-2649*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Spanish Translator Certification		Yes
Form	Application		Yes
Form	Application Addendum		Yes
Form	Conditional Receipt		Yes
Form	Bilingual Application		Yes
Form	Bilingual Application Addendum		Yes
Form	Bilingual Conditional Receipt		Yes

Form Schedule

Lead Form Number: AG-2649

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	AG-2549B-3	Application/ Enrollment Form	Application	Initial		45.500	AG-2549B-3.pdf
	AG-2549C	Application/ Enrollment Form	Application Addendum	Initial		45.500	AG-2549C.pdf
	AG-2592	Application/ Enrollment Form	Conditional Receipt	Initial		45.500	AG-2592.pdf
	AG-2649	Application/ Enrollment Form	Bilingual Application	Initial		46.000	AG-2649.pdf
	AG-2649C	Application/ Enrollment Form	Bilingual Application Addendum	Initial		0.000	AG-2649C.pdf
	AG-2692	Application/ Enrollment Form	Bilingual Conditional Receipt	Initial		0.000	AG-2692.pdf

Application to AMERICAN INCOME LIFE INSURANCE COMPANY _____
P.O. Box 2608 Waco, TX 76797

Affiliation

_____ ID No.

*Complete shaded areas for spouse coverage.

☐ UN ☐ CU ☐ Assoc ☐ V-PRIV ☐ SR ☐ Lics Prof
☐ GL ☐ POS ☐ Ref ☐ F-CHSF ☐ DC ☐ _____

1. Names of Proposed Insureds	I Saw	D.O.B.	Age	Birthplace	Ht	Wt	Sex	NTU	2. SS#
A Adult									— —
B *Spouse									* — —
C1 Child									3. Driver's License# & State ★
C2 Child									
C3 Child									*

4. Person to be Owner of Policy ☐ Proposed Insured A
☐ Other, name and relationship

5. Occupation/Duties
*

6. Employer's Name
*

7. Address of Owner of Policy

8. Phone#( ) -
Cell# ( ) -

9. E-mail Address _____ @ _____

10. **Complete B, C1, C2 & C3 ONLY if applying for separate life policies.**

	Primary Beneficiary	Relationship to Insured	Contingent Beneficiary	Relationship to Insured
A				
B				
C1				
C2				
C3				

11. Is any insurance applied for intended to replace or change any insurance or annuities in this or any other company? ☐ Yes ☐ No

12. Amount of insurance on each proposed Insured

Type	Company	Benefit
*		

13. Is proposed Insured a U.S. citizen? ☐ Yes ☐ No

14. Do you wish the Automatic Premium Loan Provision on your life policy/policies? ☐ Yes ☐ No

Life Insurance - Complete B, C1, C2 & C3 ONLY if applying for separate Life policies.

Proposed Insured	A	B	C
Base Plan	☐ WL ☐ PR ☐ EX ☐ SL ☐ LPU65 ☐ _____	☐ WL ☐ PR ☐ EX ☐ SL ☐ LPU65 ☐ _____	
Face Amount	$_____	$_____	
Premium	$_____.___	$_____.___	
Riders and Benefits	☐TIR	☐TIR	
☐10 R&C	$_____ $_____.___	☐$_____ $_____.___	
☐ADB	$_____ $_____.___	☐$_____ $_____.___	
☐B2000	$_____.___	☐B2000 $_____.___	
☐WP (base & riders)	$_____.___	☐WP $_____.___	
☐CIR	$_____.___	☐CIR $_____.___	
☐Spouse	$_____ $_____.___	Other Riders or Benefits	
☐Child	$_____ $_____.___	☐ _____	
☐_____	$_____ $_____.___	$_____ $_____.___	
☐_____	$_____ $_____.___	☐ _____	
☐_____	$_____ $_____.___	$_____ $_____.___	
Life Ins. Premium A	$_____.___	**Premium B**	$_____.___

C1 (under 18)	Benefits	Face Amount	Premium
☐ WL ☐ PR ☐ LPU65	☐ADB	$_____	$_____.___
☐ _____	☐B2000		$_____.___
Face Amount Premium	☐GIO	$_____	$_____.___
$_____ $_____.___	☐TIR	**Premium C1**	$_____.___

C2 (under 18)	Benefits	Face Amount	Premium
☐ WL ☐ PR ☐ LPU65	☐ADB	$_____	$_____.___
☐ _____	☐B2000		$_____.___
Face Amount Premium	☐GIO	$_____	$_____.___
$_____ $_____.___	☐TIR	**Premium C2**	$_____.___

C3 (under 18)	Benefits	Face Amount	Premium
☐ WL ☐ PR ☐ LPU65	☐ADB	$_____	$_____.___
☐ _____	☐B2000		$_____.___
Face Amount Premium	☐GIO	$_____	$_____.___
$_____ $_____.___	☐TIR	**Premium C3**	$_____.___

Accident Ins. Policy (A B C)
☐A71 $_____ Benefit
☐ Individual ☐ Family
☐ Optional Recup. Rider
☐ Single ☐ Double
Premium $_____.___
Policy Fee $_____.___
A71 Prem. $_____.___

Cancer Ins. Policy (A B C)
☐ CNM ☐ Ind. ☐ Fam.
$_____ Benefit
$_____.___ Premium
$_____.___ Policy Fee
$_____.___ **CNM/C20 Prem. $**_____.___

(A B C)
☐ C20 ☐ Ind. ☐ Fam.
$_____ Benefit
$_____.___ Premium
$_____.___ Policy Fee

Hospital Indemnity Ins. Policy (A B C)
☐ H34 $_____ Benefit
☐ Optional Recup. Rider
Adult $_____.___
Spouse $_____.___
Child X _____ $_____.___
(# of children)
Policy Fee $_____.___
H34 Prem. $_____.___

Proposed Insureds
◀Circle all that apply

Mode Premium
☐A ☐MBD
☐SS ☐_____

Total Paid with application
$_____.___

Critical Illness Ins. Policy (A B)
☐ CI
$ _____ Benefit
Adult $_____.___
Spouse $_____.___
Policy Fee $_____.___
CI Prem. $_____.___

15. I have received an outline of coverage?
☐ A71 ☐ CNM ☐ C20 ☐ H34 ☐ CI

16. Does proposed Insured have a Medicaid Eligibility Card or otherwise eligible for benefits under Medicaid (Title XIX)? ☐ Yes ☐ No

17. Age 65 and Older Only - I have received the Important Notice to Persons on Medicare - This Insurance Duplicates Some Medicare Benefits. ☐ Yes ☐ No

PLACE ORAL SPECIMEN STICKER HERE

PLACE ORAL SPECIMEN STICKER HERE

AUTHORIZATION FOR PREAUTHORIZED PAYMENTS

American Income Life Insurance Company is authorized to initiate debit entries to the account indicated below, and the depository institution named below is authorized to debit the same to such account. This authority can be terminated by the undersigned at any time by written notification to the Company, provided only that the Company and the depository will have a reasonable opportunity to act on such notification.

Depository Name _____ City _____ State _____

Transit/ABA No. _____ Account No. _____ Type of Account: ☐ Checking ☐ Savings

X _____ Date _____ Requested draw date, if any: _____
Signature of Payor

PLEASE ATTACH A VOIDED PERSONAL CHECK

PLACE AN 'X' IN THE BOX WITH THE CORRECT ANSWER

ANSWER ALL QUESTIONS IF APPLYING FOR LIFE, HOSPITAL INDEMNITY OR CRITICAL ILLNESS POLICY

ANSWER **ONLY SECTION "A"** IF APPLYING ONLY FOR **ACCIDENT** POLICY

ANSWER **ONLY SECTION "B"** IF APPLYING ONLY FOR **CANCER** POLICY

SECTION A

18. Has any proposed Insured ever been treated or advised to be treated for alcoholism or alcohol abuse, including membership in A.A. or been advised by a physician to reduce alcohol consumption? ☐Yes ☐ No
19. Has any proposed Insured ever used drugs not prescribed by a physician, such as cocaine, amphetamines, barbiturates, hallucinogens, tranquilizers, narcotics or sedatives? ☐Yes ☐ No
20. Has any proposed Insured ever had their driver's license suspended or revoked because of a moving violation or been arrested (including arrests for driving while intoxicated or under the influence)? ☐Yes ☐ No
21. Has any proposed Insured flown within the last 2 years, or intend to fly in the future, as other than a passenger on a scheduled airline? ☐Yes ☐ No
22. Has any proposed Insured participated within the last 2 years, or intend to participate, in any of the following activities: Auto, Motorcycle, or Boat Racing; Parachute Jumping; Skin, Scuba, or Sky Diving? ☐Yes ☐ No
23. Has any proposed Insured ever been advised to take tests and not done so or not received the results, been diagnosed as having, or received treatment for high blood pressure, chest pain, heart attack, stroke or any heart, blood or circulatory disorder (excluding information regarding HIV)? ☐Yes ☐ No
24. Has any proposed Insured ever had or been treated for any of the following conditions:
    a. Diabetes or other endocrine disorder? ☐Yes ☐ No
    b. Paralysis, epilepsy, mental disease or disorder or any other nervous system or brain disorder? ☐Yes ☐ No
25. Has any proposed Insured ever had arthritis or any injury to or trouble with your back, knees or any of your joints? ☐Yes ☐ No
26. To the best of your knowledge and belief, do you have any physical impairment or departure from good health? (give details) ☐Yes ☐ No

SECTION B

27. Has any proposed Insured ever been advised to take tests and not done so or not received the results, been diagnosed as having, or received treatment for cancer, tumor or unexplained masses? ☐Yes ☐ No
28. Has any proposed Insured ever been rejected for life or medical-hospital insurance, rated, or failed to receive a policy as applied for? ☐Yes ☐No
29. Has any proposed Insured in the last 5 years:
    a. Had a physical examination? ☐Yes ☐No
    b. Had any medical treatment? (includes prescription medications) ☐Yes ☐No
    c. Been hospitalized? ☐Yes ☐No
30. Is any proposed Insured currently a resident in a nursing home or ever been diagnosed as having a terminal illness, including Alzheimer's disease? ☐Yes ☐No
31. Has any proposed Insured ever had or been treated for any of the following conditions:
    a. Asthma, emphysema, sleep apnea or other respiratory disorder? ☐Yes ☐No
    b. Ulcer, colitis or other digestive tract disorder? ☐Yes ☐No
    c. Cirrhosis, hepatitis or other liver disorder or any blood disorder **(except for HIV)** or received a bone marrow transplant? ☐Yes ☐No
    d. Kidney, prostate, urinary bladder or other genitourinary disorder? ☐Yes ☐No
    e. Disease of the breasts, uterus or ovaries? ☐Yes ☐No
    f. Rheumatoid arthritis or any other musculoskeletal disorder? ☐Yes ☐No
    g. Loss of hearing or loss of sight? ☐Yes ☐No
    h. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or AIDS related conditions? ☐Yes ☐No
32. Has any proposed Insured ever tested positive for antibodies to the "AIDS" (HIV) virus? ☐Yes ☐No
33. Does any proposed Insured smoke cigarettes or use tobacco in any other form? ☐Yes ☐No
34. If a former user of tobacco, when did proposed Insured quit?
    Name/Date _____
    Name/Date _____
35. Has any proposed Insured used marijuana in the past year? ☐Yes ☐No

If questions are answered "yes", give explanations, dates, names & addresses of physicians & hospital (if any) below.

Proposed Insured	Explanation or Medication	Date	Hospital	How Long	Physician	Address
			☐Yes ☐No			
			☐Yes ☐No			

Name, Address, and Phone Number of Personal Physician	Date Last Seen	Medical Records ID#
( ) -		
* ( ) -	*	*

The proposed Insureds ☐do ☐do not have existing individual life insurance policies or annuity contracts. (This does not include group coverage.)

Any person who knowingly and with intent to injure, defraud or deceive any insurer, submits an application or files a claim containing any false, incomplete, or misleading information may be guilty of insurance fraud, as determined by a court of law.

I agree that no insurance shall be in effect until: (a) a policy has been issued; and (b) the first premium is paid while my insurability remains unchanged and then only if I am actually in the state of health represented in this application. I state that the answers set forth above, are full, complete and true to the best of my knowledge and belief. The answers are to be the basis of any insurance issued. No agent may bind, alter, change or waive any underwriting requirements or other provisions of the application or policy. Final application acceptance is made by the Underwriting Department of the Company. I also acknowledge that I have received the Investigative Consumer Reports notification and MIB Notice and authorize obtaining medical or investigative consumer reporting information, including MIB, in order to evaluate my application for insurance. American Income Life may also request or obtain additional information to establish or verify my identity. I further acknowledge that American Income Life may report information to MIB or to other insurers which I have or may apply.

X _____ Date _____ at _____

Proposed Insured (if 18 or over) City State

X _____ * _____

Signature of Owner (if other than proposed Insured) Signature of Spouse (if a proposed Insured) Signature of Agent

AGENT'S STATEMENT

I certify that I have asked all questions and truly and accurately recorded the information supplied by the Applicant. To the best of my knowledge and belief, the insurance applied for ☐is ☐ is not intended to replace, discontinue or change an existing policy or contract.

Agent L. Name (5 ltrs) Agent# Signature of Agent

REMARKS OR INSTRUCTIONS

_____ Best time to call _____

★ Driver's License # for children age 16 + — For separate life policies ONLY:

Mail Policy To: ☐ Agency ☐ Policyholder

AMERICAN INCOME LIFE INSURANCE COMPANY
P.O. Box 2608 Waco, TX 76797

Application Addendum
Additional Proposed Insured Children

1. Names of Proposed Insureds		I Saw	D.O.B.	Age	Birthplace	Ht	Wt	Sex
C4	Child							
C5	Child							
C6	Child							
C7	Child							
C8	Child							
C9	Child							

10.	Primary Beneficiary	Relationship to Insured	Contingent Beneficiary	Relationship to Insured
C4	_____	_____	_____	_____
C5	_____	_____	_____	_____
C6	_____	_____	_____	_____
C7	_____	_____	_____	_____
C8	_____	_____	_____	_____
C9	_____	_____	_____	_____

C4 (under 18)	Benefits	Face Amount	Premium
☐ WL ☐ PR ☐ LPU65	☐ ADB	$_____	$_____.___
☐ _____	☐ B2000		$_____.___
Face Amount Premium	☐ GIO	$_____	$_____.___
$_____ $_____.___	☐ TIR	**Premium C4**	**$_____.___**

C5 (under 18)	Benefits	Face Amount	Premium
☐ WL ☐ PR ☐ LPU65	☐ ADB	$_____	$_____.___
☐ _____	☐ B2000		$_____.___
Face Amount Premium	☐ GIO	$_____	$_____.___
$_____ $_____.___	☐ TIR	**Premium C5**	**$_____.___**

C6 (under 18)	Benefits	Face Amount	Premium
☐ WL ☐ PR ☐ LPU65	☐ ADB	$_____	$_____.___
☐ _____	☐ B2000		$_____.___
Face Amount Premium	☐ GIO	$_____	$_____.___
$_____ $_____.___	☐ TIR	**Premium C6**	**$_____.___**

C7 (under 18)	Benefits	Face Amount	Premium
☐ WL ☐ PR ☐ LPU65	☐ ADB	$_____	$_____.___
☐ _____	☐ B2000		$_____.___
Face Amount Premium	☐ GIO	$_____	$_____.___
$_____ $_____.___	☐ TIR	**Premium C7**	**$_____.___**

C8 (under 18)	Benefits	Face Amount	Premium
☐ WL ☐ PR ☐ LPU65	☐ ADB	$_____	$_____.___
☐ _____	☐ B2000		$_____.___
Face Amount Premium	☐ GIO	$_____	$_____.___
$_____ $_____.___	☐ TIR	**Premium C8**	**$_____.___**

C9 (under 18)	Benefits	Face Amount	Premium
☐ WL ☐ PR ☐ LPU65	☐ ADB	$_____	$_____.___
☐ _____	☐ B2000		$_____.___
Face Amount Premium	☐ GIO	$_____	$_____.___
$_____ $_____.___	☐ TIR	**Premium C9**	**$_____.___**

AMERICAN INCOME LIFE INSURANCE COMPANY

P.O. Box 2608 Waco, Tx 76797

CONDITIONAL RECEIPT

NO COVERAGE WILL BECOME EFFECTIVE PRIOR TO POLICY DELIVERY UNLESS AND UNTIL ALL CONDITIONS OF THIS RECEIPT ARE MET. NO AGENT HAS THE AUTHORITY TO ALTER THE TERMS OR CONDITIONS OF THIS RECEIPT.

Received of_____ the sum of $_____ as first payment on this application.

Date _____ Agent_____

If (1) an amount equal to the first full premium is submitted; (2) all underwriting requirements, including any medical examinations required by the Company's rules, are completed; (3) the proposed insured is on the effective date indicated a risk acceptable for insurance exactly as applied for without modification of plan, premium rate, or amount under the Company's rules and practices, then insurance under the policy applied for shall become effective on the latest of (a) the date of application, (b) the date of completion of all underwriting requirements, and (c) any date of issue requested in the application.

THE AMOUNT OF INSURANCE WHICH MAY BECOME EFFECTIVE PRIOR TO POLICY DELIVERY SHALL NOT EXCEED $50,000.

If any of the above conditions are not met, the liability of the Company shall be limited to the return of the amount submitted.

"ALL CHECKS MUST BE MADE PAYABLE TO THE COMPANY: DO NOT MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK."

INVESTIGATIVE CONSUMER REPORTS NOTIFICATION

As part of our routine underwriting procedure, an investigative consumer report may be obtained which will provide applicable information concerning character, general reputation, personal characteristics, and mode of living. This information will be obtained through consumer reporting agencies, the Department of Motor Vehicles, and personal interviews with your friends, neighbors, and associates. You may request to be interviewed in connection with the preparation of the report and upon request may receive a copy of the report.

MIB NOTICE

Information regarding your insurability will be treated as confidential. American Income Life Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

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

American Income Life Insurance Company may also release information from its file to its reinsurers or to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

NOTICE OF INFORMATION PRACTICES

Personal information may be collected from other parties. Such information, and other personal or privileged information later collected, may be disclosed to third parties without authorization. You have the right of access and correction with respect to all personal information collected, and a full notice of your rights will be furnished upon request.

ID No./*Núm. de ID* _____ Application to/*Solicitud remitida a* AMERICAN INCOME LIFE INSURANCE COMPANY _____ Affiliation/*Afiliación*

P.O. Box 2608 Waco, TX 76797

*Complete shaded areas for spouse coverage. *Llene las áreas sombreadas para la cobertura para cónyuges.*

☐ UN ☐ CU ☐ Assoc ☐ V-PRIV ☐ SR ☐ Lics Prof
☐ GL ☐ POS ☐ Ref ☐ F-CHSF ☐ DC ☐ _____

1. Names of Proposed Insureds *Nombres de los Asegurados Propuestos*	I Saw Lo entrevisté personalmente	D.O.B. *F. de N.*	Age *Edad*	Birthplace *Lugar de Nac.*	HT *Estatura*	WT *Peso*	Sex *Sexo*	NTU *NTU*	2. SS# *#Seg. Soc.*
A Adult/Adulto									— —
B *Spouse/Cónyuge									* — —
C1 Child/Hijo									3. Driver's License# & State ★ *Núm Licencia de Conductor y Estado*
C2 Child/Hijo									
C3 Child/Hijo									*

4. Person to be Owner of Policy *Persona que será el Dueño de la Póliza* ☐ Proposed Insured A *Asegurado Propuesto A* ☐ Other, name and relationship/*Otro, nombre y vínculo*

5. Occupation/Duties *Ocupación/Responsabilidades* *

6. Employer's Name *Nombre del Empleador* *

7. Address of Owner of Policy/*Domicilio del Dueño de la Póliza*

8. Phone#( ) - *Teléfono*
Cell# ( ) - *Celular*

9. E-mail Address/*Correo electrónico* _____ @ _____

10. **Complete B, C1, C2 & C3 ONLY if applying for separate life policies.**
Llene B, C1, C2 y C3 SÓLO si se solicitaran pólizas de seguro de vida por separado.

	Primary Beneficiary *Beneficiario Primario*	Relationship to Insured *Vínculo con el Asegurado*	Contingent Beneficiary *Beneficiario Contingente*	Relationship to Insured *Vínculo con el Asegurado*
A				
B				
C1				
C2				
C3				

11. Is any insurance applied for intended to replace or change any insurance or annuities in this or any other company? ☐ Sí ☐ No
¿Pretende utilizar el seguro solicitado para reemplazar o cambiar algún seguro o contrato de anualidad proveniente de ésta o cualquier otra compañía?

12. Amount of insurance on each proposed Insured *Cantidad de Seguro para cada Asegurado Propuesto*

Type *Tipo*	Company *Compañía*	Benefit *Beneficio*
*		

13. Is proposed Insured a U.S. citizen? ☐ Sí ☐ No
¿Es el Asegurado propuesto ciudadano de los EUA?

14. Do you wish the Automatic Premium Loan Provision on your life policy/policies? ☐ Sí ☐ No
¿Desea la Disposición de Préstamo Automático para el Pago de las Primas correspondientes a la(s) póliza(s) de su seguro de vida?

AUTHORIZATION FOR PREAUTHORIZED PAYMENTS
AUTORIZACIÓN PARA PAGOS PREAUTORIZADOS

American Income Life Insurance Company is authorized to initiate debit entries to the account indicated below, and the depository institution named below is authorized to debit the same to such account. This authority can be terminated by the undersigned at any time by written notification to the Company, provided only that the Company and the depository will have a reasonable opportunity to act on such notification.

American Income Life Insurance Company está autorizada para iniciar el registro de débitos contra la cuenta indicada a continuación. Asimismo, la institución depositaria nombrada a continuación está autorizada para efectuar los débitos mencionados contra dicha cuenta. Esta autorización podrá ser anulada por el suscrito en cualquier momento mediante una notificación remitida en forma escrita a la Compañía, siempre y cuando la Compañía y la entidad despositaria puedan, oportunamente, tomar acción sobre dicha notificación.

Depository Name _____ City _____ State _____
Nombre de la Entidad Depositaria *Ciudad* *Estado*

Transit/ABA No. _____ Account No. _____ Type of Account: ☐ Checking ☐ Savings
Núm de. Transferencia/Núm. ABA *Núm. de Cuenta* *Tipo de Cuenta:* *Cheques* *Ahorros*

X _____ Date _____ Requested draw date, if any: _____
Signature of Payor *Fecha* *Fecha solicitada para los retiros, si deseara alguna:*
Firma del Pagador

PLEASE ATTACH A VOIDED PERSONAL CHECK
FAVOR DE ACOMPAÑAR UN CHEQUE PERSONAL ANULADO, CON LA PALABRA "VOID".

Life Insurance - Complete B, C1, C2 & C3 ONLY if applying for separate Life policies.

Seguro de Vida - Llene B, C1, C2 y C3 SÓLO si se solicitaran Pólizas de Seguro de Vida por separado.

Proposed Insured *Asegurado Propuesto*	A	B	C
Base Plan *Plan Básico*	☐ WL ☐ PR ☐ EX ☐ SL ☐ LPU65 ☐ _____		
Face Amount *Cantidad Nominal* / Premium *Prima*	$ _____ $ _____.___		
Riders and Benefits *Aditamentos y Beneficios*	☐TIR		
☐10 R&C	$ _____ $ _____.___		
☐ADB	$ _____ $ _____.___		
☐B2000	$ _____.___		
☐WP (base & riders) *(básico y aditamentos)*	$ _____.___		
☐CIR	$ _____.___		
☐Spouse *Cónyuge*	$ _____ $ _____.___		
☐Child *Hijo*	$ _____ $ _____.___		
☐ _____	$ _____ $ _____.___		
☐ _____	$ _____ $ _____.___		
☐ _____	$ _____ $ _____.___		
Life Ins. Premium A *Seg. Vida - Prima A*	$ _____.___		

B
☐ WL ☐ PR ☐ EX ☐ SL ☐ LPU65 ☐ _____
Face Amount *Cantidad Nominal* / Premium *Prima*
$ _____ $ _____.___
☐TIR
☐$ _____ $ _____.___
☐$ _____ $ _____.___
☐WP $ _____.___
Other Riders or Benefits *Otros Aditamentos o Beneficios*
☐ _____
$ _____ $ _____.___
☐ _____
$ _____ $ _____.___
☐ _____
$ _____ $ _____.___
Premium B *Prima B* $ _____.___

C1 (under 18) *C1 (menor de 18)*	Benefits *Beneficios*	Face Amount *Cantidad Nominal*	Premium *Prima*
☐ WL ☐ PR ☐ LPU65 ☐ _____	☐ADB	$ _____	$ _____.___
	☐B2000		$ _____.___
Face Amount *Cantidad Nominal* / Premium *Prima*	☐GIO	$ _____	$ _____.___
_____ $ _____.___	☐TIR	**Premium C1** *Prima C1*	$ _____.___

C2 (under 18) *C2 (menor de 18)*	Benefits *Beneficios*	Face Amount *Cantidad Nominal*	Premium *Prima*
☐ WL ☐ PR ☐ LPU65 ☐ _____	☐ADB	$ _____	$ _____.___
	☐B2000		$ _____.___
Face Amount *Cantidad Nominal* / Premium *Prima*	☐GIO	$ _____	$ _____.___
_____ $ _____.___	☐TIR	**Premium C2** *Prima C2*	$ _____.___

C3 (under 18) *C3 (menor de 18)*	Benefits *Beneficios*	Face Amount *Cantidad Nominal*	Premium *Prima*
☐ WL ☐ PR ☐ LPU65 ☐ _____	☐ADB	$ _____	$ _____.___
	☐B2000		$ _____.___
Face Amount *Cantidad Nominal* / Premium *Prima*	☐GIO	$ _____	$ _____.___
_____ $ _____.___	☐TIR	**Premium C3** *Prima C3*	$ _____.___

Accident Ins. Policy *Póliza Seg. Accidental*

A B C

☐A71 $ _____ Benefit *Beneficio*

☐ Individual *Individual* ☐ Family *Familiar*

☐Optional Recup. Rider *Aditamento Opcional de Recup.*

☐ Single *Uno Solo* ☐ Double *Doble*

Premium $ _____.___ *Prima*

Policy Fee $ _____.___ *Cargo por la Póliza*

A71 Prem. $ _____.___ *Prima A71*

Cancer Ins. Policy *Póliza Seg. Cáncer*

A B C	A B C
☐CNM	☐C20
☐Ind. ☐Fam.	☐Ind. ☐Fam.
$ _____ Benefit *Beneficio*	$ _____
$ _____.___ Premium *Prima*	$ _____.___
$ _____.___ Policy Fee *Cargo por la Póliza*	$ _____.___
$ _____.___ **CNM/C20 Prem.** *Prima CNM/C20*	$ _____.___

Hospital Indemnity Ins. Policy *Póliza Seg. de Indem. Hospitalización*

A B C

☐H34 $ _____ Benefit/*Beneficio*

☐Optional Recup. Rider *Aditamento Opcional de Recup.*

Adult/*Adulto* $ _____.___

Spouse/*Cónyuge* $ _____.___

Child X _____ (# of children) *Hijo X _____ (# de hijos)* $ _____.___

Policy Fee *Cargo por la Póliza* $ _____.___

H34 Prem. *Prima H34* $ _____.___

Proposed Insureds *Asegurados Propuestos*

◀Circle all that apply *Circule todo lo que aplique*

Mode Premium *Prima Modal*

☐A ☐MBD

☐SS ☐ _____

Total Paid with application *Cantidad total remitida con solicitud*

$ _____.___

Critical Illness Ins. Policy *Póliza Seg. Enfermedad Grave*

A B

☐ CI

$ _____ Benefit *Beneficio*

Adult/*Adulto* $ _____.___

Spouse *Cónyuge* $ _____.___

Policy Fee *Cargo por la Póliza* $ _____.___

CI Prem. *Prima CI* $ _____.___

15. I have received an outline of coverage?
¿He recibido una sinopsis de la cobertura?
☐ A71 ☐ CNM ☐ C20 ☐ H34 ☐ CI

16. Does proposed Insured have a Medicaid Eligibility Card or otherwise eligible for benefits under Medicaid (Title XIX)? ☐ Sí ☐ No
¿Cuenta el Asegurado con una Tarjeta de Elegibilidad para Medicaid o reúne los requisitos para los beneficios de Médicaid (Título XIX)?

17. Age 65 and Older Only - I have received the Important Notice to Persons on Medicare - This Insurance Duplicates Some Medicare Benefits. ☐ Sí ☐ No
Sólo para las edades de 65 y mayor - He recibido la Notificación Importante para las Personas bajo Medicare - Este seguro duplica algunos de los beneficios de Medicare.

PLACE ORAL SPECIMEN STICKER HERE
COLOQUE AQUÍ LA ETIQUETA PARA MUESTRAS BUCALES

PLACE ORAL SPECIMEN STICKER HERE
COLOQUE AQUÍ LA ETIQUETA PARA MUESTRAS BUCALES

PLACE AN 'X' IN THE BOX WITH THE CORRECT ANSWER
CON UNA "X" MARQUE LA CASILLA CORRESPONDIENTE A LA RESPUESTA CORRECTA.

ANSWER ALL QUESTIONS IF APPLYING FOR LIFE, HOSPITAL INDEMNITY OR CRITICAL ILLNESS POLICY
CONTESTE TODAS LAS PREGUNTAS SI SE SOLICITA UNA PÓLIZA DE SEGURO DE VIDA, DE INDEMNIZACIÓN POR HOSPITALICACIÓN O DE ENFERMEDAD GRAVE

ANSWER **ONLY SECTION "A"** IF APPLYING ONLY FOR **ACCIDENT** POLICY
*CONTESTE **SOLAMENTE LA SECCIÓN "A"** SI SE SOLICITA ÚNICAMENTE UNA PÓLIZA DE SEGURO CONTRA **ACCIDENTES***

ANSWER **ONLY SECTION "B"** IF APPLYING ONLY FOR **CANCER** POLICY
*CONTESTE **SOLAMENTE LA SECCIÓN "B"** SI SE SOLICITA ÚNICAMENTE UNA PÓLIZA DE SEGURO CONTRA **CÁNCER***

SECTION A/ *SECCIÓN A*

18. Has any proposed Insured ever been treated or advised to be treated for alcoholism or alcohol abuse, including membership in A.A. or been advised by a physician to reduce alcohol consumption? ☐ Sí ☐ No
En alguna ocasión, alguno de los Asegurados propuestos ¿ha sido tratado o se le ha recomendado que se someta a tratamiento por concepto de alcoholismo o abuso de alcohol, incluyendo afiliación con la A.A. o le ha recomendado un médico que reduzca el consumo de alcohol?

19. Has any proposed Insured ever used drugs not prescribed by a physician, such as cocaine, amphetamines, barbiturates, hallucinogens, tranquilizers, narcotics or sedatives? ☐ Sí ☐ No
En alguna ocasión, algún Asegurado propuesto ¿ha consumido drogas que no hayan sido recetadas por un médico, tales como cocaína, anfetaminas, barbitúricos, alucinógenos, tranquilizantes, narcóticos o sedantes?

20. Has any proposed Insured ever had their driver's license suspended or revoked because of a moving violation or been arrested (including arrests for driving while intoxicated or under the influence)? ☐ Sí ☐ No
En alguna ocasión, a algún Asegurado propuesto ¿se le ha suspendido o revocado su licencia de conductor debido a una violación por automóvil en movimiento o ha sido arrestado (incluso por manejar mientras se encontraba intoxicado o bajo la influencia)?

21. Has any proposed Insured flown within the last 2 years, or intend to fly in the future, as other than a passenger on a scheduled airline? ☐ Sí ☐ No
Algún Asegurado propuesto, ¿ha volado durante los últimos 2 años o pretende volar en el futuro, salvo como pasajero que paga pasaje en una línea aérea comercial de servicio programado?

22. Has any proposed Insured participated within the last 2 years, or intend to participate, in any of the following activities: Auto, Motorcycle, or Boat Racing; Parachute Jumping; Skin, Scuba, or Sky Diving? ☐ Sí ☐ No
Algún Asegurado propuesto, ¿ha participado durante los últimos 2 años, o prentende participar en alguna de las siguientes actividades? Carreras de automóviles, motocicletas o lanchas; paracaidismo; buceo, con o sin scuba; o sky diving

23. Has any proposed Insured ever been advised to take tests and not done so or not received the results, been diagnosed as having, or received treatment for high blood pressure, chest pain, heart attack, stroke or any heart, blood or circulatory disorder? ☐ Sí ☐ No
En alguna ocasión, a algún Asegurado propuesto ¿se le ha recomendado que se someta a pruebas que no han sido practicadas o que aún no ha recibido resultados, ha sido diagnosticado o recibido tratamiento por concepto de presión sanguínea alta, dolor de pecho, ataque al corazón, derrame cerebral, o algún trastorno del corazón, la sangre o del sistema circulatorio?

24. Has any proposed Insured ever had or been treated for any of the following conditions:
En alguna ocasión, algún Asegurado propuesto ¿ha padecido de o ha sido tratado por concepto de alguna de las siguientes condiciones?
   a. Diabetes or other endocrine disorder? ☐ Sí ☐ No
   Diabetes o algún otro trastorno endocrino
   b. Paralysis, epilepsy, mental disease or disorder or any other nervous system or brain disorder? ☐ Sí ☐ No
   Parálisis, epilepsia, enfermedad o trastorno mental o algún otro trastorno del sistema nervioso o del cerebro

25. Has any proposed Insured ever had arthritis or any injury to or trouble with your back, knees or any of your joints? ☐ Sí ☐ No
En alguna ocasión, algún Asegurado propuesto ¿ha padecido de artritis o alguna lesión de o problemas con su espalda, rodillas o alguna de sus articulaciones?

26. To the best of your knowledge and belief, do you have any physical impairment or departure from good health? (give details) ☐ Sí ☐ No
Basado en su mejor saber y entender, ¿padece de algún impedimento físico o se encuentra en mal estado de salud? (explique detalladamente)

SECTION B/*SECCIÓN B*

27. Has any proposed Insured ever been advised to take tests and not done so or not received the results, been diagnosed as having, or received treatment for cancer, tumor or unexplained masses? ☐ Sí ☐ No
En alguna ocasión, a algún Asegurado propuesto ¿se le ha recomendado que se someta a pruebas que no han sido practicadas o que aún no ha recibido resultados, ha sido diagnosticado o recibido tratamiento por concepto de cáncer, tumores o nódulos inexplicados?

28. Has any proposed Insured ever been rejected for life or medical-hospital insurance, rated, or failed to receive a policy as applied for? ☐ Sí ☐ No
En algún momento, a algún Asegurado propuesto ¿se le ha rechazado alguna solicitud para seguro de vida o de hospitalización médica, se le ha emitido dicho seguro con tarifa ajustada o se le ha rechazado la emisión de una póliza en la forma solicitada?

29. Has any proposed Insured in the last 5 years:
Alguno de los Asegurados propuestos, ¿durante los últimos 5 años:
   a. Had a physical examination? ☐ Sí ☐ No
   Se ha sometido a un examen físico?
   b. Had any medical treatment? (includes prescription medications) ☐ Sí ☐ No
   Ha recibido algún tratamiento médico? (incluso los medicamentos recetados)
   c. Been hospitalized? ☐ Sí ☐ No
   Ha sido hospitalizado?

30. Is any proposed Insured currently a resident in a nursing home or ever been diagnosed as having a terminal illness, including Alzheimer's disease? ☐Sí ☐No
¿Se encuentra algún Asegurado propuesto actualmente internado en un asilo de enfermos o en alguna ocasión se le ha diagnosticado una enfermedad terminal, incluso la Enfermedad de Alzheimer?

31. Has any proposed Insured ever had or been treated for any of the following conditions:
En alguna ocasión, algún Asegurado propuesto ¿ha padecido de o ha sido tratado por concepto de alguna de las siguientes condiciones?

a. Asthma, emphysema, sleep apnea or other respiratory disorder? ☐Sí ☐No
Asma, enfisema, apnea durante el sueño o algún otro trastorno del sistema respiratorio

b. Ulcer, colitis or other digestive tract disorder? ☐Sí ☐No
Ulceras, colitis o algún otro trastorno del sistema digestivo

c. Cirrhosis, hepatitis or other liver disorder or any blood disorder or received a bone marrow transplant? ☐Sí ☐No
Cirrosis, hepatitis o algún otro trastorno del hígado o de la sangre o ha recibido un trasplante de médula ósea?

d. Kidney, prostate, urinary bladder or other genitourinary disorder? ☐Sí ☐No
Riñón, próstata, vejiga urinaria o algún otro trastorno del sistema genitourinario

e. Disease of the breasts, uterus or ovaries? ☐Sí ☐No
Enfermedad de las mamas, útero u ovarios

f. Rheumatoid arthritis or any other musculoskeletal disorder? ☐Sí ☐No
Artritis reumatoide o algún otro trastorno musculoesquelético

g. Loss of hearing or loss of sight? ☐Sí ☐No
Pérdida de la audición o de la visión

h. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or AIDS related conditions? ☐Sí ☐No
Síndrome de Inmunodeficiencia Adquirida (SIDA), complejo relacionado con el SIDA (CRS) o condiciones relacionadas con el SIDA.

32. Has any proposed Insured ever tested positive for antibodies to the "AIDS" (HIV) virus? ☐Sí ☐No
En alguna ocasión, algún Asegurado propuesto, ¿ha dado resultado positivo a las pruebas de los anticuerpos al virus del "SIDA" (VIH)?

33. Does any proposed Insured smoke cigarettes or use tobacco in any other form? ☐Sí ☐No
Algún Asegurado propuesto, ¿fuma cigarrillos o consume tabaco en alguna otra forma?

34. If a former user of tobacco, when did proposed Insured quit?
Si ha consumido tabaco en el pasado, ¿cuando dejó el Asegurado propuesto de consumirlo?
Name/Date _____
Nombre/Fecha

Name/Date _____
Nombre/Fecha

35. Has any proposed Insured used marijuana in the past year? ☐Sí ☐No
Durante el año pasado, algún Asegurado propuesto, ¿ha usado marihuana?

If questions are answered "yes", give explanations, dates, names & addresses of physicians & hospital (if any) below.
Si alguna de las precedentes preguntas hubiera sido contestada "sí", indique a continuación los detalles, fechas, nombres y domicilio de los médicos y hospitales (si hubiera alguno).

Proposed Insured *Asegurado Propuesto*	**Explanation or Medication** *Detalles o Medicamentos*	**Date** *Fecha*	**Hospital** *Hospital*	**How Long** *Cuanto Tiempo*	**Physician** *Médico*	**Address** *Domicilio*
			☐Sí ☐No			
			☐Sí ☐No			
			☐Si ☐No			

Name, Address, and Phone Number of Personal Physician *Nombre, domicilio y teléfono del médico personal*	Date Last Seen *Fecha de la última consulta*	Medical Records ID# *Núm. de identificación de los expedientes médicos*
( ) -		
* ( ) -	*	*

Any person who knowingly and with intent to injure, defraud or deceive any insurer, submits an application or files a claim containing any false, incomplete, or misleading information is guilty of insurance fraud, which is a crime.
Cualquier persona que, deliberadamente y con la intención de perjudicar, defraudar o engañar a cualquier compañía de seguros, remita una solicitud o reclamación con información falsa, incompleta o engañosa, será culpable de haber cometido fraude contra la industria de seguros, lo cual es un delito.

I agree that no insurance shall be in effect until: (a) a policy has been issued; and (b) the first premium is paid while my insurability remains unchanged and then only if I am actually in the state of health represented in this application. I state that the answers set forth above, are full, complete and true to the best of my knowledge and belief. The answers are to be the basis of any insurance issued. No agent may bind, alter, change or waive any underwriting requirements or other provisions of the application or policy. Final application acceptance is made by the Underwriting Department of the Company. I also acknowledge that I have received the Investigative Consumer Reports notification and MIB Notice and authorize obtaining medical or other information, including MIB, in order to evaluate my application for insurance. American Income Life may also request or obtain additional information to establish or verify my identity. I further acknowledge that American Income Life may report information to MIB or to other insurers which I have or may apply.

Reconozco y acepto que ningún seguro surtirá efectos, hasta que: (a) una póliza haya sido emitita; y (b) la primera prima haya sido pagada mientras mi estado de asegurabilidad no haya cambiado y sólo si actualmente me encontrara en el estado de salud detallado en esta solicitud. Hago constar que las respuestas manifestadas en este formulario son completas, verídicas y basadas en mi mejor saber y entender. Cualquier seguro que fuera emitido se basará en dichas respuestas. Ningún agente podrá obligar, alterar, cambiar ni rescindir ninguno de los requisitos de contratación u otras disposiciones de la solicitud o la póliza. La decisión final, en torno a la aceptación de la solicitud, será tomada por el Departamento de Suscripción (Underwriting Department) de la Compañía. Además, hago constar que he recibido la notificación referente al Informe de Investigación Crediticia y la Notificación Referente a la Agencia de Información Médica (MIB por sus siglas en inglés). Por consiguiente, otorgo mi autorización para recabar información médica o cualquier otra información pertinente, incluso información mantenida por la MIB con la finalidad de evaluar mi solicitud para seguro. American Income Life también podrá solicitar o recabar información adicional para establecer o verificar mi identidad. Además reconozco que American Income Life podrá divulgar información a la MIB o a otras compañías de seguros de las cuales yo hubiera solicitado o pudiera solicitar cobertura de seguro.

X _____ Date _____ at _____

Proposed Insured (if 18 or over)/*Asegurado Propuesto (si ha cumplido los 18 años de edad)* — *Fecha* — *en* — City/*Ciudad* — State/*Estado*

X _____ * _____ _____

Signature of Owner (if other than proposed Insured) *Firma del Dueño (si no fuera el Asegurado propuesto)* — Signature of Spouse (if a proposed Insured) *Firma del Cónyuge (si fuera un Asegurado propuesto)* — Signature of Agent *Firma del Agente*

AGENT'S STATEMENT/*DECLARACIÓN DEL AGENTE*

I certify that I have asked all questions and truly and accurately recorded the information supplied by the Applicant. To the best of my knowledge and belief, the insurance applied for ☐ is ☐ is not intended to replace any insurance now in effect.

Hago constar que he formulado todas las preguntas y anotado verídica y fidedignamente la información proporcionada por el Solicitante. A mi mejor saber y entender, el seguro solicitado ☐ se ☐ no se pretende utilizar para reemplazar un seguro que se encuentre vigente.

Agent L. Name (5 ltrs) *Apellido del Agente (5 letras)* — _____ Agent# *Núm. del Agente* — _____ Signature of Agent *Firma del Agente*

REMARKS OR INSTRUCTIONS
COMENTARIOS O INSTRUCCIONES

_____ Best time to call _____ *Mejor hora para llamar:*

_____

_____

★ Driver's License # for children age 16 + — For separate life policies ONLY:
Núm. de Licencia de Conductor para los hijos de 16 años de edad y mayores — SÓLO si se solicitaran pólizas de seguro de vida por separado.

Mail Policy To: ☐ Agency ☐ Policyholder
Envíe la póliza a: *Agencia* *Titular de la Póliza*

AMERICAN INCOME LIFE INSURANCE COMPANY
P.O. Box 2608 Waco, TX 76797

Application Addendum
Anexo a la Solicitud

Additional Proposed Insured Children
Hijos Adicionales Propuestos como Asegurados

1. Names of Proposed Insureds *Nombres de los Asegurados Propuestos*	I Saw Lo entrevisté personalmente	D.O.B. *Fecha de Nac.*	Age *Edad*	Birthplace *Lugar de Nac.*	Ht Estatura	Wt *Peso*	Sex *Sexo*
C4 Child/Hijo							
C5 ChildHijo							
C6 Child/Hijo							
C7 Child/Hijo							
C8 Child/Hijo							
C9 Child/Hijo							

10.	Primary Beneficiary *Beneficiario Primario*	Relationship to Insured *Vínculo con el Asegurado*	Contingent Beneficiary *Beneficiario Contingente*	Relationship to Insured *Vínculo con el Asegurado*
C4				
C5				
C6				
C7				
C8				
C9				

C4 (under 18) *C4 (menor de 18)*	**Benefits** *Beneficios*	**Face Amount** *Cantidad Nominal*	**Premium** *Prima*
☐ WL ☐ PR ☐ LPU65	☐ ADB	$_____	$_____.____
☐ _____	☐ B2000		$_____.____
Face Amount *Cantidad Nominal* / Premium *Prima*	☐ GIO	$ _____	$_____.____
$_____ $_____.____	☐ TIR		
		Premium C4 $_____.____ *Prima C4*	

C7 (under 18) *C7 (menor de 18)*	**Benefits** *Beneficios*	**Face Amount** *Cantidad Nominal*	**Premium** *Prima*
☐ WL ☐ PR ☐ LPU65	☐ ADB	$_____	$_____.____
☐ _____	☐ B2000		$_____.____
Face Amount *Cantidad Nominal* / Premium *Prima*	☐ GIO	$ _____	$_____.____
$_____ $_____.____	☐ TIR		
		Premium C7 $_____.____ *Prima C7*	

C5 (under 18) *C5 (menor de 18)*	**Benefits** *Beneficios*	**Face Amount** *Cantidad Nominal*	**Premium** *Prima*
☐ WL ☐ PR ☐ LPU65	☐ ADB	$_____	$_____.____
☐ _____	☐ B2000		$_____.____
Face Amount *Cantidad Nominal* / Premium *Prima*	☐ GIO	$ _____	$_____.____
$_____ $_____.____	☐ TIR		
		Premium C5 $_____.____ *Prima C5*	

C8 (under 18) *C8 (menor de 18)*	**Benefits** *Beneficios*	**Face Amount** *Cantidad Nominal*	**Premium** *Prima*
☐ WL ☐ PR ☐ LPU65	☐ ADB	$_____	$_____.____
☐ _____	☐ B2000		$_____.____
Face Amount *Cantidad Nominal* / Premium *Prima*	☐ GIO	$ _____	$_____.____
$_____ $_____.____	☐ TIR		
		Premium C8 $_____.____ *Prima C8*	

C6 (under 18) *C6 (menor de 18)*	**Benefits** *Beneficios*	**Face Amount** *Cantidad Nominal*	**Premium** *Prima*
☐ WL ☐ PR ☐ LPU65	☐ ADB	$_____	$_____.____
☐ _____	☐ B2000		$_____.____
Face Amount *Cantidad Nominal* / Premium *Prima*	☐ GIO	$ _____	$_____.____
$_____ $_____.____	☐ TIR		
		Premium C6 $_____.____ *Prima C6*	

C9 (under 18) *C9 (menor de 18)*	**Benefits** *Beneficios*	**Face Amount** *Cantidad Nominal*	**Premium** *Prima*
☐ WL ☐ PR ☐ LPU65	☐ ADB	$_____	$_____.____
☐ _____	☐ B2000		$_____.____
Face Amount *Cantidad Nominal* / Premium *Prima*	☐ GIO	$ _____	$_____.____
$_____ $_____.____	☐ TIR		
		Premium C9 $_____.____ *Prima C9*	

AMERICAN INCOME LIFE INSURANCE COMPANY
P.O. Box 2608 Waco, Tx 76797

CONDITIONAL RECEIPT
RECIBO CONDICIONAL

NO COVERAGE WILL BECOME EFFECTIVE PRIOR TO POLICY DELIVERY UNLESS AND UNTIL ALL CONDITIONS OF THIS RECEIPT ARE MET. NO AGENT HAS THE AUTHORITY TO ALTER THE TERMS OR CONDITIONS OF THIS RECEIPT.
NINGUNA COBERTURA SURTIRÁ EFECTOS ANTES DE LA ENTREGA DE LA PÓLIZA, A MENOS Y HASTA QUE SE CUMPLA CON TODAS LAS CONDICIONES ESTIPULADAS EN ESTE RECIBO. A NINGÚN AGENTE SE LE CONFIERE LA AUTORIDAD DE ALTERAR LAS DISPOSICIONES O CONDICIONES ACORDADAS EN ESTE RECIBO CONDICIONAL.

Received of _____ the sum of $_____ as first payment on this application.
Recibí de *la cantidad de $* *como primer pago por concepto de esta solicitud.*

Date _____ Agent _____
Fecha *Agente*

If (1) an amount equal to the first full premium is submitted; (2) all underwriting requirements, including any medical examinations required by the Company's rules, are completed; (3) the proposed insured is on the effective date indicated a risk acceptable for insurance exactly as applied for without modification of plan, premium rate, or amount under the Company's rules and practices, then insurance under the policy applied for shall become effective on the latest of (a) the date of application, (b) the date of completion of all underwriting requirements, and (c) any date of issue requested in the application.
Si (1) la cantidad equivalente a la totalidad de la primera prima haya sido remitida; (2) se haya cumplido con todos los requisitos de contratación (underwriting), incluso con las evaluaciones médicas requeridas de conformidad con los reglamentos de la Compañía; (3) en la precitada fecha de efectividad, el asegurado propuesto representara un riesgo aceptable por concepto del seguro solicitado, sin cambio alguno al plan, la tarifa de la prima o la cantidad de seguro, de conformidad con los reglamentos y prácticas de la Compañia, entonces la póliza solicitada surtirá efectos cuando se cumpla la más reciente de las siguientes fechas: (a) la fecha de la solicitud, (b) la fecha en que se cumpla con todos los requisitos de contratación, y (c) la fecha de emisión solicitada en el formulario de solicitud.

THE AMOUNT OF INSURANCE WHICH MAY BECOME EFFECTIVE PRIOR TO POLICY DELIVERY SHALL NOT EXCEED $50,000.
LA CANTIDAD DE SEGURO QUE PODRÁ ENTRAR EN VIGOR ANTES DE LA ENTREGA DE LA PÓLIZA NO EXCEDERÁ DE $50,000.

If any of the above conditions are not met, the liability of the Company shall be limited to the return of the amount submitted.
Si no se cumpliera con alguna de las precitadas condiciones, la única responsabilidad de la Compañía será rembolsar la cantidad remitida.

"ALL CHECKS MUST BE MADE PAYABLE TO THE COMPANY: DO NOT MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK."
"TODO CHEQUE REMITIDO POR CONCEPTO DE LA PRIMA DEBERÁ SER EXTENDIDO A NOMBRE DE LA COMPAÑÍA: NO EXTIENDA CHEQUES A NOMBRE DEL AGENTE NI ENTREGUE CHEQUES EN BLANCO."

INVESTIGATIVE CONSUMER REPORTS NOTIFICATION
NOTIFICACIÓN REFERENTE A LOS INFORMES DE INVESTIGACIÓN CREDITICIA

As part of our routine underwriting procedure, an investigative consumer report may be obtained which will provide applicable information concerning character, general reputation, personal characteristics, and mode of living. This information will be obtained through consumer reporting agencies, the Department of Motor Vehicles, andpersonal interviews with your friends, neighbors, and associates. You may request to be interviewed in connection with the preparation of the report and upon request may receive a copy of the report.
Como parte de nuestros procedimientos de contratación rutinarios, nosotros podremos recabar una investigación crediticia (investigative consumer report). El informe derivado de dicha investigación incluirá información aplicable referente a su carácter, reputación general, características personales y estilo de vida. La información para este informe será recopilada mediante los reportes emitidos por las agencias de informes del consumidor, el Departamento de Vehículos de Motor y entrevistas personales con sus amigos, vecinos y socios. Usted podrá solicitar ser entrevistado con motivo de la preparación del informe y si lo solicitara, podrá recibir una copia del informe.

MIB NOTICE
ADVERTENCIA REFERENTE A LA MIB

Information regarding your insurability will be treated as confidential. American Income Life Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.
La información referente a su asegurabilidad será tratada confidencialmente. No obstante, American Income Life Insurance Company o sus reaseguradores podrán remitir un informe breve sobre su estado de asegurabilidad a la MIB, Inc. conocida en el pasado como la Agencia de Información Médica (Medical Information Bureau), una organización que opera sin fines de lucro con la finalidad de ofrecer un servicio de intercambio de información a las compañías de seguros de vida afiliadas a la misma. Si usted solicitara seguro de vida o seguro médico o remitiera una reclamación para beneficios a una compañía afiliada a la MIB, dicha compañía podrá solicitar la información pertinente a su solicitud o reclamación mantenida en los archivos de la MIB. Si la compañía solicitara dicha información, la Agencia se la proporcionará.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.
Cuando hayamos recibido su solicitud, la MIB hará los arreglos para divulgar cualquier información, referente a su persona, que existiera en los archivos de dicha Agencia. Por favor, contacte a la MIB al 866-692-6901 (TTY 866-346-3642). Si tiene alguna pregunta sobre la autenticidad de la información mantenida por la MIB, usted podrá contactar a la MIB para corregirla. Este derecho se le concede bajo la Ley Federal para la Información Justa en el Informe Crediticio (Fair Credit Reporting Act). El domicilio de la oficina de información de la MIB es 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

American Income Life Insurance Company may also release information from its file to its reinsurers or to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.
American Income Life Insurance Company también podrá proporcionar la información mantenida en sus expedientes a sus reaseguradoras u otras compañías de seguros de las cuales usted pudiera solicitar seguro de vida o seguro médico o ante las cuales usted pudiera remitir una reclamación para la recaudación de beneficios. Información referente a la MIB para los consumidores podrá ser obtenida de su página de Internet, www.mib.com.

NOTICE OF INFORMATION PRACTICES
ADVERTENCIA REFERENTE A LOS PROCEDIMIENTOS DE MANEJO DE INFORMACIÓN

Personal information may be collected from other parties. Such information, and other personal or privileged information later collected, may be disclosed to third parties without authorization. You have the right of access and correction with respect to all personal information collected, and a full notice of your rights will be furnished upon request.
La información de índole personal podrá ser recopilada por otras entidades. Dicha información, así como otra información de índole personal o privilegiada, que fuera recopilada posteriormente, podrá ser divulgada a terceros sin autorización alguna. Usted tiene el derecho de obtener y corregir toda información personal que fuera recopilada. Además, si usted lo solicitara, nosotros le proporcionaremos una notificación detallada de sus derechos.

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification

Comments:

Attachment:

ARReadCert.pdf

Item Status: **Status Date:**

Bypassed - Item: Application

Bypass Reason: This filing is for approval of the application.

Comments:

Item Status: **Status Date:**

Satisfied - Item: Spanish Translator Certification

Comments:

Attachment:

AG-2649, et al. Certif.pdf

STATE OF ARKANSAS

CERTIFICATE OF COMPLIANCE

I, PAMELA D. MILLER, AN OFFICER OF THE AMERICAN INCOME LIFE INSURANCE COMPANY, HEREBY CERTIFY THAT THE ENGLISH TEXT IN THE FOLLOWING FORM(S) HAS (HAVE) THE FOLLOWING READABILITY SCORE(S) AS CALCULATED BY THE FLESCH READING EASE TEST AND THAT THE FORM(S) MEET ALL REQUIREMENTS SET FORTH IN ARKANSAS STATUTES 66-3251 THROUGH 66-3258, CITED AS THE LIFE AND DISABILITY INSURANCE POLICY LANGUAGE SIMPLIFICATION ACT.

FORM(S)	SCORE
AG-2649 AG-2649C AG-2692	Combined Score of 46.0

DATED November 11, 2011

AMERICAN INCOME LIFE INSURANCE COMPANY

PAMELA D. MILLER, FLMI/M, AIRC, ACS
VICE PRESIDENT
COMPLIANCE

PFCERTAR

CC Scientific, Ltd.

Hispanic Market Consultations & Spanish Translations

CERTIFICATE

Issued by CC Scientific, Ltd. to:

American Income Life Insurance Company

AG-2649
AG-2649C
AG-2692

CC Scientific, Ltd. hereby certifies that the translation of the above-captioned form(s) from English to Spanish is complete and accurate, to the best knowledge and ability of the undersigned, and that the entire translated form(s) have been reviewed for the purpose of assuring that the provisions contained therein convey the same meaning and value and have the same legal effect as the corresponding provisions in the English version of the form(s).

It is understood that this certificate is void and null when and if any changes are made to the above-captioned form(s).

Jaime R. Carlo-Casellas, Ph. D.

CERTIFICATE NUMBER 2392

Date: July 19, 2011

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