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

ID No. _____

*Complete shaded areas for spouse coverage.

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

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

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

5. Occupation/Duties
*

6. Employer's Name
*

7. Address of Owner of Policy

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

9. E-mail Address _____ @ _____

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

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

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

12. Amount of insurance on each proposed Insured — Type _____ Company _____ Benefit _____
*

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

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

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

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

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

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

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

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

Cancer Ins. Policy (A B C)
☐ C10
Units _____
Detection Rider Units _____
$_____.___
Premium $_____.___
$_____.___
Policy Fee $_____.___
$_____.___ **C10/C20 Prem.** $_____.___

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

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

Proposed Insureds ◀Circle all that apply

Mode Premium
☐ A ☐ MBD
☐ SS ☐ _____

Total Paid with application
$_____.___

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

15. I have received an outline of coverage?
☐ A71 ☐ C10 ☐ C20 ☐ H34 ☐ CI

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

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

PLACE ORAL SPECIMEN STICKER HERE

PLACE ORAL SPECIMEN STICKER HERE

AUTHORIZATION FOR PREAUTHORIZED PAYMENTS

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

Depository Name _____ City _____ State _____

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

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

PLEASE ATTACH A VOIDED PERSONAL CHECK

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

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

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

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

SECTION A

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

SECTION B

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

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

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

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

Any person who knowingly and with intent to injure, defraud or deceive any insurer, submits an application or files a claim containing any false, incomplete, or misleading information is guilty of insurance fraud, which is a crime.

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

X _____ Date _____ at _____

Proposed Insured (if 18 or over) City State

X _____ * _____

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

AGENT'S STATEMENT

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

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

REMARKS OR INSTRUCTIONS

_____ Best time to call _____

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

Mail Policy To: ☐ Agency ☐ Policyholder