Application Packet

for Term & Universal Life Insurance

This packet contains the basic forms needed to write the following products:

125 · 100 · 125 CBO · HMS w/ADB

Forms included in this packet:

- Application (Series 5120)
- HMS w/ADB Disclosure (11-149-9)– *Required when applying for HMS w/ADB.*

Additional forms that may be required:

These forms can be ordered or downloaded from americo.com.

- **Supplemental Applications** – *Refer to americo.com for additional information. State variations apply.*
- **Replacement Forms** – *Required in applicable states when replacing an existing life insurance policy or annuity contract.* ***Important Note:*** *States may require a completed replacement form even when an existing policy or contract is not being replaced. Refer to americo.com for additional information. State variations apply.*
- **Health Questionnaires** – *May be required due to underwriting. Refer to americo.com for additional information. State variations apply.*
- **HIV Consent Forms** – *May be required in applicable states due to underwriting. State variations apply.*
- **Transfer Funds Form** – *Required when transferring funds from another financial institution to Americo.*

Important Note: In Florida, only the 30/30 guarantee period is available for CBO products.

For additional information, contact Sales Support at 800.231.0801, ext. 8410, or log on to www.americo.com.

AMERICO®

For Use in Florida
11-188-4-FL (03/12)

Application for Simplified Issue

Individual Life Insurance

AFL5120 (06/11)

Americo Financial Life and Annuity Insurance Company

1. PROPOSED INSURED INFORMATION

a. Proposed Insured's Name *(Last, First, MI)*

b. ☐ Single ☐ Married

c. ☐ Male ☐ Female

d. Address *(Include City, State, and ZIP. If mailing address is a PO Box, a street address is also required.)*

e. Home Phone

f. Work Phone

g. Email Address

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

i. Social Security Number

j. Date of Birth *(MM/DD/YYYY)*

k. Age

l. Place of Birth *(City, State, Country)*

m. Is the Proposed Insured currently employed? ☐ Yes ☐ No

n. Occupation

o. Annual Salary

p. Provide description of job duties:

2. PRODUCT INFORMATION *(Verify that the product is available in the state where the application is being signed.)*

a. ☐ 125 ☐ 125 CBO ☐ 100 ☐ Other: _____

☐ HMS w/ADB *(if selected, skip sections 2b & 2c.)*
Base Face Amount: $1,000
ADB Rider: $ _____

b. Guarantee Periods (Level Period/Guarantee Period)
☐ 15/15 ☐ 20/20 ☐ 25/25 ☐ 30/30
☐ 15/5 ☐ 20/5 ☐ 25/5 ☐ 30/5
☐ Other: _____

IMPORTANT NOTE: 5-Year Guarantee Periods are NOT available with UL products.

c. Payment Information
Face Amount $ _____

d. Mode Premium $ _____
Mode: ☐ Monthly Bank Draft ☐ Annually

e. Effective Date *(If not checked, will be "Issue Date". Date cannot be the 29th, 30th, or 31st of the month.)*
☐ Issue Date
☐ Save Age of _____
☐ Specific Date _____

3. RIDERS *(Verify rider availability. Optional riders are not available with HMS w/ADB.)*

a. ☐ Additional Insured Term Insurance* .....$ _____
Additional Insured's Occupation ..... _____
Additional Insured's Annual Salary .....$ _____

b. ☐ Children's Term* .....$ _____

c. ☐ Critical Illness Accelerated Benefit†‡ .....$ _____

d. ☐ Disability Income†
☐ Primary Insured ☐ 1 Year ☐ 2 Years $_____
☐ Additional Insured ☐ 1 Year ☐ 2 Years $_____

e. ☐ Waiver of Premium‡

f. ☐ Other _____

*Complete section 4 of this application. †Supplemental application required. ‡Critical Illness Accelerated Benefit and Waiver of Premium riders cannot be issued on the same policy.

4. ADDITIONAL PROPOSED INSURED(S) *(To include Additional Insured and Children's Term rider.)*

Name of Other Proposed Insured *(Last, First, MI)*	Date of Birth *(MM/DD/YYYY)*	State of Birth	Sex	Height	Weight *(lbs.)*	Social Security Number	Relationship to Proposed Insured
			☐M ☐F	' "			
			☐M ☐F	' "			
			☐M ☐F	' "			
			☐M ☐F	' "			
			☐M ☐F	' "			

5. BENEFICIARY INFORMATION (*Include percentage shares. If shares are not given, they will be equal.)*

If not specified, all beneficiaries will be Primary.	Name	Social Security Number or Taxpayer ID	Relationship	Date of Birth	% of Share *(Must total 100%)*
☐Primary					
☐Primary ☐Contingent					
☐Primary ☐Contingent					

6. LIFE INSURANCE IN FORCE AND REPLACEMENT INFORMATION | **Yes** | **No**

a. Does any Proposed Insured have life insurance or annuity applications pending with other companies? ☐ ☐

b. Is there any existing life insurance or annuity coverage on the life of any Proposed Insured? *(If **Yes**, provide information below.)* ☐ ☐

c. Will the life insurance applied for replace or otherwise reduce in value any existing life insurance or annuities now in force? ☐ ☐

*(If **Yes**, complete applicable replacement form(s) and submit with application. Application and replacement form(s) must be dated on the same date.)*

d. Is this an internal replacement? *(If **Yes,** include a Surrender form or Absolute Assignment form for the life insurance or annuity being replaced.)* ☐ ☐

e. If current life insurance or annuity is being replaced, indicate the amount of surrender charges that will be assessed. $ _____

Insured's Name *(Last, First, MI)*	Company	Owner	Amount	Accidental Death Benefit	Policy Date *(MM/DD/YYYY)*

7. OWNER INFORMATION *(If different from the Proposed Insured.)*

a. Owner's Name *(Last, First, MI)*	b. Relationship to Proposed Insured	c. SSN or Taxpayer ID

d. Address *(Include City, State, and ZIP. If mailing address is a PO Box, a street address is also required.)*

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

f. Home Phone	g. Work Phone	h. Date of Birth *(MM/DD/YYYY)*	i. Place of Birth *(City, State, Country)*

8. PAYOR INFORMATION *(If different from the Proposed Insured and Owner.)*

a. Payor's Name *(Last, First, MI)*	b. Relationship to Proposed Insured	c. SSN or Taxpayer ID

d. Address *(Include City, State, and ZIP. If mailing address is a PO Box, a street address is also required.)*

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

f. Do you wish to designate another person (secondary addressee) to receive copies of any premium lapse notices? ☐Yes ☐No If "Yes" provide name and address. Name: _____ Complete Address_____

9. SPECIAL REQUESTS

PERSONAL HISTORY *(Provide details of all "Yes" answers in the Personal History Details section below.)*

	Proposed Insured Yes	Proposed Insured No	Additional Proposed Insured Yes	Additional Proposed Insured No
10. Has any Proposed Insured ever been declined, rated, or modified for life or health insurance?	☐	☐	☐	☐
11. Within the past two (2) years, has any Proposed Insured:				
a. made any flights as a pilot, student pilot, or member of a flight crew? ***(If Yes, complete aviation questionnaire.)***	☐	☐	☐	☐
b. engaged in the following hazardous sports: bungee or base jumping, parachuting, hang gliding; competitive skiing/snowboarding (heli-skiing or ski jumping); diving activities (scuba, cave diving, or underwater photography); canyoning, kayaking, or white water rafting; organized racing (automobiles, drag racers, or motorcycles); rock or mountain climbing, rodeo riding? ***(If Yes, complete sports questionnaire.)***	☐	☐	☐	☐
12. Within the past seven (7) years, has any Proposed Insured been convicted of, pleaded guilty to, or entered a plea of no contest to any felony?	☐	☐	☐	☐
13. Is any Proposed Insured currently on probation or been placed on probation within the last twelve (12) months?	☐	☐	☐	☐
14. Within the next two (2) years, does any Proposed Insured intend to work, travel, or reside in Afghanistan or Iraq for more than thirty (30) days? ***(If Yes, Provide details below.)***	☐	☐	☐	☐
15. Within the past five (5) years, has any Proposed Insured:				
a. pleaded guilty to or been convicted of three (3) or more moving violations?	☐	☐	☐	☐
b. had a driver's license suspended or revoked, or are you currently under license suspension or revocation?	☐	☐	☐	☐
c. been convicted of reckless driving or driving under the influence of alcohol or drugs?	☐	☐	☐	☐

16. Driver's License Number(s) during the past five (5) years:

Name of Proposed Insured(s) on Driver's License	Driver's License Number	State Issued

PERSONAL HISTORY DETAILS

Question #	Proposed Insured's Name	Dates	Details

MEDICAL HISTORY *(Provide details of all "Yes" answers in the Medical History Details section below.)*

17. a. Proposed Insured's Height ..... ' " b. Proposed Insured's Weight ..... lbs.

If you are applying for HMS w/ADB, answers provided to questions 18-26 will NOT be considered. Please DO NOT answer questions 18-26 for HMS w/ADB.	**Proposed Insured** Yes	No	**Additional Proposed Insured** Yes	No
18. Has any Proposed Insured used cigarettes, cigars, pipes, chewing tobacco, nicotine patches, snuff, nicotine chewing gum, or other products containing nicotine within the last twelve (12) months?	☐	☐	☐	☐
19. Within the past seven (7) years, has any Proposed Insured:				
a. been treated for or been advised or diagnosed by a medical professional to seek treatment for the use of alcohol or prescription drugs?	☐	☐	☐	☐
b. been advised by a licensed member of the medical profession to reduce or discontinue the intake of alcohol or prescription drugs? ***(If Yes, complete the alcohol usage and/or prescription medication and drug use questionnaire.)***	☐	☐	☐	☐
20. Within the past seven (7) years, has any Proposed Insured used, except as prescribed by a physician: heroin, morphine, other narcotics, ecstasy, opium derivatives, marijuana, cocaine, crack, barbiturates, amphetamines, methamphetamines, hallucinogens, any other illegal, restricted or controlled substances, been treated for or been advised by a medical professional to seek treatment for the intake of any drug? ***(If Yes, complete the prescription medication and drug use questionnaire.)***	☐	☐	☐	☐
21. Within the past five (5) years, has any Proposed Insured been diagnosed, treated, or been advised by a licensed member of the medical profession for:				
a. hypertension, heart disease or disorder, valve disorders, angina, cardiac arrhythmia, heart surgery including bypass, angioplasty or stent placement, circulatory disorder, blood vessel or blood disorders?	☐	☐	☐	☐
b. lung or respiratory disorder, COPD, emphysema, current use of oxygen, shortness of breath, or sleep apnea?	☐	☐	☐	☐
c. cancer in any form?	☐	☐	☐	☐
d. diabetes or pancreatic disorders?	☐	☐	☐	☐
e. digestive disorder, kidney or liver disease to include hepatitis, Crohn's disease or ulcerative colitis, gastrointestinal bleeding, bladder disorders, or unexplained weight loss?	☐	☐	☐	☐
f. Alzheimer's disease, dementia, nervous system disorder, emotional or psychiatric disorder, paralysis, sexually transmitted disease, systemic lupus, any blood disorders, or birth defects?	☐	☐	☐	☐
g. rheumatoid arthritis, any disease or disorder of the bones or muscles?	☐	☐	☐	☐
22. Within the last five (5) years, has any Proposed Insured consulted a physician, had tests performed (such as an EKG, echocardiogram, X-ray, or blood tests) or been hospitalized or had surgery for any reason?	☐	☐	☐	☐
23. Has any Proposed Insured tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection, or other sickness or condition derived from such infection? ***(If "Yes" DO NOT provide details in the Medical History Details section below.)***.....	☐	☐	☐	☐
24. Within the last twelve (12) months, has any Proposed Insured had tests, surgery, treatment or hospitalization recommended, by a licensed member of the medical profession but not completed, or consulted any health care provider(s) not already identified, for any reason?	☐	☐	☐	☐
25. Do any of the Proposed Insured(s):				
a. currently use prescription medicines? ***(If Yes, list each medication and describe the reason for its use.)***	☐	☐	☐	☐
b. currently have a personal physician? ***(If Yes, list name, address, and telephone number along with date, reason, and results of last consultation.)***	☐	☐	☐	☐
ANSWER QUESTION #26 BELOW <u>ONLY</u> IF ANY PROPOSED INSURED IS AGE 65 OR OLDER:				
26. Within the past five (5) years, has any Proposed Insured been diagnosed, treated, or been advised by a licensed member of the medical profession to have or had treatment for: stroke, TIA, prostate disorders, any disease or disorders of the back or joints, memory loss, or taking any prescription medication for Alzheimer's disease or dementia?	☐	☐	☐	☐

MEDICAL HISTORY DETAILS

Please provide details of all "Yes" answers in the area below. *(Attach a separate sheet if more space is needed; additional sheet MUST be signed and dated by applicable Proposed Insured/Owner to avoid amendments.)*

Question #	Proposed Insured's Name	Date of Onset/ Treatment	Details/Results	Name, Address, and Telephone Number of Attending Physician

AUTHORIZATION AND ACKNOWLEDGMENT

I/We authorize any insurance or reinsurance company, employer, licensed medical physician, medical professional, hospital, pharmacy or pharmacy benefit manager, records custodians, other medical or medically related facility, clearing house, consumer reporting agency, and/or the Medical Information Bureau (MIB, Inc.) that has any record of information about me/us or my/our minor children who are to be insured, to give Americo Financial Life and Annuity Insurance Company (Americo), its reinsurers or its authorized representatives, information about other insurance coverage, employment, age, general character, motor vehicle records, habits, court records, foreign travel, finances, participation in hazardous activities, medical care or advice about any physical or mental condition, including information about drugs and alcoholism required by Americo to determine insurability and/or claims eligibility for the duration of the claim.

Americo may release information obtained by this Authorization to its reinsurers, to MIB, Inc., to other insurers with whom I/we have policies or to whom I/we may apply or submit a claim, to other persons or organizations performing business or legal services in connection with an insurance transaction for me/us, or as may otherwise be lawfully required. Although federal regulations require that Americo inform You of the potential that information disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and no longer be protected by such regulation, all information received by Americo pursuant to this Authorization will be protected by federal and state privacy laws and regulations.

I/We have received a copy of the Notice of Insurance Information Practices. I/We, or my/our authorized representative, may obtain a copy of this Authorization on request. This Authorization will be valid for two (2) years from the date signed. It is Americo's practice to prohibit third parties who lawfully receive nonpublic health information from redisclosing or reusing the disclosed information. A photographic copy shall be as valid as the original. I/We understand that a copy of this Authorization will be provided, upon request, to me/us or a person authorized on my/our behalf.

This Authorization may be revoked; however, it may not be revoked during the contestability period of the policy or to the extent Americo has taken action in reliance on this Authorization. Notice of revocation may be sent, in writing, to Americo at its Administrative Office address.

IN ACCORDANCE WITH STATE LAW, WE MUST PROVIDE YOU WITH THE FOLLOWING FRAUD NOTICE: Any person who knowingly and with intent to injure, defraud, deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

The **USA PATRIOT ACT** requires all financial institutions, including insurance companies, to verify the identity of their customers. Providing your name, address, date of birth and taxpayer identification number allows us to verify your identity. Our verification process may include the use of third-party sources to verify the information provided.

REQUEST FOR OWNER'S TAXPAYER IDENTIFICATION NUMBER AND CERTIFICATION: Under penalties of perjury, I as the Owner, certify that the number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me).

Any policy issued on this application will be deemed to be delivered in and governed by the laws of the jurisdiction in which this application was signed. Notwithstanding the foregoing, if this application is not solicited face to face or is effected through any electronic means, any policy issued on this application will be deemed to be delivered in and governed by the laws of the jurisdiction of the Owner, and said jurisdiction will also be the "Signed at (City and State)" inserted below.

No agent or medical examiner can waive the answer to any question in this application nor decide on insurability nor waive any of the company's underwriting requirements nor make or change any contract. The company shall have no knowledge of statements made by or to the Agent or medical examiner unless such statements are shown on the application.

I/We have read this application and represent to Americo that the statements made on this application are true, complete and correctly recorded to the best of my/our knowledge and belief. I/We agree that Americo can rely on these statements. I/We agree that this application and/or any medical exam form and any supplemental application or amendment to the application will be the basis for any policy issued on this application or any amendment to the application. **I/WE AGREE THAT ALL ANSWERS TO THE PERSONAL HISTORY QUESTIONS ON PAGE 2 AND TO MEDICAL HISTORY QUESTIONS ON PAGE 3 OF THIS APPLICATION, SIGNED AND DATED BELOW, ARE COMPLETE AND ACCURATE.**

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

_____ _____

Signature of Proposed Insured *(required)* Signature of Owner (*if different than the Proposed Insured)*

_____ _____

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

AGENT'S REPORT

Important Note: Agent's Report must be completed and submitted with all applications

Proposed Insured's Name: _____

	Yes	No
1. Are you related to the Proposed Insured(s)?	☐	☐
If **Yes**, provide relationship: _____		
2. How long have you known the Proposed Insured(s)? _____		
3. Did the applicant approach you to purchase insurance? *(If **Yes,** list their stated need for the insurance in the Agent Comments/Remarks section below.)*	☐	☐
4. At the time this application was taken, were all of the Proposed Insureds present and did you witness their signatures?	☐	☐
5. Did the Proposed Insured(s) directly respond to you regarding each application question?	☐	☐
6. Was a government-issued picture ID requested, reviewed, and confirmed (by reviewing a second document such as a utility bill, tax return, etc.) for the Proposed Insured, Owner, and Payor *(if different than the Proposed Insured)*?	☐	☐

Provide details of all NO answers to questions 4-6 in the Agent Comments/Remarks section below.

Replacement Information	Yes	No
7. Does the applicant have any existing life insurance or annuities on the life of any Proposed Insured?	☐	☐
8. Will the life insurance applied for replace, or otherwise reduce in value, any life insurance or annuity now in force? *(If **Yes**, complete applicable replacement form(s). Provide copies of replacement form(s) to the Owner and the Company. Leave copies of sales materials with Owner. If you used an electronic sales presentation, you must mail a copy to the Owner.)*	☐	☐

Agent Comments/Remarks:

I hereby certify that I have personally asked each question on this application to the Proposed Insured(s), that I have truly and accurately recorded on the application the information supplied by him/her, and that I have no reason to believe that any of the information provided is inaccurate or incomplete. If not, I have set forth my reservations in the "Agent Comments/Remarks" section above.

Print Agent's Name	Agent's Signature	Americo Agent Number	Florida Agent Number	% Split

Writing Agent's Phone Number	Writing Agent's Fax Number	Writing Agent's Email Address

Does Americo have your current contact information? If not, email: licensing@americo.com.

Disclosure for
HMS w/ADB

The features and benefits of term and/or universal life insurance have been presented to me by my agent. I understand that I had the opportunity to apply for a policy that offers a higher death benefit payable upon the death of the insured for any reason.

HMS w/ADB offers term life insurance with an Accidental Death Benefit Rider. It provides the following benefits:

- Subject to policy provisions, the Term Life policy will pay **$1,000** if the insured dies for any reason.
- The Accidental Death Benefit Rider will pay, in addition to the Term Life policy, if the insured dies from a bodily injury which is a direct result of an accident within 180 days of the injury.
- The Common Carrier Accidental Death Benefit will pay, in addition to the Term Life policy and the Accidental Death Benefit, only if the insured dies from a bodily injury which is a direct result of an accident while riding as a fare-paying passenger in a Common Carrier. The Common Carrier benefit equals the Accidental Death Benefit Rider amount.
- The amount of the Accidental Death Benefit Rider is selected upon application and will be included on the Policy Data Page of your issued policy.

ACKNOWLEDGMENT

I, the undersigned Insured (and Policy Owner, if other than the Insured), acknowledge that I have read this Disclosure. I understand the above-stated benefits and will consult the policy and rider forms for all other terms, limitations, and exclusions.

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

_____ _____

Signature of Proposed Insured *(required)* Signature of Owner *(if different than Proposed Insured)*

****This signed Disclosure must be completed and returned with the application for HMS w/ADB****

HMS w/ADB (Policy Series 301) and Accidental Death Benefit Rider (Rider Series 2165) are offered on a group or individual basis depending on the state and are underwritten by Americo Financial Life and Annuity Insurance Company (Americo), Kansas City, MO, and may vary in accordance with state laws. Products and benefits may not be available in all states. Certain restrictions apply. Consult policy and rider for all terms, exclusions, and limitations as well as to determine what constitutes accidental death.

No Premium

Conditional Receipt

IMPORTANT NOTICE — PLEASE READ CAREFULLY!

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

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

Dated at _____ this _____ day of _____, _____.

_____ _____

Signature of Licensed Agent Signature of Applicant

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

Premium

Conditional Receipt

THIS IS A CONDITIONAL RECEIPT — PLEASE READ CAREFULLY!

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

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

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

IF ANY PROPOSED INSURED DIES DURING THE PROCESSING OF THIS APPLICATION AND BEFORE ALL OF THE FOREGOING TERMS HAVE BEEN MET, NO INSURANCE COVERAGE WILL EXIST, AND THE COMPANY'S ONLY LIABILITY WILL BE TO REFUND PREMIUMS RECEIVED, IF ANY.

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

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

Dated at _____ this _____day of _____, _____ .

_____ _____

Signature of Licensed Agent Signature of Applicant

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

INFORMATION PRACTICES NOTICE

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

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

MIB, INC. PRE-NOTICE

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

Upon receipt of a request from you, the MIB, Inc., will arrange disclosure of any information it has in your file. Please contact MIB at 866-692-6901 (TTY 866 346-3642. If you question the accuracy of information in the file, you may contact the MIB and seek a correction in accordance with the procedures in the Fair Credit Reporting Act. The MIB's information office address is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734. The Company or its reinsurers may release information in its file to its reinsurers and to other life and health insurance companies to whom you apply for insurance or to whom a claim is submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

INVESTIGATIVE CONSUMER REPORTS

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

AAA8394

INFORMATION PRACTICES NOTICE

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

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

MIB, INC. PRE-NOTICE

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

Upon receipt of a request from you, the MIB, Inc., will arrange disclosure of any information it has in your file. Please contact MIB at 866-692-6901 (TTY 866 346-3642. If you question the accuracy of information in the file, you may contact the MIB and seek a correction in accordance with the procedures in the Fair Credit Reporting Act. The MIB's information office address is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734. The Company or its reinsurers may release information in its file to its reinsurers and to other life and health insurance companies to whom you apply for insurance or to whom a claim is submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

INVESTIGATIVE CONSUMER REPORTS

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

Bank Draft
Authorization Form
AF55019 (09/10)

AMERICO

DRAFT INFORMATION

As a convenience to me, I hereby request and authorize the banking institution below (the "Bank") to pay and charge to my account drafts on my account by and payable to the order of the company who issued or assumed the policy listed below (the "Company") administering my insurance policy provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that the Bank's rights in respect to such draft shall be the same as if it were a check drawn on the bank and signed personally by me. This authority is to remain in effect until revoked by me. I agree that the Bank shall be fully protected in honoring any such draft. I further agree that if any such draft be dishonored, whether with or without cause and whether intentionally or inadvertently, the Bank shall be under no liability whatsoever. Should any draft not be honored by the Bank upon presentation, I understand that this method of payment may be terminated. **I further understand that should any draft not be honored for the reason of "insufficient funds", a second attempt to draft may occur within 5-10 days**.

I understand that Americo requires a ***five*** business day advance notice to set up, change, or discontinue my bank draft information. I also understand that my insurance policy may lapse if said draft is returned unpaid by my Bank, or if I discontinue payments, prior to receiving confirmation of draft processing from the Company. ***Please keep a copy of this authorization with your banking records.***

FOR NEW BUSINESS APPLICATIONS: **Premium will be drafted from your account immediately upon issuance, except in the event of additional delivery requirements needed, or if an alternate draft date is chosen.**

FOR EXISTING POLICIES: **Unless otherwise requested, premium draft date will be the existing premium due date. Drafts occurring more than 10 days after the payment due date may generate a grace notice.**

ALTERNATE DRAFT DATE: **I request an alternate draft date of: _____, in lieu of my regular premium due date.**
(If the 29th, 30th or 31st is requested, the draft date will default to the 1st of the following month.)

CHECK ONE:
- ☐ Checking account (attach voided check)
- ☐ Savings account (attach deposit slip)
- ☐ Check with Application (use the deposit and routing numbers from the enclosed check in lieu of a voided check)
- ☐ Please use Bank Draft information from Americo policy number: _____

INSURED INFORMATION

Insured Name(s)	Policy Number(s)

PAYOR INFORMATION

Name	Relationship to Proposed Insured
Address (If mailing address is a PO Box, a street address is also required)	
How long at current address? _____ If less than 5 years at current address, prior address required.	

SIGNATURE

_____ _____

*****Payor's Signature (REQUIRED, as it appears on bank records)***** **Date**

**********Attach Voided Check/Deposit Slip Here**********

Complete below only when voided check or deposit slip is not available

ALTERNATE ACCOUNT VERIFICATION

Routing Number															
Account Number															

☐ Check here if this is a business account

Name of Financial Institution: _____

Agent's Certification (For New Business only)

I do hereby attest that I personally verified this information. I understand that any misrepresentation or falsification on my part will rescind my privilege to use this form and may lead to immediate termination of my appointment with the Company.

_____ _____

*****Agent's Signature (REQUIRED)***** **Agent's Number**