APPLICATION FOR INSURANCE * UNITED AMERICAN INSURANCE COMPANY
A LEGAL RESERVE STOCK CO., * ADMINISTRATIVE OFFICE: MCKINNEY, TX 75070

DISTRICT OF COLUMBIA

Requested Effective Date (mm-dd-yyyy) __ __ - __ __ - 2 0 __ __

Payment Mode
○ Monthly ○ Semi-Annual
○ Quarterly ○ Annually

Payment Type
○ Bank Draft
○ Direct

Draft Day (01 to 28 only) ____

○ **Primary Insured**

LIFE Plans: ○ **10 Year Renewable Term** ○ **10 Year Term to ART** ○ **20 Year Term to ART** ○ **Whole Life**

Life Face Amount $ ___,___ Premium (including riders) $ _,___.__

Optional Riders: **Child Term Rider** ○ $5,000 ○ $10,000 **Accident Benefit Rider** ○ $25,000 ○ $50,000 ○ $75,000 ○ $100,000 ○ **Waiver of Premium Rider**

○ **Spouse**

LIFE Plans: ○ **10 Year Renewable Term** ○ **10 Year Term to ART** ○ **20 Year Term to ART** ○ **Whole Life**

Life Face Amount $ ___,___ Premium (including riders) $ _,___.__

Optional Riders: **Child Term Rider** ○ $5,000 ○ $10,000 **Accident Benefit Rider** ○ $25,000 ○ $50,000 ○ $75,000 ○ $100,000 ○ **Waiver of Premium Rider**

○ **Child 1**
LIFE Plans: ○ **10 Year Renewable Term** ○ **Whole Life**
Life Face Amount $ ___,___ Premium $ _,___.__

○ **Child 2**
LIFE Plans: ○ **10 Year Renewable Term** ○ **Whole Life**
Life Face Amount $ ___,___ Premium $ _,___.__

○ **Child 3**
LIFE Plans: ○ **10 Year Renewable Term** ○ **Whole Life**
Life Face Amount $ ___,___ Premium $ _,___.__

Best time to call: ○ 8 AM - Noon ○ Noon - 6 PM ○ 6 PM - 9 PM

Home Phone No. ___ - ___ - ____

Work Phone No. ___ - ___ - ____

Total Premium $ _,___.__

Total Collected with Application $ __,___.__

Applicant if other than Primary Insured/Owner

Name: ____________________ Relationship to Primary Insured: ____________

Address: ____________________ City: __________ State: _____ ZIP: _______

Is Applicant to be Owner of all Policies? *If "No", Owner shall be Primary Insured.* ○ **Yes** ○ **No**

Primary Insured (or Owner if Application is for Children's Insurance Only)

Marital Status ○ Single ○ Married ○ Widowed ○ Divorced

First Name ____________ M.I. __ Height (ft. in.) __ __

Last Name ____________ ○ Male ○ Female Weight (lbs.) ____

Address ____________

City ____________ State ____ Zip Code ____ Age ____

Birth State ____ Date of Birth (mm-dd-yyyy) __ __ - __ __ - __ __ __ __ SS # ___ - __ - ____

Driver's Lic. Issue State ____ Driver's Lic. Number ____________

Primary Insured's Occupation ____________ Employer's Name ____________

Primary Insured's E-mail Address: ____________ I, the agent, have personally seen this person: ○ **Yes** ○ **No**

29571

ILAP(08)

(Application Continued)

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DISTRICT OF COLUMBIA

Spouse First Name ______ M.I. ___ Height (ft. in.) ___ ___

Last Name ______ ◯ Male ◯ Female Weight (lbs.) ___

Age ___ Birth State ___ Date of Birth (mm-dd-yyyy) __ __ - __ __ - __ __ __ __ I, the agent, have personally seen this person. ◯ **Yes** ◯ **No**

Driver's Lic. Issue State ___ Driver's Lic. Number ______

Spouse's Occupation ______ Employer's Name ______

Child 1 First Name ______ M.I. ___ Height (ft. in.) ___ ___

Last Name ______ ◯ Male ◯ Female Weight (lbs.) ___

Age ___ Date of Birth (mm-dd-yyyy) __ __ - __ __ - __ __ __ __ I, the agent, have personally seen this person. ◯ **Yes** ◯ **No**

Driver's Lic. Issue State ___ Driver's Lic. Number ______

Child 2 First Name ______ M.I. ___ Height (ft. in.) ___ ___

Last Name ______ ◯ Male ◯ Female Weight (lbs.) ___

Age ___ Date of Birth (mm-dd-yyyy) __ __ - __ __ - __ __ __ __ I, the agent, have personally seen this person. ◯ **Yes** ◯ **No**

Driver's Lic. Issue State ___ Driver's Lic. Number ______

Child 3 First Name ______ M.I. ___ Height (ft. in.) ___ ___

Last Name ______ ◯ Male ◯ Female Weight (lbs.) ___

Age ___ Date of Birth (mm-dd-yyyy) __ __ - __ __ - __ __ __ __ I, the agent, have personally seen this person. ◯ **Yes** ◯ **No**

Driver's Lic. Issue State ___ Driver's Lic. Number ______

1. Has any Proposed Insured ever had or been treated for any of the following conditions:	PRIMARY INSURED **YES/NO**	SPOUSE **YES/NO**	CHILD 1 **YES/NO**	CHILD 2 **YES/NO**	CHILD 3 **YES/NO**
a. High blood pressure, chest pain, heart attack, stroke or any heart or circulatory disorder?	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯
b. Asthma, emphysema, or other respiratory disorder?	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯
c. Ulcer, colitis, or other digestive tract disorder?	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯
d. Cirrhosis, hepatitis, or other liver disorder, or blood disorder?	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯
e. Diabetes or other endocrine disorder?	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯
f. Kidney, prostate, urinary bladder or other genitourinary disorder?	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯
g. Paralysis, epilepsy, mental disease or disorder or any other nervous system or brain disorder?	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯
h. Cancer, tumor, or unexplained masses?	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯
i. Disease of the breasts, uterus or ovaries?	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯
j. Rheumatoid arthritis or any other musculoskeletal disorder?	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯
k. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or AIDS related conditions?	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯

(Application Continued)

Question	PRIMARY INSURED YES/NO	SPOUSE YES/NO	CHILD 1 YES/NO	CHILD 2 YES/NO	CHILD 3 YES/NO
2. Has any Proposed Insured tested positive for exposure to the HIV infection or been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) caused by the HIV infection or other sickness or conditions derived from such infection?	○○	○○	○○	○○	○○
3. Has any Proposed Insured in the last 5 years:					
a. Had a physical examination?	○○	○○	○○	○○	○○
b. Had any medical treatment? (includes prescription medications)	○○	○○	○○	○○	○○
c. Been hospitalized?	○○	○○	○○	○○	○○
4. 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?	○○	○○	○○	○○	○○
5. Has any Proposed Insured ever used alcohol to excess or used narcotics, sedatives, or hallucinogens?	○○	○○	○○	○○	○○
6. Has any Proposed Insured used marijuana in the past year?	○○	○○	○○	○○	○○

Important - Details of "Yes" answers to questions 1 thru 6

* In column below list "**I** " for Insured, "**S**" for Spouse, "**C1**" for Child 1, "**C2**" for Child 2 and "**C3**" for Child 3.

*	Question No.	Name, Address and Telephone No. of Each Physician Practitioner and/or Health Facility	Dates and Durations	Name and Severity of Condition, Frequency of Attacks, Specific Diagnosis and Treatment

Question	PRIMARY INSURED YES/NO	SPOUSE YES/NO	CHILD 1 YES/NO	CHILD 2 YES/NO	CHILD 3 YES/NO
7. Has any Proposed Insured ever been arrested, including arrests for driving while intoxicated, or under the influence?	○○	○○	○○	○○	○○
8. Has any Proposed Insured:					
a. Used tobacco in any form within the past 12 months?	○○	○○	○○	○○	○○
b. Ever used tobacco? If "Yes" give date of last use, frequency and amount used:	○○	○○	○○	○○	○○

Date (mm-dd-yyyy) ☐☐ - ☐☐ - ☐☐☐☐ Frequency and Amount ________

9. **Supplemental Questions 9a through 9d if Face Amount Applied for is $100,000 or Greater:**

a. Total life insurance in force: **$** ________

Question	PRIMARY INSURED YES/NO	SPOUSE YES/NO	CHILD 1 YES/NO	CHILD 2 YES/NO	CHILD 3 YES/NO
b. Has the Proposed Insured within the last 2 years made or intended to make any flights other than as a passenger on a scheduled airline?	○○	○○	○○	○○	○○
c. Has the Proposed Insured within the last 2 years engaged in or intended to engage in automobile, motorboat, or motorcycle racing, scuba, skin, or sky diving?	○○	○○	○○	○○	○○
d. Does any Proposed Insured plan to travel or reside outside the United States or Canada within the next year?	○○	○○	○○	○○	○○
10. Is any Proposed Insured a non-citizen of the United States?	○○	○○	○○	○○	○○
11. Is the insurance applied for intended to replace or change any insurance or annuities with this or any other company?	○○	○○	○○	○○	○○
12. Has any Proposed Insured ever been rejected for life insurance, rated, or failed to receive a policy as applied for?	○○	○○	○○	○○	○○

Please provide the primary personal physician details below for each Proposed Insured

* In column below list "**I** " for Insured, "**S**" for Spouse, "**C1**" for Child 1, "**C2**" for Child 2 and "**C3**" for Child 3.

*	Name, Address and Telephone No. of Each Physician Practitioner and/or Health Facility	Date Last Seen

(Application Continued)

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Primary Insured's Beneficiary

Beneficiary Relationship

Beneficiary for Spouse and/or Children will be Primary Insured (owner) *unless notice is given to United American Insurance Company's Home Office.*

AGREEMENT: 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 and complete and true to the best of my knowledge and belief and shall be considered to be representations and not warranties. 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 authorize the Medical Information Bureau, any insurance company, hospital, physician or other practitioner having any information available as to my diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment, to disclose such information to the United American Insurance Company for the purpose of determining my eligibility for insurance and eligibility for benefits under this policy. I understand that any information obtained will not be released to any person or organization except to the Medical Information Bureau, reinsuring companies or other persons or organization performing business or legal services in connection with this application, with a claim or as may be otherwise lawfully required, and that data being collected will be used only for evaluation/underwriting or anything related to the policy being applied for. I agree that a copy of this authorization is to be acceptable. This authorization will remain in effect for a period of 24 months from the date signed or for the purpose of collecting information in connection with a claim for benefits, no longer than the duration of the claim. I understand that I or an authorized representative of mine may request a copy of this authorization by writing the Company at United American Insurance Company, P. O. Box 8080, McKinney, TX 75070, and that any revocation thereof may be a basis of denying benefits. Failure to sign this authorization statement may impair the Company's ability to evaluate claims or process this application and may be a basis for denying this application or a claim for benefits.

Personal information may be collected from other parties. Such information, and other personal or privileged information later collected, may be disclosed to third parties without authorization. You have the right to access and correction with respect to all personal information collected, and a full notice of your rights will be furnished upon request.

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

To the best of your knowledge as writing agent, is the insurance applied for intended to replace any existing insurance?
If "YES", complete a replacement form. ○ **Yes** ○ **No**

I certify I have personally seen the applicant and accurately recorded the information supplied by the applicant.

Agent's Signature

Last Name ____ Agent No. ____

Print First 5 Letters of Agent's Last Name

SEND POLICY TO: ○ Agent ○ Insured

(The Policy will be sent to Insured unless otherwise instructed.)

Date Application Signed (mm-dd-yyyy) __ __ - __ __ - __ __ __ __

City ____ State ____

Signed ____
Primary Insured

Signed ____
Applicant (If other than the Primary Insured)

Signed ____
Spouse

Signed ____
Child's Signature (If over the age of 18)

ILAP(08)

"Automatic" Payment Plan / Bank Draft

Please **TAPE** personalized **VOIDED CHECK** here.
DO NOT STAPLE

"AUTOMATIC" PAYMENT PLAN / BANK DRAFT AUTHORIZATION: I authorize you to pay and charge to my account, checks or electronic debits drawn on my account by and payable to the order of United American Insurance Company. This authorization is to remain in effect until revoked by me. All premiums and non-insurance charges may be automatically withdrawn from my account on **MONTHLY** mode, *unless a different mode has been selected on page one of the application.*

Account Holder's Signature (as it appears on financial institution records)

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