

SERFF Tracking Number: AFLC-127292748 State: Arkansas  
Filing Company: Americo Financial Life and Annuity Insurance Company State Tracking Number: 49575  
Company Tracking Number: 1300  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: 1300: 5120 (06/11)  
Project Name/Number: 1300: 5120 (06/11)/1300

## Filing at a Glance

Company: Americo Financial Life and Annuity Insurance Company

Product Name: 1300: 5120 (06/11)

TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Filing Type: Form

SERFF Tr Num: AFLC-127292748 State: Arkansas

SERFF Status: Closed-Approved-  
Closed State Tr Num: 49575

Co Tr Num: 1300

Author: Ronni Jones

Date Submitted: 08/16/2011

State Status: Approved-Closed

Reviewer(s): Linda Bird

Disposition Date: 08/19/2011

Disposition Status: Approved-  
Closed

Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

## General Information

Project Name: 1300: 5120 (06/11)

Project Number: 1300

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Deemer Date:

Submitted By: Ronni Jones

Filing Description:

Submission description

Enclosed, for review and approval, is revised life insurance application ABB5120 (06/11). This application replaces ABB5120, which was previously approved in your jurisdiction on 1/05/2011, under SERFF tracking number AFLC-126961275.

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments: Texas is our state  
of domicile.

Market Type: Individual

Individual Market Type:

Filing Status Changed: 08/19/2011

State Status Changed: 08/19/2011

Created By: Ronni Jones

Corresponding Filing Tracking Number:

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

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#### ABB5120 (06/11) description

We have made changes in the following Sections in this application from the aforementioned previously approved application. The Sections are as follows:

- Page 1/Section 3. RIDERS;
- Page 3/MEDICAL HISTORY disclosure statement;
- Page 3/Question 24.; and,
- Page 4/AUTHORIZATION & ACKNOWLEDGMENT.

A redline copy of the application is provided under the Supporting Documentation tab for you to reference the revisions in detail.

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: \$100.00  
Retaliatory? Yes

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Fee Explanation: TX retaliatory filing fee for 1 form = \$100.00  
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Americo Financial Life and Annuity Insurance Company	\$100.00	08/16/2011	50679677

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved- Closed	Linda Bird	08/19/2011	08/19/2011

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## Disposition

Disposition Date: 08/19/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Agent Report		Yes
Supporting Document	Statement of Variability		Yes
Supporting Document	Redlined Copy of Form		Yes
Supporting Document	Associated Forms List		Yes
Form	Application for Simplified Issue Individual Life Insurance		Yes

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## Form Schedule

### Lead Form Number: ABB5120 (06/11)

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	ABB5120 (06/11)	Application/ Enrollment Form Application for Simplified Issue Individual Life Insurance	Initial		52.200	ABB5120 (06-11) [FILING FORM 2011 08.16].pdf

**1. PROPOSED INSURED INFORMATION**

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

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

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

**3. RIDERS** (Verify rider availability.) [Optional riders are not available with the HMS Term w/ADB product.]

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

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

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

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

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

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

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

**Yes No**

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

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

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

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

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

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

**9. SPECIAL REQUESTS**

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

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

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

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

**PERSONAL HISTORY DETAILS**

Question #	Proposed Insured's Name	Dates	Details

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

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

	Proposed Insured		Additional Proposed Insured	
	Yes	No	Yes	No
18. Has any Proposed Insured used cigarettes, cigars, pipes, chewing tobacco, nicotine patches, snuff, nicotine chewing gum, or other products containing nicotine within the last twelve (12) months? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Within the past seven (7) years, has any Proposed Insured:				
a. been treated for or been advised or diagnosed by a medical professional to seek treatment for the use of alcohol or prescription drugs? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. been advised to reduce or discontinue the intake of alcohol or prescription drugs? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>(If Yes, complete the alcohol usage and/or prescription medication and drug use questionnaire.)</i>				
20. Within the past seven (7) years, has any Proposed Insured used, except as prescribed by a physician: heroin, morphine, other narcotics, ecstasy, opium derivatives, marijuana, cocaine, crack, barbiturates, amphetamines, methamphetamines, hallucinogens, any other illegal, restricted or controlled substances, been treated for or been advised by a medical professional to seek treatment for the intake of any drug? <i>(If Yes, complete the prescription medication and drug use questionnaire.)</i> .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Within the past five (5) years, has any Proposed Insured been diagnosed with or been advised to have or had treatment for:				
a. hypertension, heart disease or disorder, valve disorders, angina, cardiac arrhythmia, heart surgery including bypass, angioplasty or stent placement, circulatory disorder, blood vessel or blood disorders? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. lung or respiratory disorder, COPD, emphysema, current use of oxygen, shortness of breath, or sleep apnea? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. cancer in any form? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. diabetes or pancreatic disorders? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. digestive disorder, kidney or liver disease to include hepatitis, Crohn's disease or ulcerative colitis, gastrointestinal bleeding, bladder disorders, or unexplained weight loss? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Alzheimer's disease, dementia, nervous system disorder, emotional or psychiatric disorder, paralysis, sexually transmitted disease, systemic lupus, any blood disorders, or birth defects? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. rheumatoid arthritis, any disease or disorder of the bones or muscles? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Within the last five (5) years, has any Proposed Insured consulted a physician, had tests performed (such as an EKG, echocardiogram, X-ray, or blood tests) or been hospitalized or had surgery for any reason? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Has any Proposed Insured ever been diagnosed as having, been told by a medical professional that you have, or been treated by a medical professional for Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or any immune deficiency related disorder or tested positive for antibodies to the Human Immunodeficiency Virus (HIV)? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. Within the last twelve (12) months, has any Proposed Insured had tests, surgery, treatment or hospitalization recommended, but not completed, or consulted any health care provider(s) not already identified, for any reason? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Do any of the Proposed Insured(s):				
a. currently use prescription medicines? <i>(If Yes, list each medication and describe the reason for its use.)</i> .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. currently have a personal physician? <i>(If Yes, list name, address, and telephone number along with date, reason, and results of last consultation.)</i> .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

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

**MEDICAL HISTORY DETAILS**

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

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

**AUTHORIZATION AND ACKNOWLEDGMENT**

I/We authorize any insurance or reinsurance company, employer, licensed medical physician, medical professional, hospital, pharmacy or pharmacy benefit manager, records custodians, other medical or medically related facility, clearing house, consumer reporting agency, and/or the Medical Information Bureau (MIB, Inc.) that has any record of information about me/us or my/our minor children who are to be insured, to give Americo Financial Life and Annuity Insurance Company (Americo), its reinsurers or its authorized representatives, information about other insurance coverage, employment, age, general character, motor vehicle records, habits, court records, foreign travel, finances, participation in hazardous activities, medical care or advice about any physical or mental condition, including information about drugs and alcoholism required by Americo to determine insurability and/or claims eligibility for the duration of the claim.

Americo may release information obtained by this Authorization to its reinsurers, to MIB, Inc., 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. Although federal regulations require that Americo inform You of the potential that information disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and no longer be protected by such regulation, all information received by Americo pursuant to this Authorization will be protected by federal and state privacy laws and regulations.

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.

This Authorization may be revoked; however, it may not be revoked during the contestability period of the policy or to the extent Americo has taken action in reliance on this Authorization. Notice of revocation may be sent, in writing, to Americo at its Administrative Office address.

**IN ACCORDANCE WITH STATE LAW, WE MUST PROVIDE YOU WITH THE FOLLOWING FRAUD NOTICE:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**DC Residents Only:** WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**TN Residents only:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

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

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

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

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

I/We have read this application and represent to Americo that the statements made on this application are true, complete and correctly recorded to the best of my/our knowledge and belief. I/We agree that Americo can rely on these statements. I/We agree that this application and/or any medical exam form and any supplemental application or amendment to the application will be the basis for any policy issued on this application or any amendment to the application. **I/WE AGREE THAT ALL ANSWERS TO THE PERSONAL HISTORY QUESTIONS ON PAGE 2 AND TO MEDICAL HISTORY QUESTIONS ON PAGE 3 OF THIS APPLICATION, 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 the Proposed Insured)

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

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

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## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Flesch Certification		
<b>Comments:</b>		
<b>Attachment:</b> Readability Certification [individual].pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b> Application		
<b>Bypass Reason:</b> This filing requirement is not applicable to this filing.		
<b>Comments:</b>		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Agent Report		
<b>Comments:</b>		
<b>Attachment:</b> ABB5120-AS (06-11) [FILING FORM 2011 08.16].pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Statement of Variability		
<b>Comments:</b>		
<b>Attachment:</b> 5120 (06-11) Statement of Variability.pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Redlined Copy of Form		
<b>Comments:</b>		

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**Attachment:**

ABB5120 (06-11) [REDLINE 2011 08.16].pdf

**Item Status:**

**Status**

**Date:**

**Satisfied - Item:** Associated Forms List

**Comments:**

**Attachment:**

Associated Forms List-AR.pdf

**AMERICO FINANCIAL LIFE AND ANNUITY INSURANCE COMPANY**

NAIC number: 0449-61999

FEIN number: 35-0810610

**Readability Certification**

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

<u>Form Number</u>	<u>Form Description</u>	<u>Readability Score</u>
ABB5120 (06/11)	Application for Simplified Issue Individual Life Insurance	52.2



Digitally signed by Eric Petersen  
Date: 2011.08.16 16:32:37  
-05'00'

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

Assistant Vice President – Product Development  
Title

August 16, 2011  
Date

**AGENT'S REPORT**

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

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

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

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

**Replacement Information**

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

Agent Comments/Remarks:

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

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

Writing Agent's Phone Number	Writing Agent's Fax Number	Writing Agent's Email Address
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**Does Americo have your current contact information? If not, email: [licensing@americo.com](mailto:licensing@americo.com).**

# AMERICO FINANCIAL LIFE AND ANNUITY INSURANCE COMPANY

## STATEMENT OF VARIABILITY for FORM SERIES 5120 (06/11)

### **PRODUCT INFORMATION - Product Names (Section 2a.)**

The product names are bracketed to facilitate the removal of products that are discontinued, 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 to use (if required).

### **PRODUCT INFORMATION - Guarantee Periods (Section 2b.)**

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

### **PRODUCT INFORMATION - Guarantee Period Disclosures (Section 2b.)**

The disclosures in this section are to assist in making product elections for the guarantee periods approved by your jurisdiction and available for different products. Either the disclosures will appear, or will not appear, based on product availability.

### **PRODUCT INFORMATION - Premium Mode (Section 2d.)**

The premium mode is bracketed to facilitate any change to availability. If availability of a premium 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.

### **RIDERS – Rider Names (Section 3a.-3f)**

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

### **ADDITIONAL PROPOSED INSURANCE(S) – Disclosure (4.)**

The product names are bracketed to facilitate the removal of products that are discontinued, 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 to use (if required).

### **MEDICAL HISTORY – Disclosure (Pg. 3 of 4, immediately above question #18)**

The disclosure will appear based on products approved by your jurisdiction and made available in your jurisdiction. The disclosure will appear, or it will not appear, based on product availability.

**1. PROPOSED INSURED INFORMATION**

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

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

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

**3. RIDERS** (Verify rider availability.) [Optional riders are not available with the HMS Term w/ADB product.]

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

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

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

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

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

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

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

**Yes No**

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

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

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

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

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

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

**9. SPECIAL REQUESTS**

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

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

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

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

**PERSONAL HISTORY DETAILS**

Question #	Proposed Insured's Name	Dates	Details

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

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

**[NOTE: Questions 18-26 are NOT required when applying for HMS Term with ADB. If you are applying for HMS Term w/ADB, answers provided to questions 18-26 will NOT be considered. Please DO NOT answer questions 18-26 for HMS Term w/ADB.]**

Proposed Insured		Additional Proposed Insured	
Yes	No	Yes	No

- 18. Has any Proposed Insured used cigarettes, cigars, pipes, chewing tobacco, nicotine patches, snuff, nicotine chewing gum, or other products containing nicotine within the last twelve (12) months? .....
- 19. Within the past seven (7) years, has any Proposed Insured:
  - a. been treated for or been advised or diagnosed by a medical professional to seek treatment for the use of alcohol or prescription drugs? .....
  - b. been advised to reduce or discontinue the intake of alcohol or prescription drugs? .....

*(If Yes, complete the alcohol usage and/or prescription medication and drug use questionnaire.)*
- 20. Within the past seven (7) years, has any Proposed Insured used, except as prescribed by a physician: heroin, morphine, other narcotics, ecstasy, opium derivatives, marijuana, cocaine, crack, barbiturates, amphetamines, methamphetamines, hallucinogens, any other illegal, restricted or controlled substances, been treated for or been advised by a medical professional to seek treatment for the intake of any drug? *(If Yes, complete the prescription medication and drug use questionnaire.)* .....
- 21. Within the past five (5) years, has any Proposed Insured been diagnosed with or been advised to have or had treatment for:
  - a. hypertension, heart disease or disorder, valve disorders, angina, cardiac arrhythmia, heart surgery including bypass, angioplasty or stent placement, circulatory disorder, blood vessel or blood disorders? .....
  - b. lung or respiratory disorder, COPD, emphysema, current use of oxygen, shortness of breath, or sleep apnea? .....
  - c. cancer in any form? .....
  - d. diabetes or pancreatic disorders? .....
  - e. digestive disorder, kidney or liver disease to include hepatitis, Crohn's disease or ulcerative colitis, gastrointestinal bleeding, bladder disorders, or unexplained weight loss? .....
  - f. Alzheimer's disease, dementia, nervous system disorder, emotional or psychiatric disorder, paralysis, sexually transmitted disease, systemic lupus, any blood disorders, or birth defects? .....
  - g. rheumatoid arthritis, any disease or disorder of the bones or muscles? .....
- 22. Within the last five (5) years, has any Proposed Insured consulted a physician, had tests performed (such as an EKG, echocardiogram, X-ray, or blood tests) or been hospitalized or had surgery for any reason? .....
- 23. Has any Proposed Insured ever been diagnosed as having, been told by a medical professional that you have, or been treated by a medical professional for Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or any immune deficiency related disorder or tested positive for antibodies to the Human Immunodeficiency Virus (HIV)? .....
- 24. Within the last twelve (12) months, has any Proposed Insured had tests, surgery, treatment or hospitalization recommended, but not completed, or consulted any health care provider(s) not already identified, for any reason? .....
- 25. Do any of the Proposed Insured(s):
  - a. currently use prescription medicines? *(If Yes, list each medication and describe the reason for its use.)* .....
  - b. currently have a personal physician? *(If Yes, list name, address, and telephone number along with date, reason, and results of last consultation.)* .....

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

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

**MEDICAL HISTORY DETAILS**

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

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

**AUTHORIZATION AND ACKNOWLEDGMENT**

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

Americo may release information obtained by this Authorization to its reinsurers, to ~~MIB, Inc. the Medical Information Bureau,~~ to other insurers with whom I/we have ~~life insurance 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. ~~Although federal regulations require that Americo inform You of the potential that information disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and no longer be protected by such regulation, all information received by Americo pursuant to this Authorization will be protected by federal and state privacy laws and regulations.~~

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 ~~A~~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 ~~a~~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 ~~a~~Authorization. Notice of revocation may be sent, in writing, to Americo at its Administrative Office address.

**IN ACCORDANCE WITH STATE LAW, WE MUST PROVIDE YOU WITH THE FOLLOWING FRAUD NOTICE:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**DC Residents Only:** WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**TN Residents only:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

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

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

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

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

I/We have read this application and represent to Americo that the statements made on this application are true, complete and correctly recorded to the best of my/our knowledge and belief. I/We agree that Americo can rely on these statements. I/We agree that this application and/or any medical exam form and any supplemental application or amendment to the application will be the basis for any policy issued on this application or any amendment to the application. **I/WE AGREE THAT ALL ANSWERS TO THE PERSONAL HISTORY QUESTIONS ON PAGE 2 AND TO MEDICAL HISTORY QUESTIONS ON PAGE 3 OF THIS APPLICATION, WHICH IS SIGNED AND DATED BELOW, ARE COMPLETE AND ACCURATE.**

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

\_\_\_\_\_  
Signature of Proposed Insured (required)

\_\_\_\_\_  
Signature of Owner (~~if different from~~ ~~than~~ the Proposed Insured)

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

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

**AMERICO FINANCIAL LIFE AND ANNUITY INSURANCE COMPANY**

NAIC: 0449-61999

FEIN: 35-0810610

**STATE OF ARKANSAS**

**Associated Forms List**

Description	Form Number	Disposition	Disposition Date	SERFF Tracking No.
Term to 105 & data pages; Term to 100 & data pages; Term to 95 & data pages	AAR300, AAR301, AAR302, AAR300 (15), AAR300 (15/5), AAR300 (20), AAR300 (20/5), AAR300 (25), AAR300 (25/5), AAR300 (30), AAR300 (30/5), AAR301 (15), AAR301 (15/5), AAR301 (20), AAR301 (20/5), AAR301 (25), AAR301 (25/5), AAR301 (30), AAR301 (30/5), AAR302 (15), AAR302 (15/5), AAR302 (20), AAR302 (20/5), AAR302 (25), AAR302 (25/5), AAR302 (30), AAR302 (30/5)	approved	9/28/2010	AFLC-126748984
Flexible Premium Adj. Life Policy End at 105 & data pages; Flexible Premium Adj. Life Policy End at 100 & data pages; Flexible Premium Adj. Life Policy End at 95 & data pages	ABB295, ABB295 (15), ABB295 (20), ABB295(25), ABB295 (30), ABB296, ABB296 (15), ABB296 (20), ABB296 (25), ABB296 (30), ABB297, ABB297 (15), ABB297 (20), ABB297 (25), ABB297 (30)	approved	9/3/2010	AFLC-126775221
Additional Insured Riders	AAR2160-105, AAR2160-100, AAR2160-95,	approved	9/28/2010	AFLC-126748984
Accidental Death Benefit Rider	AAA2165	approved	9/28/2010	AFLC-126748984
Children's Term Insurance Rider	AAR2162	approved	9/3/2010	AFLC-126775221
Disability Income Rider & Supp. Application	ABB2145, ABB5083	approved	1/7/2003	USPH-5HETMM694
Critical Illness Accelerated Benefit Rider	AAA2139	approved	12/5/2002	USPH-5EBNJJ585
Critical Illness Accelerated Benefit Payment Supp. Application	ABB5082	approved	12/5/2002	USPH-5EBNJJ585
Involuntary Unemployment Waiver of Premium Rider	AAA2140	approved	1/21/2003	USPH-5HUS59864
Waiver of Monthly Specified Premium Rider (UL)	AAA2158-UL	approved	9/3/2010	AFLC-126775221
Waiver of Premium Rider	AAA2158	approved	1/22/2009	AFLC-125988249
Questionnaires: Alcohol Usage, Arthritis, Aviation, Back Disorders, Chest Pain, Diabetic, Epilepsy/Seizure, High Blood Pressure, Military, Nervous Disorders, Prescription Medication & Drug Use, Respiratory Disorders, Sports Activities, Tumor	AAA5101, AAA5102, AAA5103, AAA5104, AAA5105, AAA5106, AAA5107, AAA5108, AAA5109, AAA5110, AAA5111, AAA5112, AAA5113, AAA5114	approved	3/4/2009	AFLC-126007301