

SERFF Tracking Number: APLE-128005508 State: Arkansas  
Filing Company: IA American Life Insurance Company State Tracking Number:  
Company Tracking Number: GL213(11/11)  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: Life Insurance Application - GL213(11/11)  
Project Name/Number: /

## Filing at a Glance

Company: IA American Life Insurance Company

Product Name: Life Insurance Application - SERFF Tr Num: APLE-128005508 State: Arkansas  
GL213(11/11)

TOI: L08 Life - Other

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

Sub-TOI: L08.000 Life - Other

Co Tr Num: GL213(11/11)

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Linda Bird

Author: Traci Baty

Disposition Date: 02/02/2012

Date Submitted: 01/25/2012

Disposition Status: Approved-  
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name:

Status of Filing in Domicile: Pending

Project Number:

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments: Filed in Georgia,  
our State of Domicile.

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Individual Market Type:

Overall Rate Impact:

Filing Status Changed: 02/02/2012

Deemer Date:

State Status Changed: 02/02/2012

Submitted By: Traci Baty

Created By: Traci Baty

Filing Description:

Corresponding Filing Tracking Number:

Cover Letter under Supporting Documentation.

## Company and Contact

### Filing Contact Information

Clara Keel, Product Filing Manager

ckeel@aatx.com

425 Austin Ave

254-297-2794 [Phone]

Waco, TX 76701

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**Filing Company Information**

IA American Life Insurance Company CoCode: 91693 State of Domicile: Georgia  
 17550 N. Perimeter Dr. Group Code: 315 Company Type: LAH  
 Suite 210 Group Name: Industrial Alliance State ID Number:  
 Group  
 Scottsdale, AZ 85255-0131 FEIN Number: 13-3036472  
 (480) 473-5540 ext. [Phone]

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**Filing Fees**

Fee Required? Yes  
 Fee Amount: \$50.00  
 Retaliatory? No  
 Fee Explanation:  
 Per Company: No

| COMPANY                            | AMOUNT  | DATE PROCESSED | TRANSACTION # |
|------------------------------------|---------|----------------|---------------|
| IA American Life Insurance Company | \$50.00 | 01/25/2012     | 55800367      |

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## Correspondence Summary

### Dispositions

| Status          | Created By | Created On | Date Submitted |
|-----------------|------------|------------|----------------|
| Approved-Closed | Linda Bird | 02/02/2012 | 02/02/2012     |

SERFF Tracking Number: APLE-128005508 State: Arkansas  
Filing Company: IA American Life Insurance Company State Tracking Number:  
Company Tracking Number: GL213(11/11)  
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Product Name: Life Insurance Application - GL213(11/11)  
Project Name/Number: /

## Disposition

Disposition Date: 02/02/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: *APLE-128005508* State: *Arkansas*  
 Filing Company: *IA American Life Insurance Company* State Tracking Number:  
 Company Tracking Number: *GL213(11/11)*  
 TOI: *L08 Life - Other* Sub-TOI: *L08.000 Life - Other*  
 Product Name: *Life Insurance Application - GL213(11/11)*  
 Project Name/Number: */*

| <b>Schedule</b>            | <b>Schedule Item</b>                | <b>Schedule Item Status</b> | <b>Public Access</b> |
|----------------------------|-------------------------------------|-----------------------------|----------------------|
| <b>Supporting Document</b> | Flesch Certification                |                             | Yes                  |
| <b>Supporting Document</b> | Application                         |                             | Yes                  |
| <b>Supporting Document</b> | Cover Letter                        |                             | Yes                  |
| <b>Supporting Document</b> | Redlined Application - GL213(11/11) |                             | Yes                  |
| <b>Form</b>                | Life Insurance Application          |                             | Yes                  |

SERFF Tracking Number: *APLE-128005508* State: *Arkansas*  
 Filing Company: *IA American Life Insurance Company* State Tracking Number:  
 Company Tracking Number: *GL213(11/11)*  
 TOI: *L08 Life - Other* Sub-TOI: *L08.000 Life - Other*  
 Product Name: *Life Insurance Application - GL213(11/11)*  
 Project Name/Number: */*

## Form Schedule

### Lead Form Number:

| Schedule Item Status | Form Number    | Form Type Form Name                                    | Action  | Action Specific Data | Readability | Attachment         |
|----------------------|----------------|--|---------|----------------------|-------------|--------------------|
|                      | GL213AR(11/11) | Application/Life Insurance Enrollment Application Form | Initial |                      | 42.000      | GL213AR(11-11).pdf |

www.iaamerican.com

Telephone Case No: \_\_\_\_\_

|   |  |  |   |                               |  |
|---|--|--|---|-------------------------------|--|
| Proposed Insured _____<br><small>(First) (Middle) (Last)</small>  |  |  | Telephone interview completed <input type="checkbox"/> Yes <input type="checkbox"/> No  |                               |  |
| Address (No. & Street) _____  |  |  | <input type="checkbox"/> am <input type="checkbox"/> pm   |                               |  |
| City _____  |  | State _____  | Zip Code _____  |                               | E-mail Address _____   |
| <input type="checkbox"/> Male <input type="checkbox"/> Female   | Date of Birth<br>/ /   | Age  | State of Birth  | Social Security Number<br>/ / | Height<br>ft in  |
| Weight<br>lbs   | Owner: Name _____ Relationship _____ SS# _____ / _____ / _____ |  |   |                               |  |
| Address _____   |  |  | City/State/Zip _____  |                               |  |
| Primary Beneficiary _____   |  | Relationship _____                                       | Contingent Beneficiary _____  |                               | Relationship _____   |
| Plan: <input type="checkbox"/> Immediate Death Benefit  |  |  | <input type="checkbox"/> Check here if you are willing to accept any plan for which you qualify based on this application. The insurance for which you qualify may have a graded death benefit for the first two (2) years, a face amount less than any indicated on this application, and riders may not be available. |                               |  |
| <input type="checkbox"/> Graded Death Benefit (Percentage of Face Amount)   |  |  |   |                               |  |
| Face Amount of Insurance \$ _____   |  |  |   |                               |  |
| During the past 12 months have you used tobacco in any form (excluding occasional pipe and cigar use)? <input type="checkbox"/> Yes <input type="checkbox"/> No |  |  |   |                               |  |
| Rider: <input type="checkbox"/> Grandchild/Great Grandchild Coverage (Indicate Number of Children Applying) _____   |  |  |   |                               | Automatic Premium Loan Elected? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Child Rider _____ Units <input type="checkbox"/> ADB Amt \$ _____  |  |  |   |                               |  |
| Mode: <input type="checkbox"/> Bank Draft <input type="checkbox"/> Draft 1st Prem on Req. Date  |  | CWA: <input type="checkbox"/> E-Check Immediate 1st Prem | Mail Policy To: <input type="checkbox"/> Agent <input type="checkbox"/> Insured <input type="checkbox"/> Owner  |                               |  |
| <input type="checkbox"/> Other Modal Prem \$ _____  |  | <input type="checkbox"/> Collected \$ _____              | Requested Policy Date: / /  |                               |  |
| A. Do you have existing life insurance or an annuity contract? <input type="checkbox"/> Yes <input type="checkbox"/> No   |  |  | Company _____   |                               |  |
| B. Will you replace an existing life insurance policy or an annuity? <input type="checkbox"/> Yes <input type="checkbox"/> No                                   |  |  | Policy # _____  | Amount of Coverage \$ _____   |  |
| Physician Name: _____   |  | City/State: _____  |   | Phone: _____                  |  |

**HEALTH INFORMATION**

1. Are you currently hospitalized, confined to a bed or nursing facility, confined to a wheelchair due to chronic illness or disease, or using oxygen equipment to assist in breathing, or receiving Hospice Care? .....  Yes  No
2. Have you had or been medically advised to have an organ transplant, or have you been medically diagnosed as having metastatic cancer, Alzheimer's, dementia, mental incapacity, or have you been diagnosed, treated (including dialysis) or taken medication for renal insufficiency, kidney failure, liver failure, or respiratory failure? .....  Yes  No
3. Have you been medically treated or diagnosed by a medical professional as having Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC), or any immune deficiency related disorder or tested positive for the Human Immunodeficiency Virus (HIV)? .....  Yes  No
4. Have you been medically diagnosed with diabetes combined with a medical history of any of the following: stroke, TIA, heart disease, heart attack, coronary artery bypass, angioplasty, circulatory disease, or peripheral vascular disease? .....  Yes  No
5. Have you taken insulin shots prior to age 50 or been treated for insulin shock or diabetic coma? .....  Yes  No
6. Have you ever been medically diagnosed, treated, or taken medication for congestive heart failure, cardiomyopathy, Lou Gehrig's disease, Huntington's disease, had an amputation caused by disease, or more than one occurrence of cancer (excluding basal or squamous cell skin cancer) in your lifetime? .....  Yes  No
7. Within the past 12 months have you:
  - a. been medically diagnosed or treated for angina (chest pain), stroke or TIA, cirrhosis, Hepatitis C, chronic hepatitis, chronic pancreatitis, chronic obstructive pulmonary disease (COPD), emphysema, chronic bronchitis, or required oxygen equipment to assist in breathing? .....  Yes  No
  - b. had a heart attack, aneurysm, heart valve surgery, coronary artery bypass surgery, angioplasty, or stent implant or had or been medically advised to have surgery for brain or heart disorders (including, but not limited to catheterization, a pacemaker insertion, defibrillator placement), or any procedure to improve circulation? .....  Yes  No
  - c. been medically diagnosed, treated, or taken medication for internal cancer, lymphoma, melanoma, leukemia, or systemic lupus (SLE)? .....  Yes  No
  - d. had any diagnostic testing, surgery, or hospitalization recommended by a medical professional which has not been completed or for which the results have not been received? .....  Yes  No
  - e. used illegal drugs or abused alcohol or drugs, or had or been recommended to have treatment or counseling for alcohol or drug use, or been convicted of any felony or driving under the influence of alcohol or drugs? .....  Yes  No

**If any answer to questions 1 through 7 is answered "Yes" the Proposed Insured is not eligible for any coverage.**

8. Within the past 24 months have you been medically diagnosed or treated, or hospitalized for:
  - a. stroke, angina (chest pain), heart attack, aneurysm, heart or circulatory surgery or any procedure to improve circulation? ...  Yes  No
  - b. or taken medication for internal cancer, leukemia, melanoma, emphysema, chronic bronchitis, chronic obstructive pulmonary disease (COPD), ulcerative colitis, cirrhosis, Hepatitis C, liver disease? .....  Yes  No
  - c. paralysis of two or more extremities or any neuro-muscular disease (including, but not limited to cerebral palsy, multiple sclerosis, seizures, or Parkinson's disease)? .....  Yes  No

**If any answer to question 8 is answered "Yes" the Proposed Insured should apply for the Graded Death Benefit Plan.**

**If all questions 1 through 8 are answered "No" the Proposed Insured should apply for the Immediate Death Benefit Plan.**

GL213AR(11/11)

**NOTICE**

**Printed in compliance with Public Law 91-508**

Thank you for considering IA American Life Insurance Company for your insurance needs. This is to inform you that as part of our procedure for processing your insurance application, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation and personal characteristics. You have the right to make a written request within a reasonable period of time to receive additional detailed information about the nature and scope of this investigation.

**MIB PRE-NOTICE**

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

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

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

**CHILD, GRANDCHILD, AND GREAT GRANDCHILD COVERAGE - Children Proposed for Insurance (list additional children on a separate sheet):**

| Proposed Insured Name | Sex | Birthdate | Relationship | Proposed Insured Name | Sex | Birthdate | Relationship |
|-----------------------|-----|-----------|--------------|-----------------------|-----|-----------|--------------|
|                       |     |           |              |                       |     |           |              |
|                       |     |           |              |                       |     |           |              |

**PROPOSED CHILDREN'S HEALTH STATEMENT**—To the best of my knowledge and belief, none of the children listed above for coverage have been treated for or told by a physician that they have or had any of the following medical conditions: Hypertension, heart or circulatory disorder, malignancy in any form, diabetes, sickle cell anemia, seizures, Down's Syndrome, cystic fibrosis, cerebral palsy, hydrocephalus, paralysis, or hospitalized for asthma or any respiratory disorder in past 12 months. List the names of children that are exceptions to PROPOSED CHILDREN'S HEALTH STATEMENT. **Children listed as an exception are excluded from the appropriate Child Rider Coverage.** Exceptions are: \_\_\_\_\_

**AGREEMENT**—I agree with IA American Life Insurance Company (the Company) as follows: (1) To the best of my knowledge and belief, all answers and statements contained in this application are true, complete and correctly recorded; and (2) This application and any policy issued on the basis of such application shall form the entire contract; and (3) No change in this contract shall be effected without my written consent with regard to: (a) the amount of insurance; (b) age at issue; (c) classification of risk; (d) plan of insurance; or (e) benefits. If this application is declined by the Company, I will accept the return of any premium paid. Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application containing a false or deceptive statement may be guilty of insurance fraud.

**AUTHORIZATION**—In order to properly classify my application for life insurance, I authorize any and all physicians, medical practitioners, hospitals, clinics, medical or medically-related facilities, health plans, pharmacy benefit managers, pharmacies or pharmacy-related facilities; insurance companies and their business associates and those persons or entities providing services to the insurer's business associates which are related in any way to their insurance plans; the MIB, Inc. or other organization that has knowledge or records of me and my health to give such information to: (a) IA American Life Insurance Company; and (b) its reinsurers. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization or the insurance company exercises a legal right to contest a claim or the policy itself. I may revoke the authorization by sending a written revocation to the Company address of 425 Austin Ave., Waco TX 76701. I understand that if I refuse to sign this authorization to release my complete medical records, my application for insurance with the Company will be rejected.

All said sources, except the MIB, Inc., are authorized to give records or knowledge such as statements regarding hobbies, employment, criminal records or medical history that might be required to determine eligibility for insurance to any agency employed by the Company to collect and transmit data. I authorize IA American Life Insurance Company to disclose any personal data gathered while processing this application. This data may be released to the following: (a) reinsuring companies; (b) the MIB, Inc.; (c) other persons or groups performing services in connection with this application; or (d) any others to whom it may be lawfully required or authorized. This authorization shall remain valid for two years from this date. A copy of this authorization shall be as valid as the original.

I acknowledge receiving the Fair Credit Reporting Act Notice, the MIB, Inc. Pre-Notice, the Terminal Illness Accelerated Benefit Rider and Confined Care Accelerated Benefit Rider Disclosure Forms, if applicable.

Signed at \_\_\_\_\_ Date of Application \_\_\_\_\_  
CITY STATE MONTH DAY YEAR  
 \_\_\_\_\_  
SIGNATURE OF PROPOSED INSURED SIGNATURE OF OWNER (IF OTHER THAN PROPOSED INSURED)

**AGENT'S REPORT**

Does the proposed insured have any existing life insurance or annuity contract? .....  Yes  No  
 Is the proposed insurance intended to replace or change any existing life insurance or annuity?.....  Yes  No

*I certify that I have personally asked each question on this application to the proposed insured(s), I have truly and completely recorded on the application the information supplied by him/her, and I witnessed their signature.*

I certify that the Terminal Illness Accelerated Benefit Rider and Confined Care Accelerated Benefit Rider Disclosure Forms have been presented to the applicant, if applicable. AGENT'S REMARKS: \_\_\_\_\_

AGENT'S PRINTED NAME \_\_\_\_\_ DATE \_\_\_\_\_  
 Agent \_\_\_\_\_ No: \_\_\_\_\_ % \_\_\_\_\_  
SIGNATURE SIGNATURE

**PREAUTHORIZATION CHECK PLAN - AUTHORIZATION TO HONOR CHARGE DRAWN**

Insured \_\_\_\_\_ Account Holder \_\_\_\_\_  
 Financial Institution \_\_\_\_\_ Address \_\_\_\_\_  
 Transit/ABA Number \_\_\_\_\_ Account Number \_\_\_\_\_  Checking  Savings Requested Draft Day (1st-28th) \_\_\_\_\_

**ATTACH VOIDED CHECK OR DEPOSIT SLIP**

As a convenience to me, I hereby request and authorize you to pay and charge to my account amounts drawn on my account, whether by electronic or paper means, by and payable to the order of IA American Life Insurance Company, for the purpose of paying premiums on life insurance policy, provided there are sufficient funds in said account to pay the same upon presentation. I agree that your rights with respect to each such charge shall be the same as if it were signed personally by me. This authorization is to remain in effect until revoked by me in writing and until you actually receive such notice. I agree that you shall be fully protected in honoring any such check. I further agree that if any such check be dishonored, whether with or without cause, and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

\_\_\_\_\_  
SIGNATURE (AS ON FINANCIAL INSTITUTION RECORDS) DATE

GL213AR(11/11)

**IA AMERICAN LIFE INSURANCE COMPANY**  
 P.O. BOX 2549, WACO, TX 76702-2549

**CONDITIONAL RECEIPT**

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

ALL PREMIUM CHECKS MUST BE PAYABLE TO THE COMPANY  
 DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE PAYEE BLANK

Received of \_\_\_\_\_ the sum of \$ \_\_\_\_\_ as first payment on this application.  
 Date \_\_\_\_\_ Agent \_\_\_\_\_

If (1) an amount equal to the first full premium is submitted; and if (2) all underwriting requirements, including any medical examinations required by the Company's rules, are completed; and (3) the proposed insured is, on the date of application, a risk acceptable for insurance exactly as applied for without modification of plan, premium rate, or amount under the Company's rules and practices, then insurance under the policy applied for shall become effective on the latest of (a) the date of application, or (b) the date of the latest medical exam required by the Company. THE AMOUNT OF LIFE INSURANCE, INCLUDING ANY AMOUNT IN FORCE OR BEING APPLIED FOR, WHICH MAY BECOME EFFECTIVE PRIOR TO THE DELIVERY OF THE POLICY SHALL IN NO EVENT EXCEED \$30,000.00 (INCLUDING LIFE INSURANCE AND ACCIDENTAL DEATH BENEFITS).

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

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Product Name: Life Insurance Application - GL213(11/11)  
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## Supporting Document Schedules

|   | Item Status: | Status Date: |
|---|--------------|--------------|
| <b>Satisfied - Item:</b> Flesch Certification<br><b>Comments:</b><br><b>Attachment:</b><br>AR GL213 Readability Certification.pdf |              |              |

|  | Item Status: | Status Date: |
|--|--------------|--------------|
| <b>Satisfied - Item:</b> Application<br><b>Comments:</b><br>Previous application attached approval date mentioned in cover letter.<br><b>Attachment:</b><br>GL213AR Life Insurance Application.pdf |              |              |

|  | Item Status: | Status Date: |
|--|--------------|--------------|
| <b>Satisfied - Item:</b> Cover Letter<br><b>Comments:</b><br>Cover Letter attached.<br><b>Attachment:</b><br>AR GL213 Application Cover Letter.pdf |              |              |

|   | Item Status: | Status Date: |
|---|--------------|--------------|
| <b>Satisfied - Item:</b> Redlined Application - GL213(11/11)<br><b>Comments:</b><br>Redlined Application attached.<br><b>Attachment:</b><br>AR GL213 Redlined Application.pdf |              |              |

ARKANSAS

IA AMERICAN LIFE INSURANCE COMPANY

CERTIFICATION

This is to certify that the attached Life Insurance Application, Form Number GL213AR(11/11), has achieved a Flesch Reading Ease Score of 42 and complies with the requirements of Arkansas Statute 23-80-201 through 23-80-208, cited as the Life and Disability Insurance Policy Simplification Act.



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Signature

Clara Keel, FLMI  
Product Filing Manager and Assistant Secretary  
American-Amicable Life Insurance Company of Texas  
A subsidiary of IA American Life Insurance Company

January 23, 2012

|   |                      |  |  |  |                             |
|---|----------------------|--|--|--|-----------------------------|
| Proposed Insured _____<br><small>(First) (Middle) (Last)</small>  |                      |  | Telephone interview completed <input type="checkbox"/> Yes <input type="checkbox"/> No |  |                             |
| Address (No. & Street) _____  |                      |  | <input type="checkbox"/> am <input type="checkbox"/> pm                                |  |                             |
| City _____  |                      | State _____  | Zip Code _____   |  | E-mail Address _____        |
| <input type="checkbox"/> Male <input type="checkbox"/> Female   | Date of Birth<br>/ / | Age  | State of Birth   | Social Security Number<br>/ /  | Height<br>ft in             |
|   |                      |  |  |  | Weight<br>lbs               |
| Owner: Name _____   |                      | Relationship _____                                       |  | SS# _____ / _____ / _____  |                             |
| Address _____   |                      | City/State/Zip _____                                     |  |  |                             |
| Primary Beneficiary _____   |                      | Relationship _____                                       | Contingent Beneficiary _____   |  | Relationship _____          |
| Plan: <input type="checkbox"/> Immediate Death Benefit <input type="checkbox"/> Graded Death Benefit (Percentage of Face Amount)                                |                      |  |  |  |                             |
| During the past 12 months have you used tobacco in any form (excluding occasional pipe and cigar use)? <input type="checkbox"/> Yes <input type="checkbox"/> No |                      |  |  |  |                             |
| <b>Face Amount of Insurance \$</b>  |                      |  |  |  |                             |
| Rider: <input type="checkbox"/> Grandchild/Great Grandchild Coverage (Indicate Number of Children Applying) _____   |                      |  |  | Automatic Premium  |                             |
| <input type="checkbox"/> Child Rider _____ Units <input type="checkbox"/> ADB Amt \$ _____  |                      |  |  | Loan Elected? <input type="checkbox"/> Yes <input type="checkbox"/> No   |                             |
| Mode: <input type="checkbox"/> Bank Draft <input type="checkbox"/> Draft 1st Prem on Req. Date  |                      | CWA: <input type="checkbox"/> E-Check Immediate 1st Prem |  | Mail Policy To: <input type="checkbox"/> Agent <input type="checkbox"/> Insured <input type="checkbox"/> Owner |                             |
| <input type="checkbox"/> Other Modal Prem \$ _____  |                      | <input type="checkbox"/> Collected \$ _____              |  | Requested Policy Date: / /   |                             |
| A. Do you have existing life insurance or an annuity contract? <input type="checkbox"/> Yes <input type="checkbox"/> No   |                      |  | Company _____  |  |                             |
| B. Will you replace an existing life insurance policy or an annuity? <input type="checkbox"/> Yes <input type="checkbox"/> No                                   |                      |  | Policy # _____   |  | Amount of Coverage \$ _____ |
| Physician Name: _____   |                      | City/State: _____  |  | Phone: _____   |                             |

**HEALTH INFORMATION**

1. Are you currently hospitalized, confined to a bed or nursing facility, confined to a wheelchair due to chronic illness or disease, or using oxygen equipment to assist in breathing, or receiving Hospice Care? .....  Yes  No
2. Have you had or been medically advised to have an organ transplant, or have you been medically diagnosed as having metastatic cancer, Alzheimer's, dementia, mental incapacity, or have you been diagnosed, treated (including dialysis) or taken medication for renal insufficiency, kidney failure, liver failure, or respiratory failure? .....  Yes  No
3. Have you been medically treated or diagnosed by a medical professional as having Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC), or any immune deficiency related disorder or tested positive for the Human Immunodeficiency Virus (HIV)? .....  Yes  No
4. Have you been medically diagnosed with diabetes combined with a medical history of any of the following: stroke, TIA, heart disease, heart attack, coronary artery bypass, angioplasty, circulatory disease, or peripheral vascular disease? .....  Yes  No
5. Have you taken insulin shots prior to age 50 or been treated for insulin shock or diabetic coma? .....  Yes  No
6. Have you ever been medically diagnosed, treated, or taken medication for congestive heart failure, cardiomyopathy, Lou Gehrig's disease, Huntington's disease, had an amputation caused by disease, or more than one occurrence of cancer (excluding basal or squamous cell skin cancer) in your lifetime? .....  Yes  No
7. Within the past 12 months have you:
  - a. been medically diagnosed or treated for angina (chest pain), stroke or TIA, cirrhosis, Hepatitis C, chronic hepatitis, chronic pancreatitis, chronic obstructive pulmonary disease (COPD), emphysema, chronic bronchitis, or required oxygen equipment to assist in breathing? .....  Yes  No
  - b. had a heart attack, aneurysm, heart valve surgery, coronary artery bypass surgery, angioplasty, or stent implant or had or been medically advised to have surgery for brain or heart disorders (including, but not limited to catheterization, a pacemaker insertion, defibrillator placement), or any procedure to improve circulation? .....  Yes  No
  - c. been medically diagnosed, treated, or taken medication for internal cancer, lymphoma, melanoma, leukemia, or systemic lupus (SLE)? .....  Yes  No
  - d. had any diagnostic testing, surgery, or hospitalization recommended by a medical professional which has not been completed or for which the results have not been received? .....  Yes  No
  - e. used illegal drugs or abused alcohol or drugs, or had or been recommended to have treatment or counseling for alcohol or drug use, or been convicted of any felony or driving under the influence of alcohol or drugs? .....  Yes  No

**If any answer to questions 1 through 7 is answered "Yes" the Proposed Insured is not eligible for any coverage.**

8. Within the past 24 months have you been medically diagnosed or treated, or hospitalized for:
  - a. stroke, angina (chest pain), heart attack, aneurysm, heart or circulatory surgery or any procedure to improve circulation? ...  Yes  No
  - b. or taken medication for internal cancer, leukemia, melanoma, emphysema, chronic bronchitis, chronic obstructive pulmonary disease (COPD), ulcerative colitis, cirrhosis, Hepatitis C, liver disease? .....  Yes  No
  - c. paralysis of two or more extremities or any neuro-muscular disease (including, but not limited to cerebral palsy, multiple sclerosis, seizures, or Parkinson's disease)? .....  Yes  No

**If any answer to question 8 is answered "Yes" the Proposed Insured should apply for the Graded Death Benefit Plan.**

**If all questions 1 through 8 are answered "No" the Proposed Insured should apply for the Immediate Death Benefit Plan.**

GL213AR

**NOTICE**

**Printed in compliance with Public Law 91-508**

Thank you for considering IA America Life Insurance Company for your insurance needs. This is to inform you that as part of our procedure for processing your insurance application, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation and personal characteristics. You have the right to make a written request within a reasonable period of time to receive additional detailed information about the nature and scope of this investigation.

**MIB, INC. PRE-NOTICE**

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

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

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

**CHILD, GRANDCHILD, AND GREAT GRANDCHILD COVERAGE - Children Proposed for Insurance (list additional children on a separate sheet):**

| Proposed Insured Name | Sex | Birthdate | Relationship | Proposed Insured Name | Sex | Birthdate | Relationship |
|-----------------------|-----|-----------|--------------|-----------------------|-----|-----------|--------------|
|                       |     |           |              |                       |     |           |              |
|                       |     |           |              |                       |     |           |              |

**PROPOSED CHILDREN'S HEALTH STATEMENT**—To the best of my knowledge and belief, none of the children listed above for coverage have been treated for or told by a physician that they have or had any of the following medical conditions: Hypertension, heart or circulatory disorder, malignancy in any form, diabetes, sickle cell anemia, seizures, Down's Syndrome, cystic fibrosis, cerebral palsy, hydrocephalus, paralysis, or hospitalized for asthma or any respiratory disorder in past 12 months. List the names of children that are exceptions to PROPOSED CHILDREN'S HEALTH STATEMENT. **Children listed as an exception are excluded from the appropriate Child Rider Coverage.** Exceptions are: \_\_\_\_\_

**AGREEMENT**—I agree with IA American Life Insurance Company (the Company) as follows: (1) To the best of my knowledge and belief, all answers and statements contained in this application are true, complete and correctly recorded; and (2) This application and any policy issued on the basis of such application shall form the entire contract; and (3) No change in this contract shall be effected without my written consent with regard to: (a) the amount of insurance; (b) age at issue; (c) classification of risk; (d) plan of insurance; or (e) benefits. If this application is declined by the Company, I will accept the return of any premium paid. Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application containing a false or deceptive statement may be guilty of insurance fraud.

**AUTHORIZATION**—In order to properly classify my application for life insurance, I authorize any and all physicians, medical practitioners, hospitals, clinics, medical or medically-related facilities, health plans, pharmacy benefit managers, pharmacies or pharmacy-related facilities; insurance companies and their business associates and those persons or entities providing services to the insurer's business associates which are related in any way to their insurance plans; the MIB, Inc. or other organization that has knowledge or records of me and my health to give such information to: (a) IA American Life Insurance Company; and (b) its reinsurers. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization or the insurance company exercises a legal right to contest a claim or the policy itself. I may revoke the authorization by sending a written revocation to the Company address of 425 Austin Ave., Waco TX 76701. I understand that if I refuse to sign this authorization to release my complete medical records, my application for insurance with the Company will be rejected.

All said sources, except the MIB, Inc., are authorized to give records or knowledge such as statements regarding hobbies, employment, criminal records or medical history that might be required to determine eligibility for insurance to any agency employed by the Company to collect and transmit data. I authorize IA American Life Insurance Company to disclose any personal data gathered while processing this application. This data may be released to the following: (a) reinsuring companies; (b) the MIB, Inc.; (c) other persons or groups performing services in connection with this application; or (d) any others to whom it may be lawfully required or authorized. This authorization shall remain valid for two years from this date. A copy of this authorization shall be as valid as the original.

I acknowledge receiving the Fair Credit Reporting Act Notice, the MIB, Inc. Pre-Notice, the Terminal Illness Accelerated Benefit Rider and Confined Care Accelerated Benefit Rider Disclosure Forms, if applicable.

Signed at \_\_\_\_\_ Date of Application \_\_\_\_\_  
CITY STATE MONTH DAY YEAR  
 \_\_\_\_\_  
SIGNATURE OF PROPOSED INSURED SIGNATURE OF OWNER (IF OTHER THAN PROPOSED INSURED)

**AGENT'S REPORT**

Does the proposed insured have any existing life insurance or annuity contract? .....  Yes  No  
 Is the proposed insurance intended to replace or change any existing life insurance or annuity?.....  Yes  No

*I certify that I have personally asked each question on this application to the proposed insured(s), I have truly and completely recorded on the application the information supplied by him/her, and I witnessed their signature.*

I certify that the Terminal Illness Accelerated Benefit Rider and Confined Care Accelerated Benefit Rider Disclosure Forms have been presented to the applicant, if applicable. AGENT'S REMARKS: \_\_\_\_\_

AGENT'S PRINTED NAME \_\_\_\_\_ DATE \_\_\_\_\_  
 Agent \_\_\_\_\_ No: \_\_\_\_\_ % \_\_\_\_\_  
SIGNATURE SIGNATURE

**PREAUTHORIZATION CHECK PLAN - AUTHORIZATION TO HONOR CHARGE DRAWN**

Insured \_\_\_\_\_ Account Holder \_\_\_\_\_  
 Financial Institution \_\_\_\_\_ Address \_\_\_\_\_  
 Transit/ABA Number \_\_\_\_\_ Account Number \_\_\_\_\_  Checking  Savings Requested Draft Day (1st-28th) \_\_\_\_\_

**ATTACH VOIDED CHECK OR DEPOSIT SLIP**

As a convenience to me, I hereby request and authorize you to pay and charge to my account amounts drawn on my account, whether by electronic or paper means, by and payable to the order of IA American Life Insurance Company, for the purpose of paying premiums on life insurance policy, provided there are sufficient funds in said account to pay the same upon presentation. I agree that your rights with respect to each such charge shall be the same as if it were signed personally by me. This authorization is to remain in effect until revoked by me in writing and until you actually receive such notice. I agree that you shall be fully protected in honoring any such check. I further agree that if any such check be dishonored, whether with or without cause, and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

\_\_\_\_\_  
SIGNATURE (AS ON FINANCIAL INSTITUTION RECORDS) DATE

GL213AR

**IA AMERICAN LIFE INSURANCE COMPANY**  
 P.O. BOX 2549, WACO, TX 76702-2549

**CONDITIONAL RECEIPT**

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

ALL PREMIUM CHECKS MUST BE PAYABLE TO THE COMPANY  
 DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE PAYEE BLANK

Received of \_\_\_\_\_ the sum of \$ \_\_\_\_\_ as first payment on this application.  
 Date \_\_\_\_\_ Agent \_\_\_\_\_

If (1) an amount equal to the first full premium is submitted; and if (2) all underwriting requirements, including any medical examinations required by the Company's rules, are completed; and (3) the proposed insured is, on the date of application, a risk acceptable for insurance exactly as applied for without modification of plan, premium rate, or amount under the Company's rules and practices, then insurance under the policy applied for shall become effective on the latest of (a) the date of application, or (b) the date of the latest medical exam required by the Company. THE AMOUNT OF LIFE INSURANCE, INCLUDING ANY AMOUNT IN FORCE OR BEING APPLIED FOR, WHICH MAY BECOME EFFECTIVE PRIOR TO THE DELIVERY OF THE POLICY SHALL IN NO EVENT EXCEED \$30,000.00 (INCLUDING LIFE INSURANCE AND ACCIDENTAL DEATH BENEFITS).

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

**IA AMERICAN™**  
LIFE INSURANCE COMPANY

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P.O. Box 2549 / Waco, Texas 76702-2549  
254-297-2774

January 24, 2012

NAIC No. 91693

Mr. Joe Musgrove  
Policy and Other Form Filings  
State of Arkansas  
Department of Insurance  
1200 West Third Street  
Little Rock, Arkansas 72201-1904  
Attention: Compliance - Life and Health

Re: GL213AR(11/11)  
Life Insurance Application

Dear Mr. Musgrove:

The above referenced application is new and will replace application GL213AR previously approved by your department on January 24, 2011. We have attached, to the Supporting Documentation tab, a red-lined version of the change made to application GL213AR(11/11). Additional wording was added to the "Plan" box.

Application GL213AR(11/11) is to be used when applying for whole life insurance product(s) marketed by the company. The flesch readability score is 42.

The above referenced submission meets the provisions of Arkansas Rule and Regulation 19 (Unfair Sex Discrimination in the Sale of Insurance) as well as all applicable requirements of the department.

If I may be of assistance in your review, please contact me at 1-800-736-7311, extension 3216, or [ckeel@aatx.com](mailto:ckeel@aatx.com).

Sincerely,



Clara Keel, FLMI  
Product Filing Manager & Assistant Secretary  
American-Amicable Life Insurance Company of Texas  
A subsidiary of IA American Life Insurance Company

www.iaamerican.com

Telephone Case No: \_\_\_\_\_

|   |                      |  |                    |   |  |                      |
|---|----------------------|--|--------------------|---|--|----------------------|
| Proposed Insured _____<br><small>(First) (Middle) (Last)</small>  |                      |  |                    | Telephone interview completed <input type="checkbox"/> Yes <input type="checkbox"/> No  |  |                      |
| Address (No. & Street) _____  |                      |  |                    | _____ <input type="checkbox"/> am <input type="checkbox"/> pm   |  |                      |
| City _____  |                      | State _____  |                    | Zip Code _____  |  | E-mail Address _____ |
| <input type="checkbox"/> Male <input type="checkbox"/> Female   | Date of Birth<br>/ / | Age  | State of Birth     | Social Security Number<br>/ /   | Height<br>ft in  | Weight<br>lbs        |
| Owner: Name _____   |                      | Relationship _____                                       |                    | SS# _____ / _____ / _____   |  |                      |
| Address _____   |                      | City/State/Zip _____                                     |                    |   |  |                      |
| Primary Beneficiary _____   |                      |  | Relationship _____ | Contingent Beneficiary _____  |  | Relationship _____   |
| Plan: <input type="checkbox"/> Immediate Death Benefit  |                      |  |                    | <input type="checkbox"/> Check here if you are willing to accept any plan for which you qualify based on this application. The insurance for which you qualify may have a graded death benefit for the first two (2) years, a face amount less than any indicated on this application, and riders may not be available. |  |                      |
| <input type="checkbox"/> Graded Death Benefit (Percentage of Face Amount)   |                      |  |                    |   |  |                      |
| Face Amount of Insurance \$ _____   |                      |  |                    |   |  |                      |
| During the past 12 months have you used tobacco in any form (excluding occasional pipe and cigar use)? <input type="checkbox"/> Yes <input type="checkbox"/> No |                      |  |                    |   |  |                      |
| Rider: <input type="checkbox"/> Grandchild/Great Grandchild Coverage (Indicate Number of Children Applying) _____   |                      |  |                    |   | Automatic Premium Loan Elected? <input type="checkbox"/> Yes <input type="checkbox"/> No |                      |
| <input type="checkbox"/> Child Rider _____ Units <input type="checkbox"/> ADB Amt \$ _____  |                      |  |                    |   |  |                      |
| Mode: <input type="checkbox"/> Bank Draft <input type="checkbox"/> Draft 1st Prem on Req. Date  |                      | CWA: <input type="checkbox"/> E-Check Immediate 1st Prem |                    | Mail Policy To: <input type="checkbox"/> Agent <input type="checkbox"/> Insured <input type="checkbox"/> Owner  |  |                      |
| <input type="checkbox"/> Other Modal Prem \$ _____  |                      | <input type="checkbox"/> Collected \$ _____              |                    | Requested Policy Date: / /  |  |                      |
| A. Do you have existing life insurance or an annuity contract? <input type="checkbox"/> Yes <input type="checkbox"/> No   |                      |  |                    | Company _____   |  |                      |
| B. Will you replace an existing life insurance policy or an annuity? <input type="checkbox"/> Yes <input type="checkbox"/> No                                   |                      |  |                    | Policy # _____ Amount of Coverage \$ _____  |  |                      |
| Physician Name: _____   |                      | City/State: _____  |                    | Phone: _____  |  |                      |

**HEALTH INFORMATION**

1. Are you currently hospitalized, confined to a bed or nursing facility, confined to a wheelchair due to chronic illness or disease, or using oxygen equipment to assist in breathing, or receiving Hospice Care? .....  Yes  No
  2. Have you had or been medically advised to have an organ transplant, or have you been medically diagnosed as having metastatic cancer, Alzheimer's, dementia, mental incapacity, or have you been diagnosed, treated (including dialysis) or taken medication for renal insufficiency, kidney failure, liver failure, or respiratory failure? .....  Yes  No
  3. Have you been medically treated or diagnosed by a medical professional as having Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC), or any immune deficiency related disorder or tested positive for the Human Immunodeficiency Virus (HIV)? .....  Yes  No
  4. Have you been medically diagnosed with diabetes combined with a medical history of any of the following: stroke, TIA, heart disease, heart attack, coronary artery bypass, angioplasty, circulatory disease, or peripheral vascular disease? .....  Yes  No
  5. Have you taken insulin shots prior to age 50 or been treated for insulin shock or diabetic coma? .....  Yes  No
  6. Have you ever been medically diagnosed, treated, or taken medication for congestive heart failure, cardiomyopathy, Lou Gehrig's disease, Huntington's disease, had an amputation caused by disease, or more than one occurrence of cancer (excluding basal or squamous cell skin cancer) in your lifetime? .....  Yes  No
  7. Within the past 12 months have you:
    - a. been medically diagnosed or treated for angina (chest pain), stroke or TIA, cirrhosis, Hepatitis C, chronic hepatitis, chronic pancreatitis, chronic obstructive pulmonary disease (COPD), emphysema, chronic bronchitis, or required oxygen equipment to assist in breathing? .....  Yes  No
    - b. had a heart attack, aneurysm, heart valve surgery, coronary artery bypass surgery, angioplasty, or stent implant or had or been medically advised to have surgery for brain or heart disorders (including, but not limited to catheterization, a pacemaker insertion, defibrillator placement), or any procedure to improve circulation? .....  Yes  No
    - c. been medically diagnosed, treated, or taken medication for internal cancer, lymphoma, melanoma, leukemia, or systemic lupus (SLE)? .....  Yes  No
    - d. had any diagnostic testing, surgery, or hospitalization recommended by a medical professional which has not been completed or for which the results have not been received? .....  Yes  No
    - e. used illegal drugs or abused alcohol or drugs, or had or been recommended to have treatment or counseling for alcohol or drug use, or been convicted of any felony or driving under the influence of alcohol or drugs? .....  Yes  No
- If any answer to questions 1 through 7 is answered "Yes" the Proposed Insured is not eligible for any coverage.**
8. Within the past 24 months have you been medically diagnosed or treated, or hospitalized for:
    - a. stroke, angina (chest pain), heart attack, aneurysm, heart or circulatory surgery or any procedure to improve circulation? ...  Yes  No
    - b. or taken medication for internal cancer, leukemia, melanoma, emphysema, chronic bronchitis, chronic obstructive pulmonary disease (COPD), ulcerative colitis, cirrhosis, Hepatitis C, liver disease? .....  Yes  No
    - c. paralysis of two or more extremities or any neuro-muscular disease (including, but not limited to cerebral palsy, multiple sclerosis, seizures, or Parkinson's disease)? .....  Yes  No
- If any answer to question 8 is answered "Yes" the Proposed Insured should apply for the Graded Death Benefit Plan.**
- If all questions 1 through 8 are answered "No" the Proposed Insured should apply for the Immediate Death Benefit Plan.**

GL213AR(11/11)

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|                       |     |           |              |                       |     |           |              |
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I acknowledge receiving the Fair Credit Reporting Act Notice, the MIB, Inc. Pre-Notice, the Terminal Illness Accelerated Benefit Rider and Confined Care Accelerated Benefit Rider Disclosure Forms, if applicable.

Signed at \_\_\_\_\_  
CITY STATE

Date of Application \_\_\_\_\_  
MONTH DAY YEAR

\_\_\_\_\_  
SIGNATURE OF PROPOSED INSURED

\_\_\_\_\_  
SIGNATURE OF OWNER (IF OTHER THAN PROPOSED INSURED)

**AGENT'S REPORT**

Does the proposed insured have any existing life insurance or annuity contract? .....  Yes  No  
 Is the proposed insurance intended to replace or change any existing life insurance or annuity? .....  Yes  No

*I certify that I have personally asked each question on this application to the proposed insured(s), I have truly and completely recorded on the application the information supplied by him/her, and I witnessed their signature.*

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AGENT'S PRINTED NAME \_\_\_\_\_ DATE \_\_\_\_\_  
 Agent \_\_\_\_\_ No: \_\_\_\_\_ % \_\_\_\_\_  
SIGNATURE

AGENT'S PRINTED NAME \_\_\_\_\_ DATE \_\_\_\_\_  
 Agent \_\_\_\_\_ No: \_\_\_\_\_ % \_\_\_\_\_  
SIGNATURE

**PREAUTHORIZATION CHECK PLAN - AUTHORIZATION TO HONOR CHARGE DRAWN**

Insured \_\_\_\_\_ Account Holder \_\_\_\_\_  
 Financial Institution \_\_\_\_\_ Address \_\_\_\_\_  
 Transit/ABA Number \_\_\_\_\_ Account Number \_\_\_\_\_  Checking  Savings Requested Draft Day (1st-28th) \_\_\_\_\_

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\_\_\_\_\_  
SIGNATURE (AS ON FINANCIAL INSTITUTION RECORDS)

\_\_\_\_\_  
DATE

GL213AR(11/11)

**IA AMERICAN LIFE INSURANCE COMPANY**  
 P.O. BOX 2549, WACO, TX 76702-2549

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