Application for Life Insurance

American Memorial Life Insurance Company
P.O. Box 2730 • Rapid City, SD 57709

HOME OFFICE USE ONLY
#_____
Agent Present ❑ Yes ❑ No

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.

1. Proposed Insured

_____
First Middle Initial Last

Address: _____
Street

_____
City State Zip

Telephone Number: (Home) _____ (Cell) _____ (Work) _____

Social Security Number: _____ Email Address: _____

Date of Birth: _____ Current Age: _____ Birth State: _____ ❑ Male ❑ Female

2. Owner Information (If different from Proposed Insured)

Owner's Name: _____ Email Address: _____

Owner's Address: _____

Relationship to Proposed Insured: _____ Social Security Number: _____

Telephone Number: (Home) _____ (Cell) _____ (Work) _____

3. Primary Beneficiary

Name: _____

Address: _____

_____

Telephone Number: (Home) _____

(Cell) _____ (Work) _____

Social Security Number: _____

Relationship to Proposed Insured: _____

4. Contingent Beneficiary

Name: _____

Address: _____

_____

Telephone Number: (Home) _____

(Cell) _____ (Work) _____

Social Security Number: _____

Relationship to Proposed Insured: _____

5. Face Amount: $_____ **6. Plans:** ❑ Preferred Plan ❑ Standard Plan

7. Additional Required Information for Proposed Insured:

A. Has the Proposed Insured used nicotine based products in the past 12 months? ❑ Yes ❑ No

B. Current Physician and Address: _____

_____

C. Drivers License Number: _____ State: _____

D. Are you a U.S. citizen? ❑ Yes ❑ No

If not, do you have an immigration card? ❑ Yes ❑ No Card Number: _____

8. Payment Options

Initial Payment Method:

❑ PAC (Pre-Authorized Check) ❑ Check* (Payable to AML)

❑ Credit Card (Initial payment only) ❑ VISA ❑ MasterCard

Account Number _____ Expiration Date_____

Cardholder's Printed Name_____ Cardholder's Signature _____

Premium Amount $ _____

Subsequent Premium Payment Frequency and Method of Payment:

Billing Frequency	Payment Method
❑ Monthly	PAC (Pre-Authorized Check) (Must choose PAC if Initial Payment Method above is PAC)
❑ Quarterly ❑ Semi-Annual ❑ Annual	Check *(Payable to AML)

If you selected PAC (Pre-Authorized Check), indicate subsequent premium withdrawal date_____

❑ Checking ❑ Savings

Name of Financial Institution _____

Routing Number _____ Account Number _____

Account Holder's Printed Name _____ Signature of Account Holder _____

*When you provide a check as payment, you authorize us either to use information from your check to make a one-time electronic fund transfer from your account or to process the payment as a check transaction. When we use information from your check to make an electronic fund transfer, funds may be withdrawn from your account as soon as the same day you make your payment, and may not receive your check back from your financial institution. For inquiries please call 1-800-585-8385, press zero.

9. Health Questions

PART A: If the Proposed Insured answers "YES" to any question in this section or does not meet the height and weight requirements for the product, they are not eligible for coverage.

1. Height_____ Weight _____

	YES	NO	
2.	❑	❑	Do you need assistance with the normal activities of daily living (eating, bathing, dressing, taking medications, etc.), or are you currently hospitalized, confined to a bed or nursing facility, or receiving hospice care?
3. Within the past 12 months have you			
a.	❑	❑	Been diagnosed with internal cancer, leukemia, lymphoma, or melanoma or have had more than one occurrence of any cancer in your life time (excluding basal or Squamous cell skin cancer), had a recurrence of any cancer, or currently being treated for cancer or had an amputation caused by any disease or cancer?
b.	❑	❑	Been medically diagnosed, treated, or taken medication for stroke or transient ischemic attack (TIA/mini-stroke)?
4. Within the past 24 months have you			
a.	❑	❑	Been medically diagnosed, treated or taken medication for cirrhosis, liver disease, angina, chronic obstructive pulmonary or lung disease (COPD/COLD), emphysema, chronic bronchitis, required oxygen to assist in breathing, or uncontrolled high blood pressure?
b.	❑	❑	Been diagnosed as having, been treated for or hospitalized for heart disease, Hodgkin's Disease, heart attack, heart or circulatory vascular surgery (including coronary artery bypass, pacemaker or replacement pacemaker, heart valve replacement, abdominal aortic aneurysm, but excluding angioplasty or stent placement) cardiomyopathy, or any procedure to improve circulation to the heart or brain?
5. Within the past 36 months have you			
a.	❑	❑	been convicted of a felony or are you currently incarcerated or on probation, been treated for or been advised to have treatment for alcohol or any drugs of abuse, attempted suicide, or been convicted of operating a vehicle while intoxicated or impaired?
6. Have you ever			
a.	❑	❑	Been treated for insulin shock, diabetic coma, or have you taken insulin injections or by other methods prior to age 40?
b.	❑	❑	Been medically treated or diagnosed by a medical professional as having Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC), or any immune deficiency related disorder or tested positive for the human immunodeficiency virus (HIV)?
c.	❑	❑	Had, or been medically advised to have, an organ transplant, or been diagnosed as having a terminal medical condition that is expected to result in death within the next 12 months.
d.	❑	❑	Been medically diagnosed, treated, or taken medication for chronic kidney disease (including dialysis), kidney or liver failure, congestive heart failure, Alzheimer's, dementia, Lou Gehrig's disease (ALS), schizophrenia, bipolar disorder, or mental incapacity?

PART B: If the Proposed Insured answers "YES" to any question in this section, they are eligible for the Standard Plan.

7. Within the past 24 months have you been medically diagnosed, treated, or taken medication for			
a.	❑	❑	Lymphoma, melanoma, leukemia or any internal cancer?
b.	❑	❑	Stroke, or transient ischemic attack (TIA/mini-stroke)?
c.	❑	❑	Neuromuscular or brain disease (including cerebral palsy, muscular dystrophy, multiple sclerosis, grand mal epilepsy, cystic fibrosis or Parkinson's disease) or systemic lupus (SLE)?
d.	❑	❑	Paralysis of two or more extremities or amputation caused by disease or cancer?
e.	❑	❑	Angioplasty or stent placement?
8.	❑	❑	Within the past 24 months, have you been confined three times or more to a hospital, nursing facility, convalescent care facility, assisted living facility, mental facility, or hospice care?
9.	❑	❑	If you are age 65 and under, do you have a physical or mental reason or any health reason that would prevent you from working for at least 25 hours per week in an active, normal, and gainful employment?

Conditions Relating to the Application: I have read the questions and answers in all parts of this Application. I agree that they are complete and true to the best of my knowledge and belief. I agree that this Application and any supplement to the Application, if required, shall be attached to and form a part of any policy issued.

Acknowledgement: I have read and understand the Conditions Relating to the Application, the Medical Authorization information, and this Acknowledgement. I acknowledge receipt and review of the Notice to the Applicant and (where required by law) a Buyer's Guide and any other required preliminary cost information.

I understand and agree that no insurance agent has the authority to waive an answer to any question in the Application, pass on insurability, make or alter any contract, or waive any of the Company's rights or requirements. I understand and agree that any policy applied for shall not take effect (except as provided in the Conditional Premium Receipt bearing the same name as this Application) unless and until the policy has been issued and delivered and the first full premium, according to the mode of payment selected by the applicant and as permitted by the Company and stated in the policy, has been paid and accepted by the Company during the lifetime and condition of health of the Proposed Insured as stated in this Application. I understand that I (or my authorized representative) may receive a copy of this Authorization.

SIGNATURES:

Signed at: _____
City State

Proposed Insured _____ Date _____

Will the policy that you are applying for replace any existing life insurance or annuity policy? ❑ Yes ❑ No

If yes, give name and address of the existing insurer and policy number, if available: _____

_____

Applicant/Owner _____ Date _____
(If different from Proposed Insured)

Witness - Licensed Agent _____ Date _____

Agent's Statement

Did you see the Proposed Insured at the time this application was completed? ❑ Yes ❑ No

Is the insurance applied for intended to replace or change an existing life insurance or annuity policy? ❑ Yes ❑ No

If a replacement is involved, I certify that I only used company approved sales materials.

Licensed Agent's Signature _____

Name of Agency Office _____

Agent's State License ID Number _____ Expiration Date _____

Print Agent Name _____

Agent Number _____ Agent Telephone Number (_____) _____

Medical Authorization

For use with Life Insurance Applications.
This Authorization complies with the HIPAA Privacy Rule.

_____ _____
Name(s) of primary proposed insured/patient Date(s) of birth

_____ _____
Name(s) of unemancipated minors Date(s) of birth

I authorize any health plan, physician, medical practitioner, health care professional, hospital, clinic, pharmacy benefit manager, pharmacy, MIB, Inc., laboratory, medical facility, insurance company, insurance support organization (or any of its members or affiliates), the Veteran's Administration, my employer, consumer reporting agency, or any other health care provider that has provided payment, treatment or services to me or on my behalf or on the behalf of my unemancipated minor children (collectively, "My Providers") to disclose the entire medical record and any other protected health information concerning me or my above named unemancipated minor children to American Memorial Life Insurance Company ("the Company") or its reinsurers, their agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes. I acknowledge receipt of the MIB, Inc. Pre-Notice and Fair Credit Reporting Act Pre-Notice.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information or that of my unemancipated minor children do not apply to this authorization and I instruct My Providers to release and disclose the entire medical record without restriction.

This protected health information is to be disclosed under the authorization at my request, as permitted by §164.508 of the privacy regulations issued pursuant to the Health Insurance Portability and Accountability Act ("HIPAA Privacy Rule").

This authorization shall remain in force for 24 months following the date of my signature below, regardless of my condition and whether living or deceased, and a copy of this authorization is as valid as the original. I understand that I have the right to obtain a copy of this authorization and to revoke this authorization in writing, at any time, by sending a written request for revocation to the Company at Attention: Privacy Task Force, P.O. Box 2730, Rapid City, SD 57709. I understand that a revocation is not effective to the extent that any of My Providers has relied on this authorization or to the extent that the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal regulations governing privacy and confidentiality of health information (such as the HIPAA Privacy Rule). However, the company will protect the privacy of health information in accordance with other applicable state and/or federal privacy laws and its own privacy policies.

I understand that My Providers may not refuse to provide treatment or payment for health care services because I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record or that of my unemancipated minor children, the Company may not be able to process my application, or if coverage has been issued, may not be able to make any benefit payments. I acknowledge that I (or my authorized representative) have received a copy of this authorization.

_____ _____
Signature of Primary Proposed Insured/Personal Representative Date

_____ _____
Signature of Primary Proposed Insured/Personal Representative Date

If signed by an individual's Personal Representative, describe authority to sign on behalf of individual:
{ } Parent { } Power of Attorney { } Legal Guardian { } Other_____

Notice to the Applicant

You have made a wise decision to apply for life insurance. The possibility exists that premiums paid over several years may exceed the death benefit. This notice is given to you at the time you apply for life insurance to tell you about that type of information the Company may obtain in connection with your application. We will treat all personal information about you as confidential.

Underwriting. Your application, together with the medical history you give, provides the initial basis for evaluation. The Company relies on the accuracy and completeness of your answers and may make inquiries, both before and after a policy is issued, to verify this information.

Sources of Information. The Company may request additional information from your physician(s) or hospital(s) or other medical professionals, or medical care institutions, the Medical Information Bureau (MIB), other insurance institutions to which you have applied for insurance, your employers, agents of the Company, business associates, a governmental entity, financial institution, or consumer reporting agency. Your signature on the Acknowledgement and Medical Authorization Form permits the Company to make these inquiries. Such inquiries may be made by telephone, written correspondence, or personal interview. If the Company requests information from another insurance company, it will not request underwriting action. You have the right to know what information we have about you, to copy it, and if it is incorrect, to have it corrected. If the Company received information about you from an insurance support organization, such information may be retained by the organization and released to others. In this connection, the following notice is given to you as required by the federal and various state Fair Credit Reporting Acts. You have the right to access and correction with respect to this information. If you wish a more detailed explanation of information practices, please send your written request to American Memorial Life Insurance Company, P.O. Box 2730, Rapid City, SD 57709.

Fair Credit Reporting Act Pre-Notice. In some cases, the Company may ask an independent agency to prepare an investigative consumer report for you. This report may include information about your character, general reputation, personal characteristics such as health, finances, and mode of living, except as may be related directly or indirectly to your sexual orientation. Any information obtained by an investigative agency may be kept in its file and later given to others who have a business need for it. If an investigative consumer report is ordered by the Company, the report will include information obtained through interviews with your neighbors, friends, or others with whom you are acquainted. You may request to be interviewed in connection with the preparation of the investigative consumer report. You may request, in writing, to receive information from the Company about the nature and scope of an investigative consumer report. Within five (5) business days of receipt of such request, the Company will provide you with the name, address, and phone number of any agency the Company asks to prepare such a report. You should contact them to obtain a copy of the report.

Medical Information Bureau, Inc. Pre-Notice. Information regarding your insurability will be treated as confidential. American Memorial Life Insurance Company 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.

American Memorial Life Insurance Company, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life and 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.

Conditional Premium Receipt

THIS RECEIPT PROVIDES COVERAGE ONLY IF CONDITIONS BELOW ARE MET.

The Company hereby acknowledges receipt of the initial premium from the Proposed Insured for which an application for insurance is made to American Memorial Life Insurance Company on the date of application and for the premium collected as stated on the application for insurance.

Life insurance and any additional benefits in the amount applied for shall be deemed to take effect as of the date of this application, subject to the terms and conditions printed below.

Conditions of Life Insurance Coverage (Please read carefully).

Subject to the limitations of this receipt and the terms and conditions of the policy that may be issued by the Company on the basis of the application, the life insurance and any additional benefits applied for will not be deemed to take effect unless the Company, after investigation and such medical examination (if any) as it may require, is satisfied that on the date of the application the person proposed for insurance was insurable for the amount of life insurance and any additional benefits applied for according to the Company's rules and practice of selection; provided, however, that approval by the Company of the insurability of the Proposed Insured for a plan of insurance other than that applied for shall not invalidate the terms and conditions for the receipt relating to life insurance and any other additional benefit applied for.

The amount received shall be refunded if the application is declined or if a policy is issued other than as applied for and is not accepted. Any check, draft or money order is received subject to collection.

American Memorial Life Insurance Company or its reinsurers may also release limited information in its file to other properly authorized life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted.