

SERFF Tracking Number: AFLC-127133873 State: Arkansas
Filing Company: Americo Financial Life and Annuity Insurance Company State Tracking Number: 48547
Company Tracking Number: 1289: 5099 (04/11)
TOI: L07I Individual Life - Whole Sub-TOI: L07I.101 Fixed/Indeterminate Premium - Single Life
Product Name: 1289: 5099 (04/11)
Project Name/Number: 1289: 5099 (04/11)/1289

Filing at a Glance

Company: Americo Financial Life and Annuity Insurance Company

Product Name: 1289: 5099 (04/11)

SERFF Tr Num: AFLC-127133873 State: Arkansas

TOI: L07I Individual Life - Whole

SERFF Status: Closed-Approved-Closed State Tr Num: 48547

Sub-TOI: L07I.101 Fixed/Indeterminate Premium - Single Life

Co Tr Num: 1289: 5099 (04/11) State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Linda Bird

Author: Ronni Jones

Disposition Date: 04/22/2011

Date Submitted: 04/20/2011

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: 1289: 5099 (04/11)

Status of Filing in Domicile: Pending

Project Number: 1289

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments: Texas is our domicile state.

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Individual Market Type:

Overall Rate Impact:

Filing Status Changed: 04/22/2011

Deemer Date:

State Status Changed: 04/22/2011

Submitted By: Ronni Jones

Created By: Ronni Jones

Filing Description:

Corresponding Filing Tracking Number:

Submission description

Enclosed, for review and approval, is a revised Application for Life Insurance. This application replaces application AAR5099 (10/10), which was previously approved in your jurisdiction on 12/17/2010, under SERFF tracking AFLC-126902686.

In addition, this application contains no unusual or controversial elements. This application will be used in the individual

SERFF Tracking Number: AFLC-127133873 State: Arkansas
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 Company
 Company Tracking Number: 1289: 5099 (04/11)
 TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single
 Life
 Product Name: 1289: 5099 (04/11)
 Project Name/Number: 1289: 5099 (04/11)/1289

life insurance market by our licensed independent agents. To the best of our knowledge and belief, this filing is complete and complies with the insurance laws and regulations of your jurisdiction.

AAR5099 (04/11) description

We have made three changes to this application from the aforementioned previously approved application. We revised questions 3, 4, and 7 under the Part I health questions under Section 6. Health Information on page 2 in the application. A redlined copy of the application showing the changes is provided under the Supporting Documentation tab for your reference.

This individual life insurance application will be used to apply for previously approved individual whole life policies and riders. All previously approved associated forms are described in detail in the Associated Forms List included under the Supporting Documentation tab. The previously approved policy forms are not marketed with an illustration.

This application will continue to accommodate our electronic initiatives in the taking of this application for life insurance as detailed in the aforementioned previously approved filing.

Thank you in advance for your time and consideration.

Company and Contact

Filing Contact Information

Ronni Jones, Associate Compliance Analyst ronni.jones@americo.com
 300 W. 11th Street 816-512-2831 [Phone]
 Kansas City, MO 64105 816-391-2083 [FAX]

Filing Company Information

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

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00

SERFF Tracking Number: AFLC-127133873 State: Arkansas
 Filing Company: Americo Financial Life and Annuity Insurance State Tracking Number: 48547
 Company
 Company Tracking Number: 1289: 5099 (04/11)
 TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single
 Life
 Product Name: 1289: 5099 (04/11)
 Project Name/Number: 1289: 5099 (04/11)/1289
 Retaliatory? Yes
 Fee Explanation: 1 form x \$50.00 = \$50.00. Our Domicile fee for this type of filing is also \$50.00 per filing.
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Americo Financial Life and Annuity Insurance Company	\$50.00	04/20/2011	46794708

SERFF Tracking Number: AFLC-127133873 State: Arkansas
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Company Tracking Number: 1289: 5099 (04/11)
TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single
Life
Product Name: 1289: 5099 (04/11)
Project Name/Number: 1289: 5099 (04/11)/1289

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved- Closed	Linda Bird	04/22/2011	04/22/2011

SERFF Tracking Number: AFLC-127133873 *State:* Arkansas
Filing Company: Americo Financial Life and Annuity Insurance *State Tracking Number:* 48547
Company
Company Tracking Number: 1289: 5099 (04/11)
TOI: L071 Individual Life - Whole *Sub-TOI:* L071.101 Fixed/Indeterminate Premium - Single
Life
Product Name: 1289: 5099 (04/11)
Project Name/Number: 1289: 5099 (04/11)/1289

Disposition

Disposition Date: 04/22/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: AFLC-127133873 State: Arkansas
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Life & Annuity - Acturial Memo		No
Supporting Document	Associated Forms List		Yes
Supporting Document	Redlined Copy of Application		Yes
Supporting Document	Agent Copy		Yes
Supporting Document	Statement of Variability		Yes
Form	Application for Life Insurance		Yes

SERFF Tracking Number: AFLC-127133873 State: Arkansas
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Form Schedule

Lead Form Number: AAR5099 (04/11)

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	AAR5099 (04/11)	Application/ Enrollment Form	Application for Life Insurance	Initial		50.800	AAR5099 (04-11) [F 2011 04.19].pdf

1. PROPOSED INSURED INFORMATION

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

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

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

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

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

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

4. PRODUCT INFORMATION

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

- Are you applying for the Children's Term Rider? Yes No *If Yes, complete this section.*
- Amount of Children's Term coverage desired: \$ _____

3. **Please list below any Eligible Child proposed for coverage.** NOTE: An Eligible Child means any child, stepchild, legally adopted child, or dependent grandchild of the Proposed Insured. A dependent grandchild means a grandchild who is eligible to be claimed on the federal tax return of, and resides with, the Proposed Insured.

Full Name of Eligible Child Proposed for Coverage	Date of Birth	Sex	Height	Weight
		<input type="checkbox"/> M <input type="checkbox"/> F		
		<input type="checkbox"/> M <input type="checkbox"/> F		
		<input type="checkbox"/> M <input type="checkbox"/> F		

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

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

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

5. REPLACEMENT INFORMATION

- 1. Is there any existing life insurance or annuity coverage on the life of any Proposed Insured? If Yes, provide information below.
2. 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.

Table with 6 columns: Insured's Name, Company, Owner, Life Amount, Accidental Death Benefit, Policy Date

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

Has the Proposed Insured smoked cigarettes within the last twelve (12) months?... Proposed Insured's Height Proposed Insured's Weight

PART 1 Yes No

- 1. Is the Proposed Insured currently: hospitalized, bedridden, confined to a nursing facility, receiving hospice or home health care; using oxygen to assist in breathing now or within the last six (6) months; confined to a wheelchair or using a walker for a chronic illness now or within the last six (6) months; waiting for or have received an organ transplant; advised to have tests or surgery which have not been completed within the last twelve (12) months; diagnosed with a terminal illness; or paralyzed?
2. Has the Proposed Insured ever:
a. Had, been told they have, been treated for, or been prescribed medication for: Alzheimer's disease, dementia, memory loss, muscular dystrophy, or ALS (Lou Gehrig's Disease)?
b. Been diagnosed as having, been treated by a medical professional for, or tested positive for: Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or the Human Immunodeficiency Virus (HIV)?
3. In the past three (3) years, has the Proposed Insured been told they have, or been treated by surgery, chemotherapy, radiation, been prescribed medication for any internal cancer or malignant melanoma (not basal cell skin cancer)?
4. In the past twelve (12) months, has the Proposed Insured had, been told they have, been treated for, been prescribed medication or had surgery for: heart bypass, angioplasty (balloon procedure), stent placement, heart valve disorder; cardiac arrhythmia (including atrial fibrillation or flutter and ventricular fibrillation or flutter), heart attack, or angina (chest pain)?
5. In the past two (2) years, has the Proposed Insured had, been told they have, been treated for, or been prescribed medication or had surgery for congestive heart failure, cardiomyopathy, stroke, circulation or blood clot problems in the legs or to the heart or brain, systemic lupus, chronic kidney disease, or kidney failure?
6. In the past two (2) years has the Proposed Insured:
a. Had, been told they have, been treated for, or been prescribed medication for drug or alcohol abuse/dependency or addiction?
b. Been asked to discontinue use or reduce intake of drugs or alcohol?
7. In the past two (2) years, has the Proposed Insured taken medication for diabetes in combination with a medical history of stroke or TIA, heart disease or disorders, kidney disease, eye problems or any other circulatory disease (any disease that affects the heart and the blood vessels)?

PART 2 Yes No

- 1. In the past two (2) years, has the Proposed Insured ever been told they have, been treated for, or been prescribed medication for: Parkinson's disease, cirrhosis of the liver, chronic hepatitis, or other liver diseases or disorders?
2. In the past three (3) years, has the Proposed Insured experienced complications of diabetes including: amputation, eye or kidney problems, insulin shock, or diabetic coma?
3. In the past two (2) years, has the Proposed Insured had, or been told they have, been treated for, or been prescribed medication for heart bypass, angioplasty (balloon procedure), stent placement, heart valve disorder, heart attack, angina (chest pain), or coronary disease?
4. In the past two (2) years, has the Proposed Insured had, been told they have, been treated for, or been prescribed medication for: emphysema, chronic bronchitis that is not seasonal, or any other chronic respiratory or lung problem excluding allergies or asthma?

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

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

8. AUTHORIZATION AND ACKNOWLEDGMENT

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

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

I/We have received a copy of the Notice of Insurance Information Practices. I/We, or my/our authorized representative, may obtain a copy of this Authorization on request. This Authorization will be valid for 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.

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

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

Signature of Proposed Insured *(required)*

Signature of Owner *(if different than Proposed Insured)*

Signature of Witnessing Agent *(required)*

SERFF Tracking Number: AFLC-127133873 State: Arkansas
 Filing Company: Americo Financial Life and Annuity Insurance State Tracking Number: 48547
 Company
 Company Tracking Number: 1289: 5099 (04/11)
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 Product Name: 1289: 5099 (04/11)
 Project Name/Number: 1289: 5099 (04/11)/1289

Supporting Document Schedules

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

	Item Status:	Status Date:
Satisfied - Item: Associated Forms List		
Comments:		
Attachment: Associated Forms List - AR.pdf		

	Item Status:	Status Date:
Satisfied - Item: Redlined Copy of Application		
Comments:		
Attachment: AAR5099 (04-11) [REDLINE 2011 04.19].pdf		

	Item Status:	Status Date:
Satisfied - Item: Agent Copy		
Comments:		
Attachment: ABB5099 (04-11)-AS [F 2011 04.19].pdf		

	Item Status:	Status Date:

SERFF Tracking Number: AFLC-127133873 *State:* Arkansas
Filing Company: Americo Financial Life and Annuity Insurance *State Tracking Number:* 48547
Company
Company Tracking Number: 1289: 5099 (04/11)
TOI: L07I Individual Life - Whole *Sub-TOI:* L07I.101 Fixed/Indeterminate Premium - Single
Life
Product Name: 1289: 5099 (04/11)
Project Name/Number: 1289: 5099 (04/11)/1289
Satisfied - Item: Statement of Variability
Comments:
Attachment:
Statement of Variability - SERIES 5099 (04-11).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(s) listed below have the following readability score(s) as calculated by the Flesch Reading Ease Test.

<u>Form Number</u>	<u>Form Description</u>	<u>Readability Score</u>
AAR5099 (04/11)	Application for Life Insurance	50.8



Eric H. Petersen – FSA, MAAA
Assistant Vice President – Product Development

April 20, 2011
Date

Life Application Filing

Arkansas Associated Forms List

Description	Form Number	Disposition	Disposition Date	SERFF Tracking No.
Whole Life Policy – Level Death Benefit	AAR281	Approved	12/26/2007	AFLC-125385961
Accelerated Death Benefit Payment Rider (automatic rider with Policy Series 281 only)	AAR2146	Approved	07/03/2003	SERT-5JLLVF299
Whole Life Policy – Level Death Benefit	AAR284	Approved	12/26/2007	AFLC-125385961
Children's Term Rider (optional rider)	AAA2147	Approved	6/17/2004	USPH-5ZTNAF573



1. PROPOSED INSURED INFORMATION

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

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

Name (Last, First, Middle Initial)	Relationship to Proposed Insured	SSN or Taxpayer ID
------------------------------------	----------------------------------	--------------------

Address (If address is a PO BOX, a street address is also required.)

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

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

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

4. PRODUCT INFORMATION

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

- Are you applying for the Children's Term Rider? Yes No *If Yes, complete this section.*
- Amount of Children's Term coverage desired: \$ _____

3. **Please list below any Eligible Child proposed for coverage.** NOTE: An Eligible Child means any child, stepchild, legally adopted child, or dependent grandchild of the Proposed Insured. A dependent grandchild means a grandchild who is eligible to be claimed on the federal tax return of, and resides with, the Proposed Insured.

Full Name of Eligible Child Proposed for Coverage	Date of Birth	Sex	Height	Weight
		<input type="checkbox"/> M <input type="checkbox"/> F		
		<input type="checkbox"/> M <input type="checkbox"/> F		
		<input type="checkbox"/> M <input type="checkbox"/> F		

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

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

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

5. REPLACEMENT INFORMATION

- 1. Is there any existing life insurance or annuity coverage on the life of any Proposed Insured? If Yes, provide information below.
2. 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.

Table with 6 columns: Insured's Name, Company, Owner, Life Amount, Accidental Death Benefit, Policy Date

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

Has the Proposed Insured smoked cigarettes within the last twelve (12) months?... Proposed Insured's Height Proposed Insured's Weight

PART 1 Yes No

- 1. Is the Proposed Insured currently: hospitalized, bedridden, confined to a nursing facility, receiving hospice or home health care; using oxygen to assist in breathing now or within the last six (6) months; confined to a wheelchair or using a walker for a chronic illness now or within the last six (6) months; waiting for or have received an organ transplant; advised to have tests or surgery which have not been completed within the last twelve (12) months; diagnosed with a terminal illness; or paralyzed?
2. Has the Proposed Insured ever:
a. Had, been told they have, been treated for, or been prescribed medication for: Alzheimer's disease, dementia, memory loss, muscular dystrophy, or ALS (Lou Gehrig's Disease)?
b. Been diagnosed as having, been treated by a medical professional for, or tested positive for: Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or the Human Immunodeficiency Virus (HIV)?
3. In the past three (3) years, has the Proposed Insured been told they have, or been treated by surgery, chemotherapy, radiation, taken or been prescribed medication for any internal cancer or malignant melanoma (not basal cell skin cancer)?
4. In the past twelve (12) months, has the Proposed Insured had, been told they have, been treated for, taken or been prescribed medication or had surgery for: heart bypass, angioplasty (balloon procedure), stent placement, heart valve disorder; cardiac arrhythmia (including atrial fibrillation or flutter and ventricular fibrillation or flutter), heart attack, or angina (chest pain)?
5. In the past two (2) years, has the Proposed Insured had, been told they have, been treated for, or been prescribed medication or had surgery for congestive heart failure, cardiomyopathy, stroke, circulation or blood clot problems in the legs or to the heart or brain, systemic lupus, chronic kidney disease, or kidney failure?
6. In the past two (2) years has the Proposed Insured:
a. Had, been told they have, been treated for, or been prescribed medication for drug or alcohol abuse/dependency or addiction?
b. Been asked to discontinue use or reduce intake of drugs or alcohol?
7. In the past two (2) years, has the Proposed Insured been told they have, been treated for, or taken medication for diabetes in combination with a medical history of stroke or TIA, heart disease or disorders, kidney disease, eye problems or any other circulatory disease (any disease that affects the heart and the blood vessels)?

PART 2 Yes No

- 1. In the past two (2) years, has the Proposed Insured ever been told they have, been treated for, or been prescribed medication for: Parkinson's disease, cirrhosis of the liver, chronic hepatitis, or other liver diseases or disorders?
2. In the past three (3) years, has the Proposed Insured experienced complications of diabetes including: amputation, eye or kidney problems, insulin shock, or diabetic coma?
3. In the past two (2) years, has the Proposed Insured had, or been told they have, been treated for, or been prescribed medication for heart bypass, angioplasty (balloon procedure), stent placement, heart valve disorder, heart attack, angina (chest pain), or coronary disease?
4. In the past two (2) years, has the Proposed Insured had, been told they have, been treated for, or been prescribed medication for: emphysema, chronic bronchitis that is not seasonal, or any other chronic respiratory or lung problem excluding allergies or asthma?

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

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

8. AUTHORIZATION AND ACKNOWLEDGMENT

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

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

I/We have received a copy of the Notice of Insurance Information Practices. I/We, or my/our authorized representative, may obtain a copy of this Authorization on request. This Authorization will be valid for 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.

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

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

Signature of Proposed Insured (required)

Signature of Owner (if different than Proposed Insured)

Signature of Witnessing Agent (required)

AGENT'S REPORT

Proposed Insured's Name: _____

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

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

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

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

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

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

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

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

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

8. Will the life insurance applied for replace, or otherwise reduce in value, any life insurance or annuity now in force? **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.**

Agent Comments/Remarks:

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

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

AMERICO FINANCIAL LIFE AND ANNUITY INSURANCE COMPANY

Statement of Variability for Form Series 5099 (04/11)

PRODUCT INFORMATION - Product Names

The product names are bracketed to facilitate the removal of products that are discontinued, to add products as they become approved for use in your jurisdiction, or modify marketing names without re-filing. We will never add a product for which we have not received authorization from your jurisdiction (if required) to use.

PRODUCT INFORMATION - Premium Mode

The premium mode is bracketed to facilitate any change to availability of payment mode. If availability of a payment mode is eliminated, then it will be eliminated for all new applicants. Americo Financial Life and Annuity Insurance Company will never administer in a discriminatory manner.