SERFF Tracking Number:	*AHLI-127653460*	*State:*	*Arkansas*
Filing Company:	*The American Home Life Insurance Company*	*State Tracking Number:*	*49878*
Company Tracking Number:			
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
Product Name:	*2011 Final Expense ABR*		
Project Name/Number:	*/*		

Filing at a Glance

Company: The American Home Life Insurance Company

Product Name: 2011 Final Expense ABR	SERFF Tr Num: AHLI-127653460	State: Arkansas
TOI: L07I Individual Life - Whole	SERFF Status: Closed-Approved-Closed	State Tr Num: 49878
Sub-TOI: L07I.101 Fixed/Indeterminate Premium - Single Life	Co Tr Num:	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Linda Bird
	Author: Juell Moulden	Disposition Date: 10/03/2011
	Date Submitted: 09/26/2011	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:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Individual Market Type:
Overall Rate Impact:	Filing Status Changed: 10/03/2011
	State Status Changed: 10/03/2011
Deemer Date:	Created By: Juell Moulden
Submitted By: Juell Moulden	Corresponding Filing Tracking Number:

Filing Description:

The accelerated benefit rider form, FORM 11 FEABR-AR, is attached to and made part of policy FORM 06 FEPL-AR (all premium payment options), FORM 06 FSPL-AR, and FORM 06 FEPG-AR. American Home Life's Accelerated Benefit Rider provides for payment to the policy owner of a portion of the policy's eligible proceeds, less adjustments and deductions, if the insured has a qualifying event subject to the provisions of the rider. There is no extra premium charged for this benefit. This form was previously approved in your state as FORM 06 FEABR-AR and the following change has been made:

1. The maximum amount of eligible proceeds has been increased from $25,000 to $35,000.

SERFF Tracking Number:	*AHLI-127653460*	*State:*	*Arkansas*
Filing Company:	*The American Home Life Insurance Company*	*State Tracking Number:*	*49878*
Company Tracking Number:			
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
Product Name:	*2011 Final Expense ABR*		
Project Name/Number:	*/*		

On Page 1, the first section contains the following bracketed fields [Variable Data] that will vary for each customer.

• Insured
• Policy Number
• Age at Issue
• Rider Date

Company and Contact

Filing Contact Information

Juell Nebergall, Legal Correspondent	jnebergall@amhomelife.com
400 S Kansas Ave	785-235-6276 [Phone] 344 [Ext]
P.O. Box 1497	785-235-1037 [FAX]
Topeka, KS 66601	

Filing Company Information

The American Home Life Insurance Company	CoCode: 60542	State of Domicile: Kansas
400 S Kansas Ave	Group Code:	Company Type: Life Insurance & Annuities
P.O. Box 1497	Group Name:	State ID Number:
Topeka, KS 66601	FEIN Number: 48-0119710	
(785) 235-6276 ext. [Phone]		

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	1 rider @ $50.00
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The American Home Life Insurance Company	$50.00	09/26/2011	52132294

SERFF Tracking Number:	*AHLI-127653460*	*State:*	*Arkansas*
Filing Company:	*The American Home Life Insurance Company*	*State Tracking Number:*	*49878*
Company Tracking Number:			
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
Product Name:	*2011 Final Expense ABR*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	10/03/2011	10/03/2011

SERFF Tracking Number:	*AHLI-127653460*	*State:*	*Arkansas*
Filing Company:	*The American Home Life Insurance Company*	*State Tracking Number:*	*49878*
Company Tracking Number:			
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
Product Name:	*2011 Final Expense ABR*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 10/03/2011
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AHLI-127653460*	*State:*	*Arkansas*
Filing Company:	*The American Home Life Insurance Company*	*State Tracking Number:*	*49878*
Company Tracking Number:			
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
Product Name:	*2011 Final Expense ABR*		
Project Name/Number:	*/*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Life & Annuity - Acturial Memo		No
Form	Accelerated Benefit Rider		Yes

SERFF Tracking Number:	*AHLI-127653460*	*State:*	*Arkansas*
Filing Company:	*The American Home Life Insurance Company*	*State Tracking Number:*	*49878*
Company Tracking Number:			
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
Product Name:	*2011 Final Expense ABR*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number: FORM 11 FEABR-AR

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	FORM 11 FEABR-AR	Certificate Amendment, Insert Page, Endorsement or Rider	Accelerated Benefit Rider	Initial		40.900	Form 11 FEABR-AR Bracketed.pdf

ACCELERATED BENEFIT RIDER

INSURED:[JOHN A DOE] POLICY NUMBER:[0000105]

AGE AT ISSUE:[50] RIDER DATE:[11/01/2011]

THE AMERICAN HOME LIFE INSURANCE COMPANY OF KANSAS will pay to the Owner the Accelerated Benefit described in this rider form. The benefit will be paid if the Insured has a Qualifying Event, subject to the provisions of this rider, and upon written request for payment of the benefit.

NOTICE

Death benefits, cash values and loan values will be reduced if an Accelerated Benefit is paid. An acceleration of life insurance benefits under this rider may or may not qualify for favorable tax treatment under the Internal Revenue Code of 1986, section 101(g). Qualification for favorable tax treatment will depend on factors such as the Insured's life expectancy at the time benefits are accelerated or use of benefits for necessary long-term care expenses, such as nursing home care. If the acceleration of life insurance benefits qualifies for favorable tax treatment, the benefits will be excludable from the Owner's income and not subject to federal taxation. Tax laws relating to acceleration of life insurance benefits are complex. Consult a qualified tax advisor to asses the tax consequences of accelerated benefits.

Receipt of accelerated benefits may affect eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children (AFDC), supplementary social security income (SSI) and drug assistance programs. Consult a qualified tax advisor and social service agencies concerning how receipt of accelerated benefits will affect eligibility for public assistance.

THIS RIDER DOES NOT PROVIDE COVERAGE PRIMARILY FOR CONFINEMENT TO A NURSING HOME.

PROVISIONS

CONSIDERATION

This rider is issued in consideration of the application. This rider is attached to and made a part of this policy. Unless changed by this rider, all provisions, exclusions, and limitations of the policy remain the same and apply to this rider.

RENEWABILITY

We will not cancel this rider. Unless the owner requests termination, it will remain in force as long as the base policy remains in force.

PREMIUM

There is no premium charged for this benefit.

REINSTATEMENT

If the base policy is reinstated, the rider will also be reinstated, if a benefit has not been paid under this rider.

PROVISIONS
(**Continuation**)

TERMINATION OF RIDER

This rider terminates:

(1) On the day we receive the Owner's written request for termination; or

(2) upon termination of the base policy ; or

(3) upon payment of the Accelerated Benefits equal to 100% of the Eligible Proceeds ; or

(4) upon the death of the Insured.

DEFINITIONS

ACCELERATED BENEFIT

The requested portion of the policy's Eligible Proceeds, less the adjustments and deductions explained in the Benefits section of the rider.

ADMINISTRATIVE EXPENSE FEE

A fee of $150 will be deducted for each approved claim under this rider.

ELIGIBLE PROCEEDS

That portion of the policy's death benefit that can be paid out as an Accelerated Benefit. The amount shall be equal to 100% of the policy's death benefit at the time an Accelerated Benefit is requested. Eligible Proceeds do not include additional death benefits provided by rider or endorsement. In no event shall Eligible Proceeds be greater than $35,000 nor less than $1,000.

QUALIFYING EVENTS

(1) A diagnosis of a terminal illness of the Insured, or

(2) permanent confinement of the Insured to a qualified nursing home.

ELIGIBILITY

To be eligible for the Accelerated Benefit, the Insured must have at least one Qualifying Event. No benefits will be paid if a Qualifying Event is the result of self-inflicted injuries.

NOTICE OF CLAIM

Written notice to the company naming the Insured and telling us the amount of the benefit requested. The Claimant's Statement must be signed by the Owner.

TERMINAL ILLNESS

A non-correctable medical condition that, with reasonable medical certainty, will result in the death of the Insured within 12 months from the date on which this benefit is requested.

DEFINITIONS
(**Continuation**)

PERMANENT CONFINEMENT

Continuous confinement to a qualified nursing home that begins after the effective date of this policy. It must begin at least 90 days before the request for acceleration of benefits. Confinement must be expected to last until the Insured's death. This does not include any confinement resulting from self-inflicted injury. We will require a physician's written proof of permanent confinement.

A qualified nursing home means a facility licensed by the state in which it is located. It operates for the primary purpose of providing nursing care (skilled, intermediate and custodial). The facility must:

(1) Charge patients for the care provided;

(2) provide the care on a continuing inpatient basis and under a doctor's plan of care;

(3) supervise the care through a registered professional nurse who is on duty for at least eight (8) hours per day;

(4) maintain medical records on each patient;

(5) maintain control and records of medications dispensed; and

(6) have a licensed medical practitioner available to furnish emergency medical care.

A qualified nursing home does not include any facility used for the treatment of drug addiction or alcohol abuse, a home or facility used primarily for the treatment of mental diseases or disorders or educational care or a retirement home or an assisted living center.

A qualified nursing home does include a home or facility that is primarily used to provide care and treatment for Alzheimer's Disease and/or other organic brain disorders.

BENEFITS

DESCRIPTION

If at least one Qualifying Event occurs, the Owner may request to receive an Accelerated Benefit. This benefit may be requested more than once, subject to the minimum Eligible Proceeds. Eligible Proceeds will be reduced by Accelerated Benefits already paid. A request for an Accelerated Benefit must be in writing and due to one of the following Qualifying Events;

(1) A diagnosis of a terminal illness of the Insured as defined under *Terminal Illness*; or

(2) permanent confinement of the Insured in a qualified nursing home as defined under *Permanent Confinement*.

ADJUSTMENTS AND DEDUCTIONS

The Accelerated Benefit will be subject to the following adjustments and deductions:

(1) An actuarial discount will be deducted from the requested portion of the Eligible Proceeds. This discount reflects the early payment of amounts held under the policy. It will be based on an annual interest rate (declared by us) and the then current premium, both of which are in effect as of the date the Claimant's Statement is received. The interest rate used shall be the current maximum adjustable policy loan interest rate permitted by law in effect on the date of request.

(2) If there is a policy loan, the requested portion of the Eligible Proceeds will be reduced to repay a portion of the policy loan. The policy loan will be repaid in the same proportion as the Accelerated Benefit bears to the Eligible Proceeds prior to payment of the benefit.

(3) A deduction will be made for any premiums due within the policy's grace period but unpaid at the time the Accelerated Benefit is approved for payment.

(4) A deduction will be made for an Administrative Expense Fee for each claim.

CONDITIONS FOR PAYMENT OF ACCELERATED BENEFIT RIDER

The Accelerated Benefit is subject to the following conditions:

(1) The policy must be in force other than as reduced paid-up insurance, and have Eligible Proceeds of no less than $1,000.

(2) The benefit must be requested while the Insured is still alive. We must receive proof of a Qualifying Event acceptable to us.

(3) We must receive written consent from all irrevocable beneficiaries, if any, and all assignees, if any. We reserve the right to require consent from a spouse, the Insured, other beneficiaries, and any other person if, in our judgment, such person's consent is necessary to protect our interests.

(4) This rider provides for the advance payment of a portion of the policy's death benefit. This is not meant to cause involuntary access to policy proceeds ultimately payable to the beneficiary. This benefit is not available:

   (a) if either the Owner or the Insured is required by law to use this benefit to meet the claims of creditors, whether in bankruptcy or otherwise, or

   (b) if either the Owner or the Insured is required by a governmental agency to use this benefit in order to apply for, obtain, or otherwise keep a government benefit or entitlement.

EFFECT ON POLICY BENEFITS

When payment is made under this rider, the policy and all riders will remain in force subject to the following adjustments:

(1) The policy's death benefit and its guaranteed cash value will be reduced by the Accelerated Benefit.

(2) Any policy loan will be reduced as described in *Adjustments and Deductions*.

(3) The policy's premiums will be reduced after we pay an Accelerated Benefit. The new premium will be an amount the company would charge for the same policy issued at the reduced death benefit.

(4) We will give the Owner a statement showing the effects of payment of the Accelerated Benefit on the policy's death benefit, cash values, loan amounts, and policy premiums.

(5) Any life insurance under an Accidental Death Benefit rider attached to this policy will stay in force, at the issued amount, as long as this policy is in force.

(6) At the death of the Insured, any remaining death benefit and proceeds due, will be paid under the provisions of the base policy.

The payment of this benefit will not cause any change in the Insured's premium class.

CLAIMS

NOTICE AND PROOF OF CLAIM

The Owner may request payment of this benefit at any time after the Insured is diagnosed with a Qualifying Event. We will send a Claimant's Statement within 10 days of the request. The Claimant's Statement must be completed and returned to us with a physician's statement verifying the Qualifying Event.

We may ask for additional medical information from the physician submitting the statement, or from any physician or institution as deemed necessary. In addition, we reserve the right to have a physician of our choosing examine the Insured. This will be done at our expense. If our physician disagrees with the Insured's physician, we will rely on our physician's opinion for claim purposes. We will not unreasonably withhold our acceptance of a claim under this rider.

The Claimant's Statement must be completed and sent to us within 91 days after it is sent to the Owner. We will not reduce or deny a claim if it is not possible to give proof of a Qualifying Event in the time required. However, such proof must be given to us as soon as reasonably possible.

CLAIMS
(**Continuation**)

PAYMENT OF CLAIM

The Accelerated Benefit will be paid to the Owner in a lump sum. It may also be paid in installments of not less than $250. The amount of each installment payment will be based on the following:

(1) The lump sum amount;

(2) the frequency of payment;

(3) the number of installment payments to be made; and

(4) a minimum interest rate of 3%

If the Insured and the Owner are not the same, and the Owner dies, we will pay the Accelerated Benefit to the Contingent Owner. If there is no Contingent Owner, we will pay it to the estate of the Owner. If the Insured dies before a lump sum payment or the first installment payment is made, the death benefit of the policy will be paid as if the request for Accelerated Benefits had not been made.

If the Insured dies after installment payments begin, but before the final payment is made, the present value of all remaining payments due will be paid to the Beneficiary as a death benefit. The present value will be computed on the same basis used by the company to determine the original benefit.

THE AMERICAN HOME LIFE INSURANCE COMPANY OF KANSAS

Secretary

President

SERFF Tracking Number:	*AHLI-127653460*	*State:*	*Arkansas*
Filing Company:	*The American Home Life Insurance Company*	*State Tracking Number:*	*49878*
Company Tracking Number:			
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
Product Name:	*2011 Final Expense ABR*		
Project Name/Number:	*/*		

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification

Comments:

The form submitted herein is not a policy form. The American Home Life Insurance Company certifies that the policies that are used with the form submitted within this filing comply with Arkansas Rule & Regulation 19 & 49 and the Comsumer Information Notice.

Attachment:

Flesch.pdf

Item Status: **Status Date:**

Satisfied - Item: Application

Comments:

Form 2011 FEPA-AR approved on September 21, 2011. AHLI-127627912

Attachment:

AR.pdf

Item Status: **Status Date:**

Satisfied - Item: Life & Annuity - Acturial Memo

Comments:

Attachment:

FORM 11 FEABR-AR actuarial.pdf

CERTIFICATION

This is to certify that the following form(s) has achieved the Flesch readability score required in the state of Arkansas.

Form Number	Description	Flesch Readability Score
FORM 2011 FEABR-AR	Accelerated Benefit Rider	40.9

September 26, 2011

Les E. Diehl
Vice President - General Counsel

Date

APPLICATION FOR FINAL EXPENSE INSURANCE

The American Home Life Insurance Company of Kansas
400 Kansas Avenue • P.O. Box 1497 • Topeka, KS 66601

Plan	Face Amount		Premium Submitted	Mode of Payment	Automatic Premium Loan
☐ Whole Life ☐ Single Pay ☐ Graded ☐ 5 Pay ☐ 10 Pay	$ _____	☐ ADB $_____	$_____ If COD, Premium Quoted	☐ Annual ☐ Semi Annual ☐ Quarterly ☐ Bank Draft	Yes ☐ No ☐

Proposed Insured	Birthdate	Age	Birthplace	Sex
	/ /			

E-mail Address	Phone	Height	Weight
	_____-_____-_____		

Address (Street, City, State, Zip)	Social Security Number
	/ /

Primary Beneficiary	Relationship	Birthdate
		/ /

Contingent Beneficiary	Relationship	Birthdate
		/ /

Owner (if other than insured)	Relationship	Birthdate	Social Security Number
			/ /

Address (Street, City, State, Zip)

*Contingent Owner	Relationship	Birthdate	Social Security Number
			/ /

Address (Street, City, State, Zip)

*The Owner may designate a Contingent Owner. If the Owner dies while this policy is in force, ownership will belong to the Contingent Owner. If there is no Contingent Owner named or the Contingent Owner dies before the Owner, ownership will belong to the Owner's estate.

Is there existing life insurance and/or annuity contract(s) on the life of the insured? Yes ☐ No ☐

Will this policy replace or change any existing life insurance or annuity you now carry? Yes ☐ No ☐

If either question is answered "Yes", give details below and submit all replacement forms required by state regulation:

Company _____ Policy Number _____ Effective Date _____ Face Amount _____

Company _____ Policy Number _____ Effective Date _____ Face Amount _____

AUTHORIZATION AGREEMENT FOR PREAUTHORIZED PAYMENTS

In favor of The American Home Life Insurance Company P.O. Box 1497 • Topeka, Kansas 66601 ID# 48-0119710 I (we) hereby authorize The American Home Life Insurance Company, hereinafter called the COMPANY, to initiate debit entries to my (our) ☐ Checking ☐ Savings account (select one) indicated below and the depository named below, hereinafter called DEPOSITORY, to debit same to such account.

DEPOSITORY
NAME _____ BRANCH _____

CITY _____ STATE _____ ZIP _____

TRANSIT / ABA NO. _____ ACCOUNT NO. _____

This authority is to remain in full force and effect until COMPANY and DEPOSITORY have received written notification from me (or either of us) of its termination. For any changes to this authority, including termination thereof, please allow Seven (7) business days after COMPANY has received such notification to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

NAME(S) _____ SSN _____
(Please Print)

DATE _____ SIGNED _____

IMPORTANT: ATTACH VOID CHECK TO CERTIFY ABOVE INFORMATION.

Preferred Withdrawal Date: _____ (of each month)

Form 2011 FEPA-AR

HEALTH INFORMATION

	Yes	No
If any part of questions 1-5 is answered "YES" do not submit the application.		
1. Are you hospitalized, bedridden or confined to a nursing home, hospice or long-term care facility?	☐	☐
2. Have you been diagnosed by or received treatment from a medical professional for any of the following:		
A. A terminal illness, ALS, Alzheimer's or dementia?	☐	☐
B. Diabetes accompanied by heart disease (excluding hypertension), kidney disease, peripheral arterial disease (PAD, poor circulation), Transient Ischemic Attack (TIA) or stroke?	☐	☐
C. Cirrhosis or liver failure?	☐	☐
D. Kidney failure requiring dialysis?	☐	☐
E. Used or been advised to use oxygen to assist breathing?	☐	☐
F. Leukemia or organ transplant?	☐	☐
G. Coronary artery disease (CAD) accompanied by (1) congestive heart failure or (2) cardiomyopathy?	☐	☐
H. Implantation of a defibrillator?	☐	☐
3. To the best of your knowledge, have you been diagnosed or treated by a medical professional for an immune deficiency disorder, HIV, AIDS, or AIDS related complex (ARC), or tested positive on an AIDS related blood test?	☐	☐
4. Have you, within the past **12 months**, been advised to have a diagnostic test, surgery, dialysis, home health care, nursing home, hospice or long-term care facility confinement or hospitalization which has not yet been started, completed or for which results are not known?	☐	☐
5. In the last **36 months**, have you been convicted of a felony or of operating a vehicle while intoxicated or impaired or are you presently incarcerated, on probation or parole?	☐	☐

	Yes	No
If two or less of the following questions (6-9) are answered "yes", Proposed Insured will only be eligible for Graded Benefit. If more than two questions (6-9) are answered yes, do not submit the application.		
6. Do you have diabetes diagnosed by a medical professional (a) with duration of 10 years or more, or (b) requiring insulin, or (c) diagnosed at any age and that is not controlled?	☐	☐
7. Do you need ongoing assistance with activities of daily living (help with eating, bathing, dressing, transferring, use of the toilet or the taking of medications) either provided by a family member or third party?	☐	☐
8. In the last **24 months** have you been diagnosed by or received treatment from a medical professional for any of the following:		
A. Heart disease (excluding hypertension) or any procedure to improve circulation to the heart including coronary artery bypass or stents?	☐	☐
B. Stroke or Transient Ischemic Attack (TIA) or a procedure to improve circulation to the brain?	☐	☐
C. Peripheral arterial disease (PAD, poor circulation) or any procedure to improve circulation to the extremities?	☐	☐
D. Counseling or treatment for alcohol or substance abuse?	☐	☐
E. Kidney or liver disease?	☐	☐
F. Any chronic lung disorder excluding intermittent asthma attacks?	☐	☐
9. In the last **36 months** have you been diagnosed by or received treatment from a medical professional for internal cancer, melanoma or disorder of the blood (this excludes squamous cell and basal cell skin cancers)?	☐	☐
Have you smoked cigarettes in the past 12 months?	☐	☐

PHYSICIAN INFORMATION (U.S. physician required)

Primary Physician's Name _____ Address _____ Phone Number _____

DECLARATIONS AND AUTHORIZATION DECLARATIONS

I have read and received the Pre-Notices attached to this application. I agree that: 1) all statements and answers are true and complete; 2) this application will be a part of the policy; 3) temporary insurance coverage starts and remains in effect only as provided in the "Conditional Receipt". I certify, under penalty of perjury that the social security numbers shown on the application are correct. I understand that the agent is not authorized to accept risks or pass on insurability, to make or modify contracts, or waive the Company's rights including the requirement that the adult proposed insured personally sign this application in the agent's presence.

If the Company does not issue a policy from this application, the application will be canceled and a refund will be made. By accepting a policy issued from this application, the owner agrees to any changes made by the Company.

I understand that I may attend any and all meetings of the policyholders of the Company. If I do not attend, the Executive Committee of the Board of Directors will act as my lawful proxy, until that proxy is revoked by me, in writing. The annual meeting of policyholders shall be held at 10:00 a.m. on the second Tuesday in March, each year.

I permit the Company to give information about me and any proposed insured except HIV test results to MIB, any reinsurer, and other insurer(s) from which benefits have been claimed or insurance purchased. I acknowledge receipt of the Notice Regarding MIB, Notice Regarding Fair Credit Reporting Act and Notice of Information Practices before signing this form. I understand that I may request in writing to be interviewed. If any investigative consumer report is prepared in connection with this application, upon written request, I am entitled to receive a copy. I understand that there is no benefit paid for suicide for the first two policy years (for residents of Colorado, Missouri and North Dakota, one policy year).

AUTHORIZATION TO OBTAIN INFORMATION

By this form, **I authorize** any licensed physician, medical practitioner, clinic, hospital, other medical or medically-related facility, the Veterans Administration, MIB , an employer, consumer reporting agency, any person, organization, other institution or other insurance companies that have records or knowledge about me or any children to be insured (if applicable) to release this information to The American Home Life Insurance Company of Kansas. This information may be about: (a) employment; (b) occupation; (c) avocations; (d) other insurance coverage; (e) driving record; (f) age; (g) prescription drug usage; (h) any medical history, condition, care or advice relative to the proposed insured's physical or mental health; and (i) other personal characteristics. This AUTHORIZATION extends to information on the use of alcohol, drugs and tobacco; and the diagnosis or treatment of HIV (the virus that causes AIDS) infection or other sexually transmitted disease. I understand that this information will be used by The American Home Life Insurance Company of Kansas, its representatives or reinsurers in the evaluation of this application to determine eligibility for insurance and/or to investigate claims. The American Home Life Insurance Company of Kansas or its representatives may release information covered by this AUTHORIZATION to the American Home Agent(s) listed in my application for insurance, to its subsidiaries, reinsurers, the MIB, or other insurance companies. The American Home Life Insurance Company of Kansas may also release this information to others who I authorize in writing or as allowed by law.

This AUTHORIZATION may be used for a period of 24 months from the date signed below unless sooner revoked. I may revoke this AUTHORIZATION at any time by notifying The American Home Life Insurance Company of Kansas in writing at Underwriting Department, The American Home Life Insurance Company, P.O. Box 1497, Topeka, KS 66601. My revocation will not be effective to the extent The American Home Life Insurance Company, its reinsurers, or any other person already has disclosed or collected information or taken other action in reliance on the AUTHORIZATION. I understand that my application for insurance will not be considered unless this AUTHORIZATION is signed and dated. The information The American Home Life Insurance Company of Kansas or its reinsurers obtains through this AUTHORIZATION may become subject to further disclosure, as required by law. I understand that any information that is disclosed pursuant to this AUTHORIZATION is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be redisclosed except as authorized by me or as required by law. I agree that a photocopy of this AUTHORIZATION is as valid as the original. I understand that I have the right to receive a copy of this AUTHORIZATION upon request.

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.

NOTICE: I have reviewed all answers and responses contained in this application. I certify that all answers and responses contained in this application are true and correct to the best of my knowledge. I UNDERSTAND THAT ANY INCORRECT STATEMENTS, OMISSIONS, OR MISREPRESENTATIONS IN THE APPLICATION WHICH AFFECT THE ACCEPTANCE OF THE RISK OR HAZARD ASSUMED BY THE COMPANY MAY RESULT IN THE LOSS OF COVERAGE AND NONPAYMENT OF DEATH BENEFITS SUBJECT TO THE "INCONTESTABILITY" PROVISION OF THE POLICY.

Signed at _____ Proposed Insured _____

Date _____ Applicant/Owner _____

Agent _____ Agent Name (Printed) _____

Mail Policy To: ☐ Agent ☐ Insured ☐ Owner

AGENT'S CERTIFICATION

I hereby certify that, to the best of my knowledge, there is ☐ is not ☐ existing life insurance and/or annuity contract(s) on the life of the insured. If there is, I have presented and read the applicant a notice regarding replacement, if required by applicable state law. If there is existing coverage, I certify that the insurance hereby applied for will ☐ will not ☐ replace any existing life insurance or annuity contract. I further certify that: 1) the above answers are full, complete and true to the best of my knowledge; 2) that I know of no factors affecting the insurability of any proposed insured except as stated on the application; 3) that the above signatures are those they are represented to be; and 4) that the application was signed by all proposed insureds in my presence.

Signed at _____ Licensed Agent _____

Date _____ Agent Number _____

Remarks _____

AGENT'S REMARKS

Telephone Interview Completed: ☐ Yes ☐ No **Best Time to Call:** _____AM _____PM

Premium Notices To: ☐ Insured ☐ Owner **Mail Policy To:** ☐ Agent ☐ Insured ☐ Owner

Remarks/Requests: _____

_____

_____

_____

COMPANY'S COPY OF THE CONDITIONAL RECEIPT

All Premium Checks Must Be Payable to American Home Life Insurance Company; Do Not Make Checks Payable To The Agent Or Leave The Payee Blank.

Received $_____ from _____ in connection with the application for life insurance, including any riders for which application has been made.

1. **NO INSURANCE WILL BECOME EFFECTIVE PRIOR TO DELIVERY OF THE POLICY UNLESS AND UNTIL EACH AND EVERY ONE OF THE FOLLOWING CONDITIONS HAVE BEEN FULFILLED EXACTLY:**
   (a) I**f the proposed insured(s) is/are a tobacco user**, the amount of payment taken with the application must be at least equal to the amount of the full first premium at tobacco premium rates for the mode of payment selected in the application and for the amount of insurance which may become effective prior to delivery of the policy;
   (b) **If the proposed insured(s) is/are NOT a tobacco user**, the amount of payment taken with the application must be at least equal to the amount of the full first premium at non-tobacco premium rates for the mode of payment selected in the application and for the amount of insurance which may become effective prior to delivery of the policy;
   (c) all medical examinations, tests, x-rays, and electrocardiograms required by the Company must be completed and received at its Home Office within 60 days from the date of completion of the application;
   (d) on the Effective Date, as defined below, the Company at its Home Office must be satisfied that each person proposed for insurance in this application is a risk insurable by the company at no greater than standard tobacco or standard non-tobacco premium rates under its rules, limits, and standards for the plan and the amount applied for without any modification either as to plan, amount riders, or supplemental agreements; and
   (e) on the Effective Date the state of health and all factors, including tobacco usage, affecting the insurability of each person proposed for insurance must be as stated in the application.

2. Subject to the conditions of paragraph 1, insurance, as provided by the terms and conditions of the policy applied for and in use on the Effective Date, but for an amount not exceeding that specified in paragraph 2, will become effective as of the Effective Date. "Effective Date", as used herein, is the latest of (a) the date of completion of the application questions, or (b) the date of completion of all medical examinations, prescription checks, tests, x-rays, and electrocardiograms required by the Company, or (c) the date of issue, if any, requested in the application.

3. **The total amount of insurance which may become effective on any person proposed for insurance shall not exceed $35,000 of life insurance.**

4. If one or more of the conditions of paragraph 1 have not been fulfilled exactly, there shall be no liability on the part of the Company except to return the applicable payment in exchange for this Receipt.

5. **NO AGENT OR ANY OTHER PERSON IS AUTHORIZED BY THE COMPANY TO WAIVE OR MODIFY IN ANY WAY ANY OF THE PROVISIONS OF THIS CONDITIONAL RECEIPT.**

Date at _____

this _____ day of _____ Year _____

_____
Signature of Agent

I acknowledge possession of this receipt and I certify that I have read it and the agreement in the application. The terms and conditions of this receipt, to which I agree, and the agreement in the application have been explained to me fully by the agent and I understand them.

_____
Signature of the Owner

OWNER'S COPY OF THE CONDITIONAL RECEIPT

All Premium Checks Must Be Payable to American Home Life Insurance Company; Do Not Make Checks Payable To The Agent Or Leave The Payee Blank.

1. **NO INSURANCE WILL BECOME EFFECTIVE PRIOR TO DELIVERY OF THE POLICY UNLESS AND UNTIL EACH AND EVERY ONE OF THE FOLLOWING CONDITIONS HAVE BEEN FULFILLED EXACTLY:**
   (a) I**f the proposed insured(s) is/are a tobacco user**, the amount of payment taken with the application must be at least equal to the amount of the full first premium at tobacco premium rates for the mode of payment selected in the application and for the amount of insurance which may become effective prior to delivery of the policy;
   (b) **If the proposed insured(s) is/are NOT a tobacco user**, the amount of payment taken with the application must be at least equal to the amount of the full first premium at non-tobacco premium rates for the mode of payment selected in the application and for the amount of insurance which may become effective prior to delivery of the policy;
   (c) all medical examinations, tests, x-rays, and electrocardiograms required by the Company must be completed and received at its Home Office within 60 days from the date of completion of the application;
   (d) on the Effective Date, as defined below, the Company at its Home Office must be satisfied that each person proposed for insurance in this application is a risk insurable by the company at no greater than standard tobacco or standard non-tobacco premium rates under its rules, limits, and standards for the plan and the amount applied for without any modification either as to plan, amount riders, or supplemental agreements; and
   (e) on the Effective Date the state of health and all factors, including tobacco usage, affecting the insurability of each person proposed for insurance must be as stated in the application.

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5. **NO AGENT OR ANY OTHER PERSON IS AUTHORIZED BY THE COMPANY TO WAIVE OR MODIFY IN ANY WAY ANY OF THE PROVISIONS OF THIS CONDITIONAL RECEIPT.**

OWNER'S COPY OF THE AUTHORIZATION TO OBTAIN INFORMATION

By this form, **I authorize** any licensed physician, medical practitioner, clinic, hospital, other medical or medically-related facility, the Veterans Administration, MIB , an employer, consumer reporting agency, any person, organization, other institution or other insurance companies that have records or knowledge about me or any children to be insured (if applicable) to release this information to The American Home Life Insurance Company of Kansas. This information may be about: (a) employment; (b) occupation; (c) avocations; (d) other insurance coverage; (e) driving record; (f) age; (g) prescription drug usage; (h) any medical history, condition, care or advice relative to the proposed insured's physical or mental health; and (i) other personal characteristics. This AUTHORIZATION extends to information on the use of alcohol, drugs and tobacco; and the diagnosis or treatment of HIV (the virus that causes AIDS) infection or other sexually transmitted disease. I understand that this information will be used by The American Home Life Insurance Company of Kansas, its representatives or reinsurers in the evaluation of this application to determine eligibility for insurance and/or to investigate claims. The American Home Life Insurance Company of Kansas or its representatives may release information covered by this AUTHORIZATION to the American Home Agent(s) listed in my application for insurance, to its subsidiaries, reinsurers, the MIB, or other insurance companies. The American Home Life Insurance Company of Kansas may also release this information to others who I authorize in writing or as allowed by law.

This AUTHORIZATION may be used for a period of 24 months from the date signed below unless sooner revoked. I may revoke this AUTHORIZATION at any time by notifying The American Home Life Insurance Company of Kansas in writing at Underwriting Department, The American Home Life Insurance Company, P.O. Box 1497, Topeka, KS 66601. My revocation will not be effective to the extent The American Home Life Insurance Company, its reinsurers, or any other person already has disclosed or collected information or taken other action in reliance on the AUTHORIZATION. I understand that my application for insurance will not be considered unless this AUTHORIZATION is signed and dated. The information The American Home Life Insurance Company of Kansas or its reinsurers obtains through this AUTHORIZATION may become subject to further disclosure, as required by law. I understand that any information that is disclosed pursuant to this AUTHORIZATION is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be redisclosed except as authorized by me or as required by law. I agree that a photocopy of this AUTHORIZATION is as valid as the original. I understand that I have the right to receive a copy of this AUTHORIZATION upon request.

NOTICE REGARDING MIB

Information regarding your insurability will be treated as confidential. The American Home Life Insurance Company of Kansas or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

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

The American Home Life Insurance Company of Kansas, 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 may be obtained on its website at www.mib.com.

NOTICE REGARDING FAIR CREDIT REPORTING ACT

You are entitled to know that, as a part of our regular procedures, we may request an investigative consumer report concerning the insurability of each person proposed for coverage. This report would include information as to character, general reputation, personal characteristics and mode of living, except as may be related directly or indirectly to your sexual orientation, obtained through personal interviews with friends, neighbors, and associates of the Proposed Insured(s).

Upon receipt of written request to our Home Office, we will inform you whether an investigative consumer report has, in fact, been obtained and the name and address of the consumer reporting agency from whom the report was requested. Copies of the report may be obtained from the consumer reporting agency.

NOTICE OF INFORMATION PRACTICES

To properly underwrite and administer your life insurance coverage, American Home Life must collect certain information. The primary source of information is your application and any supporting amendments, questionnaires, etc. However, it may be necessary to obtain more information from sources such as medical professionals and institutions which have provided care to you or members of your family who have applied for coverage. We may contact your employers, business associates, friends and neighbors, public records, and other insurance companies to which you may have applied. Information from these sources may be obtained by correspondence, phone, or personal contact. In some cases, we may ask an insurance support organization to complete an investigative consumer report for us. This information may be disclosed as follows:

1. To other persons or organizations who perform business, professional or insurance services for us, and whose proper performance for us requires that we disclose certain information to them.
2. To another insurance company to which you have applied for coverage or benefits.
3. To your AHL agent to assist in providing proper service to you.
4. To insurance support organizations formed to prevent or detect fraud in insurance transactions.
5. To our reinsurers if we ask them to accept a portion of the risk under your policy.
6. To a medical care institution or medical professional to verify that you have coverage with us. Also, if a medical examination for insurance purposes reveals a condition or problem unknown to the individual, we may inform the individual's personal medical professional.
7. To state regulatory authorities who conduct examinations and audits of company operations,
8. To law enforcement agencies to assist in the prevention or prosecution of fraud, or to alert them to the possibilities of illegal conduct.

You have certain rights concerning access to information about you that we have collected and retained in our files. To maintain security of that information, access will be permitted only after proper identification has been submitted to us.

If you would like access to this information you must send a signed, written request to the Underwriting Department, The American Home Life Insurance Company, P.O. Box 1497, Topeka, Kansas 66601. The request must include full name, address, telephone number and policy number. Within 30 business days after receiving your request we will tell you the nature and substance of the information in our files. If you wish to see and copy the records in person, we will advise you of the location of the records. There may be a charge for each copy made.

Also we will tell you to whom we have disclosed information about you within the last two years or to whom such information normally would have been disclosed.

There are limitations of access. We will identify sources of information which comes from institutions such as hospitals, clinics, doctors or insurance support organizations, but we will not identify sources of information which was obtained from individuals such as friends or neighbors. Also, we are not obligated to provide access to information obtained in connection with or in anticipation of a claim for policy benefits or a civil or criminal proceeding.

Medical information will be provided only through a doctor or some other medical professional, designated by you, who is licensed to provide medical care relevant to the nature of the information.

If you believe, after reviewing information in our files, that it is incorrect, you may request, in writing, that we correct, amend or delete any item of information. Requests should be directed to the Underwriting Department, The American Home Life Insurance Company, P.O. Box 1497, Topeka, Kansas 66601. We will respond within thirty business days of receipt of your written request.

If we agree that certain changes should be made, we will notify any person to whom we may have disclosed the original information during the preceding two years. We will also notify any insurance support organization to whom we have disclosed the information or who may have furnished the original information.

If we do not agree to change our records, you may file with us a brief written statement setting forth what you believe to be the correct, relevant or fair information and why you disagree with our decision not to change the original information. Your statement will become a permanent part of our file and will be disclosed in the future with the original information. Also, copies of your statement will be sent to any person or insurance support organization to whom the original information was furnished.

ACCELERATED BENEFIT RIDER
Summary and Acknowledgement

BRIEF DESCRIPTION: This rider enables the Owner to claim a portion of the policy's death benefit prior to the actual death of the Insured, when the Insured is diagnosed as having a Qualifying Event. The benefit, when paid, is treated as an advance against the death benefit, reducing the policy's death benefit, accordingly. Descriptions of major provisions are given below.

AVAILABILITY: Automatically provided in any new American Home Life final expense policy at issue.

MINIMUM BENEFIT: $1,000.

MAXIMUM BENEFIT: 100% of the policy's Eligible Proceeds which, in no event shall exceed the lesser of the policy's death benefit or $35,000. Eligible Proceeds are that portion of the policy's death benefit that can be paid out as an Accelerated Benefit. Additional death benefits provided by rider or endorsement are not a part of the policy's Eligible Proceeds. The Accelerated Benefit amount is subject to the following adjustments and deductions: (1) An actuarial discount, (2) repayment of a portion of any outstanding policy loan, (3) payment of any premium due within the policy's grace period and unpaid at the time the Accelerated Benefit is approved for payment, (4) an Administrative Expense Fee of $150 for each Accelerated Benefit claim.

BENEFIT QUALIFICATION: To make a claim for the Accelerated Benefit, the Insured must be diagnosed as having a Qualifying Event, which means (1) a non-correctable medical condition that, with reasonable medical certainty, will result in the death of the Insured within 12 months from the date on which this benefit is requested or (2) permanent and continuous confinement to a nursing home licensed and operated for nursing home care pursuant to the laws of the state in which it is located, and providing nursing care as its primary function. The Company will require a physician's statement certifying the Insured's life expectancy in the event of a terminal illness or certification of permanent confinement as outlined in the rider.

BENEFIT PAYMENT: The Accelerated Benefit may be paid in a lump sum. It may also be paid in installments of not less than $250. The amount of each installment payment will be based on the following: (1) The lump sum amount; (2) the frequency of payment; (3) the number of installment payments to be made; and (4) a minimum interest rate of 3%.

BENEFITS AND ADJUSTMENTS: The following sample illustration shows how the amount available for payment as an Accelerated Benefit is calculated:

Base Policy:	$10,000	Cash Value:	$1,000
Eligible Death Benefit:	$10,000	Policy Loan:	$ 500
Maximum Gross Accelerated Benefit:		$10,000	
Requested Accelerated Benefit:		$ 5,000	

Adjustments:	Actuarial Discount	Loan Repayment	Premiums Due	Admin Fee	Total Adjustments
	$5,000	$500			
	X .05*	.50			
	$250 +	$250 +	$50 +	$150 =	$700

*Discount rate is variable; 5% used as example only.

Maximum Net Accelerated Benefit: $ 4,300 ($5,000 - $700 = $4,300)

EFFECT ON POLICY VALUES: This shows how the benefits of the policy are altered after an Accelerated Benefit is paid:

Base Policy:	$ 5,000	($10,000 X .5 = $5,000)
Benefit at Death:	$ 5,000	
Cash Value:	$ 500	($1,000 X .5 = $500)
Policy Loan:	- 250	($ 500 X .5 = $250)
Remaining Cash Value:	$ 250	($ 500 - $250 = $250)
Premium Before Benefit:	$ 600 per year	
Premium After Benefit:	$ 300 per year	($ 600 X .5 = $300)

TAX CONSEQUENCES: Acceleration of life insurance benefits under this rider may or may not qualify for favorable tax treatment under the Internal Revenue Code of 1986, section 101 (g). Qualification for favorable tax treatment will depend on factors such as the Insured's life expectancy at the time benefits are accelerated or use of benefits for necessary long-term care expenses, such as nursing home care. If the acceleration of life insurance benefits qualifies for favorable tax treatment, the benefits will be excludable from the Owner's income and not subject to federal taxation. Tax laws relating to acceleration of life insurance benefits are complex. Consult a qualified tax advisor to assess the tax consequences of accelerated benefits.

ACCELERATED BENEFITS AND PUBLIC ASSISTANCE PROGRAMS: Receipt of accelerated benefits may affect eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children (AFDC), supplementary social security income (SSI) and drug assistance programs. Consult a qualified tax advisor and social service agencies concerning how receipt of accelerated benefits will affect eligibility for public assistance.

I hereby acknowledge receipt of the Summary and Acknowledgement form. I also acknowledge that I have reviewed the "Benefits and Adjustments" and "Effect on Policy Values".

Signature of Agent	Date	Signature of Owner	Date

RETURN WITH APPLICATION

ACCELERATED BENEFIT RIDER
Summary and Acknowledgement

BRIEF DESCRIPTION: This rider enables the Owner to claim a portion of the policy's death benefit prior to the actual death of the Insured, when the Insured is diagnosed as having a Qualifying Event. The benefit, when paid, is treated as an advance against the death benefit, reducing the policy's death benefit, accordingly. Descriptions of major provisions are given below.

AVAILABILITY: Automatically provided in any new American Home Life final expense policy at issue.

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MAXIMUM BENEFIT: 100% of the policy's Eligible Proceeds which, in no event shall exceed the lesser of the policy's death benefit or $35,000. Eligible Proceeds are that portion of the policy's death benefit that can be paid out as an Accelerated Benefit. Additional death benefits provided by rider or endorsement are not a part of the policy's Eligible Proceeds. The Accelerated Benefit amount is subject to the following adjustments and deductions: (1) An actuarial discount, (2) repayment of a portion of any outstanding policy loan, (3) payment of any premium due within the policy's grace period and unpaid at the time the Accelerated Benefit is approved for payment, (4) an Administrative Expense Fee of $150 for each Accelerated Benefit claim.

BENEFIT QUALIFICATION: To make a claim for the Accelerated Benefit, the Insured must be diagnosed as having a Qualifying Event, which means (1) a non-correctable medical condition that, with reasonable medical certainty, will result in the death of the Insured within 12 months from the date on which this benefit is requested or (2) permanent and continuous confinement to a nursing home licensed and operated for nursing home care pursuant to the laws of the state in which it is located, and providing nursing care as its primary function. The Company will require a physician's statement certifying the Insured's life expectancy in the event of a terminal illness or certification of permanent confinement as outlined in the rider.

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Eligible Death Benefit:	$10,000	Policy Loan:	$ 500
Maximum Gross Accelerated Benefit:		$10,000	
Requested Accelerated Benefit:		$ 5,000	

Adjustments:	Actuarial Discount	Loan Repayment	Premiums Due	Admin Fee	Total Adjustments
	$5,000	$500			
	X .05*	.50			
	$250 +	$250 +	$50 +	$150 =	$700

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Remaining Cash Value:	$ 250	($ 500 - $250 = $250)
Premium Before Benefit:	$ 600 per year	
Premium After Benefit:	$ 300 per year	($ 600 X .5 = $300)

TAX CONSEQUENCES: Acceleration of life insurance benefits under this rider may or may not qualify for favorable tax treatment under the Internal Revenue Code of 1986, section 101 (g). Qualification for favorable tax treatment will depend on factors such as the Insured's life expectancy at the time benefits are accelerated or use of benefits for necessary long-term care expenses, such as nursing home care. If the acceleration of life insurance benefits qualifies for favorable tax treatment, the benefits will be excludable from the Owner's income and not subject to federal taxation. Tax laws relating to acceleration of life insurance benefits are complex. Consult a qualified tax advisor to assess the tax consequences of accelerated benefits.

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I hereby acknowledge receipt of the Summary and Acknowledgement form. I also acknowledge that I have reviewed the "Benefits and Adjustments" and "Effect on Policy Values".

Signature of Agent	Date	Signature of Owner	Date