Americo Financial Life and Annuity Insurance Company

Home Office: Dallas, Texas • Administrative Office: P.O. Box 410288, Kansas City, MO 64141-0288

Application for Group Life Insurance

AGA5089-C

1a. PROPOSED INSURED (Last, First, MI)

b. Address (Include City, State, and ZIP)

c. Marital Status ☐ Single ☐ Married

d. Gender ☐ Male ☐ Female

e. Contact the Proposed Insured at: ☐ Home ☐ Work Time (CST):_____ ☐ A.M. ☐ P.M.

f. Proposed Insured Telephone Numbers Home: ( ) _____ - _____ Work: ( ) _____ - _____ Spouse's Work: ( ) _____ - _____

g. E-mail Address

h. How long at current address? _____ If less than 5 years at current address, prior address required.

i. SS# or Taxpayer ID#

j. Date of Birth (Mo/Day/Yr)_____ Age_____

Place of Birth (City, State, Country)_____

k. Height ____ ft. _____ in.

l. Weight _____ lbs.

m. Employer and Employer Address (Include City, State, and ZIP)

n. Annual Salary $_____

o. Occupation and Duties

2a. PLAN OF INSURANCE

b. Face Amount $ _____

c. Effective Date (if not checked, will be "Approval Date".) ☐ Approval Date _____ ☐ Save Age of _____ ☐ Specific Date_____

d. Modal Premium Submitted, Including Riders $_____

e. Modal Premium Amount $ _____ (Premium Amount subject to change upon underwriting review.)

f. Premium Mode (Note: Additional charges may apply for modes other than annual.) ☐ Annually ☐ Monthly Bank Draft (drawn on a U.S. Bank)

3. RIDERS

☐ Return of Premium Rider
☐ Disability Income Rider*
☐ Waiver of Premium Rider†
☐ Accidental Death Benefit Rider Amount $ _____
☐ Critical Illness Accelerated Benefit Rider*†
☐ Additional Insured Rider (Spouse) $ _____
☐ Additional Insured Disability Income Rider (Spouse)*
Spouse's Occupation _____
☐ Children's Rider $ _____
☐ Other _____

*Complete additional Supplemental Application. †Waiver of Premium Rider and Critical Illness Accelerated Benefit Rider cannot be issued on the same certificate.

4. ADDITIONAL INSURED(S) (to include Additional Insured Spouse and Child Rider Applicants)

Name of Other Proposed Insured (Last, First, MI)	Birth Date (Mo/Day/Yr)	State of Birth	Sex	Height	Weight (lbs.)	SS# or Taxpayer ID #	Relationship to Primary Proposed Insured
			☐M ☐F	' "			
			☐M ☐F	' "			
			☐M ☐F	' "			
			☐M ☐F	' "			
			☐M ☐F	' "			

5. BENEFICIARY INFORMATION If percentage not given, they will be equal.

Primary (Last, First, MI)	SS# or Taxpayer ID #	Relationship to the Proposed Insured	% of Share
Contingent (Last, First, MI)	**SS# or Taxpayer ID #**	**Relationship to the Proposed Insured**	**% of Share**

6. LIFE INSURANCE IN FORCE AND REPLACEMENT INFORMATION

a. Are there any existing life or supplemental health insurance policies in force on any person proposed for coverage?..... ☐ Yes ☐ No

Insured's Name	Company	Owner	Life Amount	Accidental Death Benefit	Certificate Date

	Yes	No
b. Will the insurance applied for replace or otherwise reduce in value any now in force? (**If Yes,** complete applicable Replacement Notice form and submit with application.) **Note: Application and Replacement form must be dated on the same day.** ..... If Yes, please indicate the amount of surrender charges that will be assessed on the policy being replaced: $ _____	☐	☐
c. Are any other applications for life or supplemental health insurance pending with other companies?	☐	☐
d. Is this an internal replacement? (**If Yes,** include a Surrender form or Absolute Assignment form for the policy being replaced.)	☐	☐

7. MORTGAGE INFORMATION

a. Mortgage Company

b. Phone Number ( )

c. Mortgage Company or Lender's Address (Include City, State, and ZIP)

d. Borrower(s) Name(s)

e. Mortgage Loan Amount $_____

f. Closing Date _____

g. Mortgage Payment (If mortgage payment includes taxes, insurance, and escrow, please provide a breakdown of each amount) $_____

h. Length of Loan _____ years

8. ADDITIONAL COMMENTS

COMPLETE SECTIONS 9 AND 10 ONLY IF APPLICABLE.

9a. OWNER (If different from the Proposed Insured) b. Relationship to Proposed Insured c. SS# or Taxpayer ID#

d. Address (Include City, State, and ZIP)

e. How long at current address? _____ If less than 5 years at current address, prior address required.

f. Home Phone ( ) g. Work Phone ( ) h. Date of Birth (Mo/Day/Yr) i. Place of Birth (City, State, Country)

10a. PAYOR (If different from the Proposed Insured and Owner) b. Relationship to Proposed Insured c. SS# or Taxpayer ID#

d. Address (Include City, State, and ZIP)

e. How long at current address? _____ If less than 5 years at current address, prior address required.

f. Home Phone ( ) g. Work Phone ( ) h. Date of Birth (Mo/Day/Yr) i. Place of Birth (City, State, Country)

DECLARATION OF INSURABILITY (Provide details of all "Yes" answers in Section 19)

	Yes	No
11. Has any Proposed Insured used cigarettes, cigars, pipes, chewing tobacco, nicotine patches, snuff, nicotine chewing gum, or other products containing nicotine within the last 12 months?	☐	☐
12. Within the past 2 years, has any Proposed Insured:		
a. made or contemplated making any flights as a pilot, student pilot, or member of a flight crew? (**If Yes,** complete Aviation Questionnaire.)	☐	☐
b. engaged in or contemplated engaging in hazardous sports including, but not limited to: 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 in/on automobiles, drag racers, or motorcycles); rock or mountain climbing, rodeo riding, or any other hazardous sport/activity? (**If Yes,** complete Sports Questionnaire.)	☐	☐
13. Has any Proposed Insured:		
a. had a driver's license suspended or revoked within the last 5 years?	☐	☐
b. been convicted of reckless driving or driving under the influence of alcohol or drugs in the past 5 years?	☐	☐
14. Within the past 7 years, has any Proposed Insured:		
a. been treated for or been advised or diagnosed by a medical professional to seek treatment for, reduce or discontinue intake of alcohol or prescription drugs? (**If Yes**, complete Alcohol Questionnaire.)	☐	☐
b. used: heroin, morphine, other narcotics, ecstasy, opium derivatives, marijuana, cocaine, crack, barbiturates, amphetamines, methamphetamines, or hallucinogens or any other illegal, restricted, or controlled substances? (**If Yes,** complete Drug Questionnaire.)	☐	☐
c. been convicted of, pleaded guilty to, or entered a plea of nolo contendere to any felony?	☐	☐
d. Has any Proposed Insured been diagnosed with or been advised to have or had treatment for high blood pressure, heart disease/disorder, stroke, lung or respiratory disorder, sleep apnea, cancer, diabetes, digestive disorder, kidney or liver disease to include hepatitis, emotional or psychiatric disorder, Crohn's disease or ulcerative colitis, Alzheimer's disease, dementia, nervous system disorder, paralysis, circulatory or blood disorders, sexually transmitted diseases, chronic fatigue syndrome, lupus, or any blood disorders or birth defects?	☐	☐
e. had any disease or disorder not mentioned above?	☐	☐
f. consulted a physician, had tests performed such as an EKG, echocardiogram, X-ray, blood tests, or been hospitalized for any reason?	☐	☐
15. In the last 10 years, have you ever been diagnosed as having, or been told by a medical professional that you have, or been treated by a medical professional for, Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC) or tested positive for antibodies to the Human Immunodeficiency Virus (HIV)?	☐	☐
16. Within the next 24 months does any Proposed Insured intend to work, travel, or reside outside of the United States for more than 30 days? **If Yes**, where? (Provide details below)	☐	☐
17. Do any of the Proposed Insured(s):		
a. currently use prescription medicines? (**If Yes,** list each medication below.)	☐	☐
b. currently have a personal physician? (**If Yes,** list name, address, and telephone number and provide date, reason and results of last consultation below.)	☐	☐
18. Has any Proposed Insured ever been declined, postponed, rated, or modified for insurance?	☐	☐

19. **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 to avoid amendments.)

Question #	Proposed Insured	Dates/ Duration	Details	Name, Address, and Telephone Number of Attending Physician

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

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

I/We have received a copy of the Notice of Insurance Information Practices. I/We, or my/our authorized representative, may obtain a copy of this Authorization on request. This Authorization will be valid for 24 months from the date signed. It is the Company's practice to prohibit third parties who lawfully receive nonpublic health information from redisclosing or reusing the disclosed information. A photographic copy shall be as valid as the original. I/We understand that a copy of this authorization will be provided, upon request, to me/us or a person authorized on my/our behalf. I/We understand that disclosure of information to the Company may subject the information to redisclosure in accordance with the Company's privacy policy and MIB, Inc. rules. This authorization may be revoked; however, it may not be revoked during the contestability period of the certificate or to the extent the Company has taken action in reliance on this authorization. Notice of revocation may be sent, in writing, to the Company at its Administrative Office address.

IN ACCORDANCE WITH STATE LAW, WE MUST PROVIDE YOU WITH THE FOLLOWING FRAUD NOTICE: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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.

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).

I/We represent to Americo Financial Life and Annuity Insurance Company 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 the Company can rely on these statements. I/We do hereby authorize Americo Financial Life and Annuity Insurance Company to confirm my/our mortgage information with said mortgage company or lender, if necessary, to process my application for life insurance. I/We agree that this application (a) shall consist of Part I and if required, Part II and/or any medical exam form and any supplemental application or amendment to the application, and (b) will be the basis for any certificate issued on this application or any amendment to the application. Any certificate 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.

_____ _____

Signature of Proposed Insured | Signature of Owner

_____ _____

Signature of Additional Proposed Insured | Signature of Witnessing Agent (required)

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

Important Note: Agent's Report Must be Completed for all Applications

20. AGENT'S REPORT	Yes	No
Provide details of all "No" answers in the "Agent Comments/Remarks" area below.		
a. How long has the Agent known the Proposed Insured(s)? _____		
b. At the time this application was taken, were all of the Proposed Insured(s) present and did you witness their signatures?	☐	☐
c. Did the Proposed Insured(s) directly respond to each application question?	☐	☐
d. Does the Proposed Insured(s) speak English?	☐	☐
1. If the Proposed Insured(s) did not speak English, did you or a translator read the application to them in a language that the Applicant(s) understood?	☐	☐
e. Was a government-issued picture I.D. requested, reviewed, and confirmed for the Proposed Insured(s), Owner, and Payor?	☐	☐
Provide details of all "Yes" answers in the "Agent Comments/Remarks" area below.		
f. Do you have any knowledge or reason to believe that the Proposed Insured(s) are intending to replace or otherwise reduce in value an existing insurance or annuities?	☐	☐
g. Did the applicant approach you to purchase insurance? (**If Yes,** please list their stated need for the insurance in "Agent Comments/Remarks" section below.)	☐	☐

Agent Comments/Remarks:

I have knowledge or reason to believe that the Proposed Insured(s) or Policyowner has a mortgage.

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
Agent's Phone Number	Agent's FAX Number	Agent's E-mail Address

Name(s) of Agent(s) to whom commissions are to be paid if different from the above agent.

Name	Agent #	% Split	Name	Agent #	% Split

Americo Financial Life and Annuity Insurance Company

Home Office: Dallas, Texas • Administrative Office: P.O. Box 410288, Kansas City, MO 64141-0288

Bank Draft Authorization

As a convenience to me, I hereby request and authorize the banking institution below (the "Bank") to pay and charge to my account drafts on my account by and payable to the order of the company which issued or assumed the certificate (the "Company") administering my insurance certificate provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that the Bank's rights in respect to such draft shall be the same as if it were a check drawn on the bank and signed personally by me. This authority is to remain in effect until revoked by me in writing and until the Bank actually receives such notice. I agree that the Bank shall be fully protected in honoring any such draft. I further agree that if any such draft were dishonored, whether with or without cause and whether intentionally or inadvertently, the Bank shall be under no liability whatsoever. Should the Bank upon presentation not honor any draft, I understand that this method of payment may be terminated.

I understand also that my insurance certificate may lapse if said draft is returned unpaid by my Bank or if I discontinue payments prior to receiving confirmation of draft processing from the Company.

Check one: ☐ Please use Bank Draft information from certificate number _____

☐ I am including an attached Voided Check or Deposit Slip to allow drafts from my ☐ Checking or ☐ Savings account

_____ _____

Signature of Depositor or Officer of Company as checks are signed Date Signed

AF55019

INFORMATION PRACTICES NOTICE

THIS NOTIFICATION MUST BE DELIVERED TO THE PROPOSED INSURED WHEN THE APPLICATION IS COMPLETED.

Thank you for your application. This notice is given to you at the time you apply for life insurance to tell you about the kinds of information we may obtain in connection with your application. We rely primarily on information provided by you. We may also collect information from others, such as medical professionals who have treated you, hospitals, other insurance companies, and consumer reporting agencies. In certain limited situations, we are allowed by law to disclose necessary items of personal information to third parties without your specific authorization. You have a right of access and correction with respect to this information. If you wish a more detailed explanation of our information practices, please write us at: Americo Financial Life and Annuity Insurance Company, P.O. Box 410288, Kansas City, MO 64141-0288, Attention: Underwriting/New Business Department. Any requests to correct, amend or alter will be responded to within 30 days. Information that is corrected will be provided to any person who is designated by the requesting party and who may have received the information in the prior two years (within a seven year timeframe). Any statement of disagreement made by a requesting party will be filed and made available to those reviewing it in the future

MIB, INC. PRE-NOTICE

Information regarding your insurability will be treated as confidential. However, Americo Financial Life and Annuity Insurance Company or its reinsurers may make a brief report to the MIB, Inc. a nonprofit membership organization of life insurance companies operating as an information exchange for its members. If you apply to another MIB member company for life or health insurance or a claim is submitted to such a company, upon request the MIB will supply the company with the information it has in its file.

Upon receipt of a request from you, the MIB, Inc., will arrange disclosure of any information it has in your file. If you question the accuracy of information in the file, you may contact the MIB and seek a correction in accordance with the procedures in the Fair Credit Reporting Act. The MIB's information office address is P.O. Box 105, Essex Station, Boston, Massachusetts 02112, (617) 426-3660. The Company and its reinsurers may release information in its file to its reinsurers and to other life and health insurance companies to whom you apply for insurance or to whom a claim is submitted.

INVESTIGATIVE CONSUMER REPORTS

We may make or obtain an investigative consumer report, which may contain information secured through personal interviews with your friends, neighbors and others with whom you are acquainted. This report may contain information as to your character, general reputation, personal characteristics and mode of living (no information collected concerning the sexual orientation of the proposed insured will be used to determine his or her eligibility for insurance). The consumer reporting agency may keep a copy of the report and may disclose its contents to others for whom it performs such services. On receipt of a request from you, we will tell you if a report has been requested and we will provide you with the name, address, and telephone number of the consumer reporting agency. You may request to be personally interviewed and, when the report is completed, you have a right to inspect and receive a copy of it from the consumer reporting agency. Please send your request to: Americo Financial Life and Annuity Insurance Company, P.O. Box 410288, Kansas City, MO 64141-0288, Attention: Underwriting Department.

IMPORTANT NOTICE — PLEASE READ CAREFULLY!

NO INSURANCE WILL BE PROVIDED UNLESS ALL TERMS STATED BELOW ARE MET EXACTLY AND IN FULL!
NO AGENT OR BROKER HAS THE AUTHORITY TO CHANGE OR WAIVE ANY OF THESE TERMS.
NO INSURANCE PREMIUMS HAVE BEEN RECEIVED WITH THIS APPLICATION.

1. ALL OF THE FOLLOWING TERMS MUST BE MET EXACTLY AND IN FULL BEFORE COVERAGE WILL BEGIN:
   (A) Payment of the first full modal premium is received by the Company;
   (B) All medical examinations, X-rays, tests, physicians' statements and any other underwriting requirements of the Company must be received; and
   (C) The Proposed Insured in the application must be acceptable to the Company without change on the Effective Date under its rules for insurance (1) on the Plan applied for (2) in the amount and (3) in a premium class not less favorable than the premium class applied for and with no ratings.
2. IF PREMIUM PAYMENT IS RECEIVED BY THE COMPANY AND ALL OF THE REQUIREMENTS IN (B) ABOVE ARE NOT RECEIVED BY THE COMPANY WITHIN THE FOLLOWING 60 DAYS, THE APPLICATION WILL BE VOID AND THE PREMIUM WILL BE RETURNED.
3. IF ANY PROPOSED INSURED DIES DURING THE PROCESSING OF THIS APPLICATION AND BEFORE ALL OF THE FOREGOING TERMS HAVE BEEN MET, NO INSURANCE COVERAGE WILL EXIST, AND THE COMPANY'S ONLY LIABILITY WILL BE TO REFUND PREMIUMS RECEIVED, IF ANY.
4. If all requirements are met the "Effective Date" will be the later of: (1) the date all of the above required information is received by the Company or (2) the date of issue, if any, requested in the application.

Dated at _____ this _____ day of _____, _____.

_____ _____
Signature of Licensed Resident Agent Signature of Applicant
AAA8393

THIS IMPORTANT NOTICE IS APPLICABLE IF NO PREMIUM IS RECEIVED WITH THE APPLICATION.

THIS IS A CONDITIONAL RECEIPT — PLEASE READ CAREFULLY!

NO INSURANCE WILL BE PROVIDED BY YOUR FIRST PAYMENT UNLESS ALL TERMS
IN PARAGRAPH "FIRST" ARE MET EXACTLY AND IN FULL!
NO AGENT OR BROKER HAS THE AUTHORITY TO CHANGE OR WAIVE ANY OF THESE TERMS.

Received from _____ this _____ day of_____, _____ $ _____ by cash or check, preauthorized order for withdrawal, or salary deduction plan. This payment is the amount of the first full modal premium for the certificate applied for in the application for life insurance to Americo Financial Life and Annuity Insurance Company having the same number and date as this Conditional Receipt. This payment is made and accepted under the terms of this Conditional Receipt. This Conditional Receipt cannot be transferred. ANY PAYMENT BY CHECK MUST BE MADE PAYABLE TO AMERICO FINANCIAL LIFE AND ANNUITY INSURANCE COMPANY. DO NOT MAKE ANY CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK. If your check or draft is not honored when first presented for payment, this Conditional Receipt will not be valid.

FIRST: TERMS ALLOWING INSURANCE TO BECOME EFFECTIVE BEFORE CERTIFICATE DELIVERY: If ALL of the following terms are met exactly and in full, insurance under the terms of the certificate applied for, if then being sold by the Company, will become effective on the Effective Date subject to the limitations in Paragraph "SECOND": (1) All representations made in the application must be true and complete in all material respects; (2) all medical examinations, X-rays, tests, physician's statements and any other underwriting requirements of the Company must be completed and received not later than 60 days from the date the application is signed; (3) all persons proposed for insurance in the application must be acceptable to the Company without change on the Effective Date under its rules for insurance (A) on the Plan applied for (B) in the amount and (C) in a premium class not less favorable than the premium class applied for and with no ratings; and (4) the amount shown above must be equal to at least the first full modal premium for insurance.

IF ALL OF THE TERMS IN PARAGRAPH "FIRST" ARE NOT MET EXACTLY AND IN FULL, THE COMPANY'S ONLY LIABILITY WILL BE TO REFUND THE AMOUNT FOR WHICH THIS CONDITIONAL RECEIPT WAS GIVEN. "Effective Date" means the latest of: (1) the date the application is signed; (2) the date all required information is completed and received by the Company; and (3) the date of issue, if any, requested in the application.

SECOND: LIMITS OF LIABILITY — MAXIMUM AMOUNT OF INSURANCE AND PERIOD OF TIME WHICH INSURANCE CAN BECOME EFFECTIVE BEFORE CERTIFICATE DELIVERY. The Company's liability for insurance under this Conditional Receipt plus all insurance which is in force or is pending in the Company on any Proposed Insured can never exceed $250,000 of life insurance including (a) Accidental Death Benefits, and (b) any coverage in force. The time for which the Company can be liable under this Conditional Receipt can never exceed a period of 60 days from the date this Receipt was signed.

Dated at _____ this _____day of _____, _____ .

_____ _____
Signature of Licensed Resident Agent Signature of Applicant

If the application is not approved and accepted within 60 days from the date it was signed,
the Company shall have no liability except for the return of this payment on surrender of this Receipt.