LIFE APPLICATION TO
AMERICAN UNDERWRITERS LIFE INSURANCE COMPANY

Home Office: Phoenix, Arizona; Administrative Office: P.O. Box 9510, Wichita, Kansas 67277

All questions must be answered completely for all proposed insureds. If additional space is needed, use space provided on page 3.

1. a. Full Name of Proposed Insured (If joint, proposed insured 'A')	b. Age	c. Sex	d. Date of Birth	e. State of Birth

f. Social Security No. – –	g. Drivers License No.	h. Home Phone No.	i. Business Phone No.	j. Employer Name

k. Occupation, title, and duties. Are you a full-time employee? ☐ Yes ☐ No. If No, hours worked per week ______________

l. Address Number and Street or R.F.D.	City	County	State	Zip Code	How Long There
Residence					
Business					
Former Residence					

m. Primary Beneficiary and relationship: To share equally or to survivor(s)	Revocable? ☐ Yes ☐ No

n. Contingent Beneficiary and relationship: To share equally or to survivor(s)

2. a. Proposed Insured 'B' or spouse	☐ joint insured ☐ other insured ☐ spouse rider	b. Age	c. Sex	d. Date of Birth	e. State of Birth

f. Social Security No. – –	g. Drivers License No.	h. Home Phone No.	i. Business Phone No.	j. Employer Name

k. Occupation, title, and duties. Are you a full-time employee? ☐ Yes ☐ No. If No, hours worked per week ____________

l. Address Number and Street or R.F.D.	City	County	State	Zip Code	How Long There
Residence					
Business					
Former Residence					

3. a. Plan of Insurance b. Amount of Insurance $__________________	c. Modal Premium $___________ ☐ Annual ☐ Qrtly ☐ Mnthly ☐ SA ☐ BOM ☐ _______	d. If UL, Death Benefit Option ☐ A ☐ B e. Premium collected with application $_________	f. Supplemental Benefits ☐ WP/WMD ☐ SR units____ ☐ OIR ☐ CR units____ ☐ Insured ADB $___________ ☐Other insured ADB $______

4. Automatic Premium Loan, if available. ☐ Yes ☐ No	5. Excess Interest, if applicable ☐ Left at interest ☐ Other ☐ Paid-up additional	6. Bill to: ☐ Insured ☐ Home or ☐ Business ☐ Owner, address below

7. Insurance Now Owned?

Name of Company	Amount of Life	Year Issued	Double Indemnity? Yes	No

10. a. Name of owner, if other than proposed insured. ______________________

b. Social Security No.________________________

c. Mailing Address___________________________

____

d. City_____________________________________

e. State_______________ Zip Code____________

8. Do you intend the replacement or change of any of your existing insurance policies in connection with this application for new life insurance? ☐ Yes ☐ No If yes, circle company and amount above, and provide policy number.

9. Any other application for insurance now pending? ☐ Yes ☐ No If yes, company, amount and plan:

11. Home Office Additions or corrections

COMPLETE FOR CHILDREN'S COVERAGE

12. Full names of all children proposed for coverage. PLEASE PRINT	State of Birth	Birth Date			Age	Sex	Ht. – Wt.	Present Life Ins.
a.								
b.								
c.								
d.								

Questions apply to ALL proposed insureds. Provide details of "YES" answers in section at right. Indicate which proposed insured.

13. Has any Proposed Insured: YES NO
   a. Been declined, postponed, rated, modified, or refused life insurance or reinstatement thereof?............................ ☐ ☐
   b. Ever been convicted of a felony?...................................... ☐ ☐
   c. In the last 3 years had 3 or more moving traffic violations, had driver's license suspended or revoked, or more than 2 auto accidents?... ☐ ☐
   d. Lived in the U.S.A. for less than 3 years or will travel out of the U.S.A. in the next 2 years? .... ☐ ☐
   e. Been advised they need to have an exam or lab test for this insurance.? If yes, provide name (_______________). ☐ ☐

14. Is any proposed insured a member of the military (active or National Guard?) Provide rank, duties, travel assignment...... ☐ ☐

COMPLETE ALL QUESTIONS (EVEN IF A MEDICAL EXAM IS SCHEDULED) FOR ALL PROPOSED INSUREDS. CIRCLE CONDITION(S) AND EXPLAIN ANY "YES" ANSWERS IN THE SPACE AT THE RIGHT OF THE QUESTION. INCLUDE PHYSICIANS' NAMES AND ADDRESSES.

15. To the best of your knowledge and belief, have you ever received a diagnosis of or treatment for:
   a. Heart attack, stroke, paralysis, or cancer?......................... ☐ ☐
   b. Alcohol abuse or been arrested for using it? .... ☐ ☐
   c. The use of any controlled substance, or arrested for the use or possession of such a substance, or are you currently using such a substance, except as prescribed by a physician? .... ☐ ☐
   d. Acquired Immune Deficiency Syndrome (AIDS), ARC (AIDS Related Complex), or AIDS related condition? .... ☐ ☐

   If question 15. a, b, c, or d is answered "Yes", do not collect any premium or give a conditional receipt!

16. Has Proposed Insured ever had, been treated or examined for, or had symptoms of any of the following:
   a. Disease, disorder, or ailment of:
      1. Lungs, bronchi, tuberculosis, asthma? .... ☐ ☐
      2. Heart trouble, pain in chest, high blood pressure?......... ☐ ☐
      3. Gall bladder, liver, ulcer, or other intestinal or digestive system disorder? .... ☐ ☐
      4. Brain, nervous system, stroke, convulsions, mental disorder? .... ☐ ☐
      5. Muscles, bones, joints, limbs, back, rheumatism, arthritis? .... ☐ ☐
      6. Kidneys, ureters, bladder, reproductive organs?............ ☐ ☐
      7. Any other impairment, sickness, injury? .... ☐ ☐
   b. Impaired sight, hearing, tumor, a growth, diabetes?........... ☐ ☐

17. Have you used tobacco, in any form, in the last 12 months?.. ☐ ☐

18. Is there a history in parents, brothers or sisters of: mental illness, suicide, cancer, coronary disease, diabetes, or stroke? ☐ ☐

19. have your ever been rejected or discharged from the armed forces because of a medical or physical condition or a mental or nervous disorder?... ☐ ☐

20. Have you ever been or are you now a user of alcoholic beverages, narcotic, hallucinogenic, or habit-forming drugs not prescribed by a physician?... ☐ ☐

	YES	NO
21. Has proposed Insured ever: (list each occurrence)		
a. Had medical, surgical, or other examination or treatment in past five years?	☐	☐
b. Had an operation; or has an operation, restricted diet, use of heart, blood pressure, or diabetes medication been advised?	☐	☐
22. Is Proposed Insured now taking medication prescribed by a physician?	☐	☐

23. Has Proposed Insured gained or lost more than 10 lbs. in past 1 year? If "Yes," number of pounds ____☐ Gained ☐ Lost

Proposed Insured "A" Height ________ Weight ______

Proposed Insured "B" Height ________ Weight ______

	YES	NO
24. For females: Has Proposed Insured ever miscarried or had disease of uterus, ovaries, tubes, or breasts?	☐	☐
25. Is the Proposed Insured in good health and free from disease?	☐	☐
26. Any past, present or expected aviation activities or hazardous sports, avocations, or hobbies? (IF "Yes", complete Questions 27. a through f, below.	☐	☐

Complete appropriate section answered "YES" **YES** **NO**

27. a. AVIATION ☐ ☐

1. Flight Status	Past 12 mos. (hrs. flown)	1 – 2 yrs. Ago (hrs. flown)	Hrs. contemplated next 12 months
Pilot-Military or Military Reserve			
Pilot – Civilian			
Crew Member			

2. Total solo hours________________________

3. Total hours flown as a pilot?

   Date of last flight________________________

4. Type of Pilot's Certificate currently held and yr. Issued?

   ____

5. What types and kinds of planes do you fly?

   ____

6. Describe purpose and nature of flying you do.

   ____

27. b. If aviation or hazardous participation does not qualify for standard coverage without additional premium, please issue as follows:

☐ Policy to include coverage with appropriate extra premium.

☐ Policy to incorporate Aviation or Hazardous Activities Exclusion Rider.

	YES	**NO**
27. c. SKIN DIVING	☐	☐
27. d. RACING	☐	☐
27. e. PARACHUTING	☐	☐
27. f. OTHER – Give details	☐	☐

27. c. SKIN DIVING

Depth of Dives____________

No. of times per year________

Name of club______________

____

Date last dive_____________

27. d. RACING

Type of vehicle____________

Type of race course_________

No. of races per year________

Date last race_____________

27. e. PARACHUTING

Jumps per year____________

Total no. of jumps__________

Name of club______________

27. f. OTHER – Give details

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28. This space provided for additional details or special requests regarding this application.

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29. Were you given a conditional receipt for the premium for this proposed insurance? ☐ YES ☐ NO

Owner and Adult Persons Proposed for Insurance: PLEASE READ CAREFULLY AND SIGN:

1. I declare that all answers written on this application are full and correct, to the best of my knowledge and belief. No information I told the agent will bind the company unless it is in writing on this application, except in Nebraska and Oregon. No agent has the authority to waive, change or modify any answer to any question in this application. All of my answers must be complete and accurate.

2. The company has the right to require a medical examination of any person proposed for insurance, even if Question 13. e. is answered “No”.

3. The company may add to or correct the application in the space "Home Office Additions or Corrections." Any changes are agreed to, if the policy issued is accepted, but written agreement will be obtained from you for any change in insurance amount, plan, benefits, payment class or age at issue.

4. Insurance will start only as provided in the Conditional Receipt. If no receipt is issued, or if insurance under it has been stopped and not started again, no insurance will start by reason of the application until the policy is delivered and the first payment is accepted by the company. In this case, the insurance will start on the date shown in the policy. No insurance will begin if on the start date of the policy the health of each person proposed for insurance is not as described in the application.

5. Each person who signs below acknowledges that he or she has read and understands this application, including the notice about the M.I.B. and consumer reports, and acknowledges receipt of the Special Notice about M.I.B. and consumer reports.

6. Only the president or secretary of the company may change the application or waive a right or requirement. No agent may do this.

7. Under penalties of perjury, I certify (1) that the number shown on this form is my correct taxpayer identification number and (2) that I am not subject to backup withholding either because I have not been notified that I am subject to backup withholding as a result of a failure to report all interest or dividends, or the Internal Revenue Service has notified me that I am no longer subject to backup withholding.

8. Authorization and Disclosure

I acknowledge receipt of the special notice about M.I.B. and consumer reports. ☐ **I want to be interviewed if an investigative consumer report is obtained on me.** I understand that the information obtained by use of this authorization will be used to determine eligibility for insurance and/or benefits. Any information obtained will not be released by the insurance company to any person or organization except to reinsuring companies, M.I.B., or other persons or organizations performing business or legal services in connection with my application or claim, as may be otherwise lawfully required or as I may further authorize.

I authorize any (a) physician, medical practitioner, hospital, clinic, other medical or medically related facility, (b) Veterans Administration, (c) insurance, or reinsuring company, (d) M.I.B., consumer reporting agency, or (e) employer having information available as to diagnosis, treatment and prognosis with respect to (1) any past and present physical, mental, drug and/or alcohol conditions and/or treatment for each person proposed for insurance and (2) any other non-medical information, including information obtained after this authorization is signed, to give any and all such information to the insurance company, its reinsurers, and (except for M.I.B. information), its legal representative, or consumer reporting agency.

I may request a copy of this authorization. I agree that a photocopy of this authorization shall be as valid as the original. This authorization shall remain valid for 30 months from the date it is signed. I may revoke this authorization in whole or in part at any time, except to the extent that action is taken in reliance thereon.

Signature of Proposed Insured “A”	Date	Owner if other than Proposed Insured	Date
Signature of Proposed Insured “B”	Date	Agent	Date

AGENT'S REPORT (All questions in this Section must be answered)

Agent Name	Agent No.	% of Commission (Split)	Agent Name	Agent No.	% of Commission (Split)

DO NOT ACCEPT PREMIUM IF THIS COVERAGE, PLUS ANY ADDITIONAL AMOUNTS WITH US, WILL EQUAL OR EXCEED $100,000.

1. a. Premium submitted with Application: $____________ b. Was a conditional receipt given? ☐ Yes ☐ No
2. Is Proposed Insured a member of your household, yourself, your spouse, your child or another one of our agents?
   ☐ Yes ☐ No
3. Indicate requirements ordered and on whom: ____________________
   ☐ Exam ☐ Urinalysis ☐ Rest EKG ☐ Stress EKG ☐ SMAC ☐ X-ray ☐ Inspection
4. Deliver Policy to:____________________
5. How long and how well have you known the persons proposed for insurance?____________________
6. If Proposed Insured is a child and brothers or sisters have less insurance, please explain.____________________
   ____
7. If more than $50,000 applied for on child(ren) ($100,000 if other than parents are Payor), how much coverage is in force on parent(s)? Father $____________ Mother $____________
8. If applicant is married, but not employed, how much coverage in force on employed spouse? $____________
9. Do you have knowledge or reason to believe that replacement of existing insurance or annuities in this or any other company may be involved? ☐ Yes ☐ No If "YES", follow state regulations.
10. Do you have any knowledge or information pertaining to the Proposed Insured(s) not disclosed herein, which may affect their insurability?____________________

I HEREBY CERTIFY that the answers given to the foregoing questions in this application are full, complete and true to the best of my knowledge and belief; that I know of nothing affecting the risk which is not fully set forth on these papers; that I asked and carefully explained each question before recording each answer prior to the application being signed; that the special notice regarding the M.I.B. and the Federal Fair Credit Reporting Act was given to the proposed primary insured.

Date	Signature of Agent	Phone Number ( )	Agent Code No.
Date	Signature of Agent	Phone Number ( )	Agent Code No.

MEDICAL INFORMATION BUREAU DISCLOSURE NOTICE

Information regarding your insurability will be treated as confidential. The Company or its reinsurer may make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. (Medical information will be disclosed only to your attending Physician.) If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is P.O. Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660.

The Company or its reinsurer may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

(see other side) MIB part I

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American Underwriters Life Insurance Company

Phoenix, Arizona; Administrative Offices: P.O. Box 9510, Wichita, KS 67277

CONDITIONAL COVERAGE RECEIPT - Void if altered or modified, or if check or draft given in payment is not honored.

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE COMPANY.

DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

RECEIVED FROM______________________________$___________, SUBJECT TO THE TERMS, CONDITIONS AND LIMITS ON REVERSE SIDE, as full ☐ annual ☐ semi-annual ☐ quarterly ☐ monthly premium with application bearing the date of this receipt, for coverage provided for ____, the Proposed Insured.

DISABILITY PLAN__________________________________ with ____

Basic Monthly Benefit Supplemental Coverages

By: Licensed Agent ____ Date_______________________

I have read this receipt or have had it read to me. I understand and consent to all its terms, conditions and limits.

Signature of Proposed Owner ____ Date_______________________

(see other side) RECEIPT part I

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REQUEST FOR AUTOMATIC WITHDRAWALS

AMERICAN UNDERWRITERS LIFE INSURANCE COMPANY

NAME OF POLICYHOLDER	PRODUCT NAME	MODE
		☐ MO ☐ QRTLY ☐S/A ☐ANN

Licensed Agent Code No. Agency

THIS FORM MUST BE COMPLETED IN FULL AND ACCOMPANIED BY A PERSONAL CHECK OR DEPOSIT SLIP MARKED "VOID" FOR ACCOUNT CODING PURPOSES

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AUTHORIZATION TO HONOR WITHDRAWALS BY AMERICAN UNDERWRITERS LIFE INSURANCE COMPANY

NAME OF DEPOSITOR AS SHOWN ON ACCOUNT RECORDS (print) **ACCOUNT NO.**

NAME OF FINANCIAL INSTITUTION **BRANCH NAME, IF ANY**

ADDRESS OF INSTITUTION OR BRANCH (City, State, and Zip)

As a convenience to me, I hereby request and authorize you to pay and charge to my account, withdrawals from my account by and payable to the order of the Company, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such withdrawal shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such withdrawal. I further agree that if any such withdrawal be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance. This authorization allows the Company to initiate a reversing entry to my account in the event that an error occurs. Upon request, you are authorized to provide the Company with the address on my account records.

Date	Signature of Depositor as shown on account records

(see other side) AUTHORIZATION part I

NOTICE

This is to inform you that as part of our procedure for processing your initial insurance application, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics, and mode of living, except as may be related directly or indirectly to your sexual orientation. You have the right to make a written request, within reasonable period of time, to receive additional detailed information about the nature and scope of this investigation. For this information, you may write the Underwriting Department of the Company.

American Underwriters Life Insurance Company
Phoenix, Arizona
Administrative Offices: P.O. Box 9510, Wichita, KS 67277

MIB part II

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TERMS, CONDITIONS, AND LIMITS – Insurance coverage under any policy issued from an application bearing the date of this receipt will take effect on the later of the date of the application, or the date of the last of any required medical exams or tests, only if these conditions are met: (1) the Company determines, at its administrative office, that on that date the Purposed Insured was insurable under its rules and practices for insurance coverage, either exactly as applied for or otherwise the same as applied for, EXCEPT that the application and the policy are required to be amended to provide for: (a) a different premium class, and/or (b) the elimination of any portion of the coverage, such as the exclusion of a person or medical condition or a reduction in the amount of insurance; (2) the first full premium for the policy applied for is paid on the date of the application; and (3) any required amendments are signed and any extra premium is paid immediately upon notice.

NOTICE: Except as stated above, no insurance coverage will become effective and the liability of the Company is limited to a refund of any amount paid. Any application not previously accepted or declined will be deemed declined on the 60th day after its date. No agent or other representative of the Company is authorized to alter or waive any of the terms, conditions, or limitations of this Receipt.

LIMITS ON INSURANCE – The maximum amount of insurance on any person proposed for insurance (combined with any issued or pending with the company) that can take effect under this Receipt is $100,000. Insurance in excess of this limit will take effect only when: (1) the policy is delivered to and accepted by the owner, and (2) any unpaid premium is paid. These events must occur while the health and occupations of all persons proposed for insurance are as described in the application.

RECEIPT part II

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American Underwriters Life Insurance Company
Phoenix, Arizona
Administrative Offices: P.O. Box 9510, Wichita, KS 67277

INDEMNIFICATION AGREEMENT

To: Institution named on the reverse side
In consideration of your compliance with the request and authorization of the depositor named on the reverse side.

The company agrees that:

1. It will indemnify and hold you harmless from any liability to any person having an account with you arising out of the withdrawal by the Company for its own credit from the account of such person, or from any liability to any such person, or to any owner or beneficiary of any policy issued by the Company in respect of which such withdrawal is made arising out of the dishonor by you whether with or without cause of any such withdrawal by the Company, provided there are sufficient funds in such account to pay the same upon presentation whether or not such claim of liability asserted against you be based upon the forfeiture or alleged forfeiture of a policy, the premiums on which are to be collected by the Company by any such withdrawal; and
2. It will refund to you any amount erroneously paid by you to the Company on any such withdrawal if claim for the amount of such erroneous payment is made by you within twelve months from the date of the withdrawal for which such erroneous payment was made.

AUTHORIZATION part II

American Underwriters Life Insurance Company
Phoenix, Arizona
Administrative Office: P.O. Box 9510, Wichita, Kansas 67277

HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Proposed Insured A ______________________ Date ____________

Proposed Insured B ______________________ Date ____________

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility or other health care provider that has provided payment, treatment or services to the above name person ("My Health Care Provider") to disclose my entire medical record, prescription history, medications prescribed and any other protected health information concerning me to the insurance company named above, its employees, agents or 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.

By my signature below, I acknowledge that any agreements made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose the entire medical record without restriction. This protected health information is to be disclosed under this Authorization so the insurance company may evaluate my application for insurance benefits.

This authorization shall remain in force for 30 months following the date of my signature below or the entire term of my coverage, whichever is later. A copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written notification to the insurance company at the administrative office address above. I understand that a revocation is not effective to the extent that any of My Health Care Providers has already relied on this authorization to disclose information about me. 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 by the insurance company except: 1) as authorized by me; 2) as required by law; or 3) to other persons or businesses with whom the insurance company has a business relationship. Such a relationship must require the receipt of my medical information in order to perform their business with the company.

I understand that My Health Care Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, the insurance company may not be able to process my application for insurance. I understand that any authorized representative or I will receive a copy of this authorization upon request.

Signature of Proposed Insured A (representative/guardian) ______________________ Date ____________

Signature of Proposed Insured B (representative/guardian) ______________________ Date ____________