

APPLICATION FOR LIFE INSURANCE

*ARIZONA
ARKANSAS
COLORADO
DELAWARE
DISTRICT OF COLUMBIA
INDIANA
IOWA
KENTUCKY
LOUISIANA
MAINE
MICHIGAN
MISSOURI
NEBRASKA
NEVADA*

*NEW HAMPSHIRE
NEW MEXICO
NORTH CAROLINA
OHIO
OKLAHOMA
SOUTH CAROLINA
TENNESSEE
TEXAS
UTAH
VIRGINIA
WEST VIRGINIA
WISCONSIN
WYOMING*

OLD AMERICAN



INSURANCE COMPANY



NEW BUSINESS COVER SHEET – ICC18A2896

INSURANCE COMPANY PLEASE SUBMIT COMPLETED SHEET WITH EVERY APPLICATION.

AGENT INFORMATION		
Agent Name		Agent ID
Agent Phone		

INSURED NAME

TO SUBMIT AN APPLICATION		
EMAIL: oaicnewbusiness@OAIC.com	DOCUMENT TRANSFER ON KCLIC	POINT OF SALE (POS): 1-800-239-7620
FAX: 1-877-523-2265 (IF FAXING, DO NOT MAIL ORIGINAL.)	OVERNIGHT ADDRESS: 3520 Broadway Kansas City, Missouri 64111	NEW BUSINESS ADDRESS: P.O. Box 219844 Kansas City, Missouri 64121

FORMS INCLUDED IN THIS PACKET
<ul style="list-style-type: none"> Bank Draft Authorization (page 7 of the application) If applicable. Conditional Receipt (page 8 of the application) Required if money is collected or P.A.P premium mode box marked on application. How the Accelerated Benefit Prepayment Option Works Required if the Accelerated Death Benefit Rider is elected. <ul style="list-style-type: none"> ✓ ID:SF486 (signature required) AR, IN, LA, MI, NC, OH, OK, VA ✓ ID:SF487 (signature not required) AZ, CO, DE, DC, IA, KY, ME, MO, NE, NV, NH, NM, SC, TN, TX, UT, WV, WI, WY ID:SF571 Authorization for Release of Information to Insurance Agent or Agency

OTHER FORMS / SUPPLEMENTS NOT INCLUDED IN THIS PACKET If this application requires any of the following forms, please access the form(s) via kclic.net (Sales & Marketing Resources) or Supply and include with the submission.

Replacement Forms		
<ul style="list-style-type: none"> ARIZONA: ID:SF535 (Internal & External) ARKANSAS: ID:SF560; ID:SF535 (Internal & External – Both Forms) COLORADO: ID:SF535 (Internal & External) DELAWARE: ID:SF338 (External); ID:SF548 (Internal & External) DISTRICT OF COLUMBIA: ID:SF548 (Internal & External) INDIANA: ID:SF280; ID:SF548 (Internal & External – Both Forms) IOWA: ID:SF535 (Internal & External) KENTUCKY: ID:SF535 (Internal & External) LOUISIANA: ID:SF535 (Internal & External) MAINE: ID:SF535 (Internal & External) 	<ul style="list-style-type: none"> MICHIGAN: ID:SF383 (External); ID:SF548 (Internal & External) MISSOURI: ID:SF535 (Internal & External) NEBRASKA: ID:SF535 (Internal & External) NEVADA: ID:SF340; ID:SF548 (Internal & External – Both Forms) NEW HAMPSHIRE: ID:SF535 (Internal & External) NEW MEXICO: ID:SF535 (Internal & External) NORTH CAROLINA: ID:SF535 (Internal & External) OHIO: ID:SF535 (Internal & External) OKLAHOMA: ID:SF480 (External); ID:SF479; ID:SF548 (Internal & External – Both Forms) 	<ul style="list-style-type: none"> SOUTH CAROLINA: ID:SF535 (Internal & External) TENNESSEE: ID:SF322 (External); ID:SF548 (Internal & External) TEXAS: ID:SF535 (Internal & External) UTAH: ID:SF535 (Internal & External) VIRGINIA: ID:SF535 (Internal & External) WEST VIRGINIA: ID:SF535 (Internal & External) WISCONSIN: ID:SF535 (Internal & External) WYOMING: ID:SF566 (External); ID:SF548 (Internal & External)
Other State Forms		
<ul style="list-style-type: none"> OHIO: A2889 Stranger Oriented Life Insurance Supplement to Application for Life Insurance All applications for face amount over \$50,000. 		



INSURANCE COMPANY
P.O. Box 218573, Kansas City, MO 64121-8573

Application for Individual Life Insurance

POINT OF SALE INTERVIEW HAS BEEN COMPLETED <input type="checkbox"/> YES <input type="checkbox"/> NO Interviewer/Case Number _____	Agent ID _____
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PROPOSED INSURED

Name			Date of Birth - -		
Address					<input type="checkbox"/> Male <input type="checkbox"/> Female
City	State	Zip	State of Birth		
SSN		Email			
Phone Number	Height	Ft.	In.	Weight	Lbs.

OWNER INFORMATION *(if different from proposed Insured)*

Name			Date of Birth - -		
Address					
City			State	Zip	
SSN		Relationship			

BENEFICIARIES

Primary	Name	SSN
	Relationship	Date of Birth - -
<input type="checkbox"/> Primary	Name	SSN
<input type="checkbox"/> Contingent	Relationship	Date of Birth - -
<input type="checkbox"/> Primary	Name	SSN
<input type="checkbox"/> Contingent	Relationship	Date of Birth - -

PRODUCT INFORMATION

PLANS	RIDERS	PREMIUM MODE
<input type="checkbox"/> BMP <input type="checkbox"/> BMS <input type="checkbox"/> BMQ <input type="checkbox"/> BMQL <input type="checkbox"/> POM - GUARANTEED <input type="checkbox"/> POM - TOMORROW <i>(Complete page 1 & 3)</i> <input type="checkbox"/> _____	<input type="checkbox"/> ABR <input type="checkbox"/> WPNH <input type="checkbox"/> ADB <input type="checkbox"/> CTR <i>(See page 3)</i> <input type="checkbox"/> _____	<input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> P.A.P. <input type="checkbox"/> Combine Monthly Billing <i>(With policy # _____)</i>
Face Amount \$ _____	MPD - Policy # _____	Automatic Premium Loan <input type="checkbox"/> Yes <input type="checkbox"/> No
Premium Amount \$ _____	<input type="checkbox"/> Mail policy to Agency	<input type="checkbox"/> Split application with Agent _____ %

Have you used any form of nicotine/tobacco (cigar, pipe, smokeless tobacco, cigarettes, nicotine patch, nicotine gum, or other products containing nicotine or tobacco) or marijuana in the last 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the proposed Insured have any existing annuity contracts or life insurance policies?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If issued, will this policy replace or change any other life insurance or annuity you now own? If your answer is yes, give details below. Name of current company _____ City _____ State _____ Policy No. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

HEALTH QUESTIONS (QUESTIONS 1-8 MUST BE ANSWERED FOR ALL PRODUCTS.)

1. Is the proposed Insured currently hospitalized, confined to a nursing home, hospice, bed, assisted living facility, convalescent home, institutionalized, permanently confined to a wheelchair due to disease or illness, or receiving assistance with performing the following Activities of Daily Living (ADLs): eating, bathing, toileting, continence, dressing, or transferring?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Has the proposed Insured ever been diagnosed with or received treatment by a member of the medical profession for acquired immune deficiency syndrome (AIDS), AIDS related complex (ARC), tested HIV positive, or been diagnosed by a member of the medical profession as having a terminal medical condition that is expected to result in death within the next 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Has the proposed Insured ever been diagnosed with or received treatment (including medication) by a member of the medical profession for Alzheimer's disease, dementia, memory loss, or Lou Gehrig's disease (ALS)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. In the last 12 months, has the proposed Insured had or been advised by any member of the medical profession to have a diagnostic test (excluding testing related to the Human Immunodeficiency Virus (HIV)), other than for routine screening purposes, for which results have not yet been received?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Has the proposed Insured been diagnosed, treated (including medication), or been given advice by any member of the medical profession:

5. ever, for mental retardation, Down syndrome, cystic fibrosis, Huntington's disease, or sickle cell anemia?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. in the last 24 months, for leukemia, lymphoma, melanoma, or any other form of cancer (other than basal cell or squamous cell skin cancer)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. in the last: a. 12 months, for stroke, TIA (transient ischemic attack), heart attack, or undergone surgery for heart or vascular disease? b. 24 months, for congestive heart failure or does the proposed Insured have a cardiac defibrillator?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
8. ever, for an organ (excluding corneal and kidney) or bone marrow transplant, or had an amputation due to disease (not injury)?	<input type="checkbox"/> Yes <input type="checkbox"/> No

COMPLETE QUESTIONS 9-12 FOR THE FOLLOWING PRODUCTS: BMP, BMS, BMQ, POM-G

9. In the last 3 years, has the proposed Insured been convicted of a felony requiring incarceration?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. In the last 24 months, has the proposed Insured had a pacemaker implant, bypass surgery, angioplasty, stent placement, or any other procedure to improve circulation to the heart or brain?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Has the proposed Insured been diagnosed, treated (including medication), or been given advice by any member of the medical profession:

11. ever: a. for hepatitis B, hepatitis C, systemic lupus, cirrhosis, liver disease, schizophrenia, hospitalized for mental or nervous disorder, emphysema, chronic obstructive pulmonary disease (COPD), chronic bronchitis, sarcoidosis, or used oxygen equipment to assist in breathing (excluding use for sleep apnea)? b. for a kidney transplant, kidney disease, dialysis, or required insulin before the age of 40?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
12. in the last 24 months: a. for stroke, TIA (transient ischemic attack), heart attack, or undergone surgery for heart or vascular disease? b. for heart disease, peripheral vascular disease, atrial or ventricular fibrillation, aneurysm, cardiomyopathy, or angina? c. for alcohol or drug overuse, abuse, or dependency, or been advised to discontinue the use of alcohol or drugs? d. for complications of diabetes, including nephropathy (kidney), retinopathy (eyes), peripheral vascular disease, diabetic coma, insulin shock?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No

COMPLETE QUESTIONS 13-16 FOR THE FOLLOWING PRODUCTS: BMP, POM-G

13. In the last 5 years, has the proposed Insured had a pacemaker implant, bypass surgery, angioplasty, stent placement, or any other procedure to improve circulation to the heart or brain?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Has the proposed Insured been diagnosed, treated (including medication), or been given advice by any member of the medical profession:

14. in the last 24 months, for seizures, multiple sclerosis, Parkinson's disease, cerebral palsy, or muscular dystrophy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
15. in the last 5 years: a. for alcohol or drug overuse, abuse, or dependency, or been advised to discontinue the use of alcohol or drugs? b. for stroke, TIA, heart attack, heart disease, peripheral vascular disease, atrial or ventricular fibrillation, aneurysm, cardiomyopathy, angina, or any form of cancer (other than basal cell or squamous cell skin cancer)? c. for bipolar disorder, requiring more than one prescription medication to control?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
16. ever, for diabetes requiring insulin treatment or was their most recent hemoglobin A1c above 7.5 or fasting blood sugar above 170?	<input type="checkbox"/> Yes <input type="checkbox"/> No



INSURANCE COMPANY
P.O. Box 218573, Kansas City, MO 64121-8573

**Application for
Individual Life Insurance
Peace of Mind for Tomorrow
Children's Term Insurance Rider**
Must complete pages 1 and 3 of the application.

JUVENILE PRODUCT

<input type="checkbox"/> PEACE OF MIND FOR TOMORROW (One Insured per application.)		<input type="checkbox"/> \$5,000	<input type="checkbox"/> \$10,000
Name		<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth - -
Address		City	State Zip
State of Birth	SSN	Height Ft. In.	Weight Lbs.
Beneficiary	Name		SSN
	Relationship		Date of Birth - -

COMPLETE THIS SECTION ONLY FOR CHILDREN'S TERM RIDER

<input type="checkbox"/> CHILDREN'S TERM RIDER (CTR)	FACE AMOUNT \$ _____
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NAME OF ELIGIBLE CHILD PROPOSED FOR COVERAGE*	DATE OF BIRTH	SEX	HEIGHT (FT. / IN.)	WEIGHT (LBS.)
		<input type="checkbox"/> Male <input type="checkbox"/> Female		
		<input type="checkbox"/> Male <input type="checkbox"/> Female		
		<input type="checkbox"/> Male <input type="checkbox"/> Female		
		<input type="checkbox"/> Male <input type="checkbox"/> Female		
		<input type="checkbox"/> Male <input type="checkbox"/> Female		

*NOTE: An "Eligible Child" means any child, stepchild, legally adopted child, or dependent grandchild of the proposed Insured. A dependent grandchild means a grandchild who is eligible to be claimed as a dependent on the federal tax return of, and resides with, the proposed Insured.

HEALTH QUESTIONS – Complete section if applying for either Peace of Mind for Tomorrow or the Children's Term Rider.

1. Has the proposed Insured child ever been diagnosed with or treated by a member of the medical profession for any of the following conditions: anemia, leukemia, diabetes, nervous disorder, ulcers, tumors, cancer, high blood pressure, or diseases of the heart, liver, kidney, stomach, lungs, or any physical or mental impairment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Within the last 2 years, has the proposed Insured child sought treatment or advice from a member of the medical profession for any illness? If yes, please explain: _____ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Has the proposed Insured child ever been diagnosed with or treated by a member of the medical profession for acquired immune deficiency syndrome (AIDS), AIDS related complex (ARC), or tested HIV positive?	<input type="checkbox"/> Yes <input type="checkbox"/> No

AGENT'S SECTION

(If you believe special consideration should be given to the proposed Insured child, please give details of all questions answered "yes".)



AGENT'S CERTIFICATION

I certify that:

- 1. I have personally seen the proposed Insured. Yes No
- 2. All responses given by the proposed Insured have been recorded accurately on this application and that any premium payment shown in item 7. under Agreements on page 5 has been collected by me and that a Conditional Receipt has been given to the Owner. Yes No

Is the proposed Insured related to you? If yes, relationship: _____ Yes No

Does the proposed Insured have any existing annuity contracts or life insurance policies? Yes No

Is the policy applied for in this application intended to replace any life insurance policy or annuity now in force? Yes No

I further certify that:

- The above answers are full, complete, and true to the best of my knowledge.
- I know of no factors affecting the insurability of the proposed Insured, except as stated.
- The signatures on page 6 are those they are represented to be and were signed in my presence. If 1. above is No, this statement will not apply.

Licensed Agent Signature

Code Number

General Agent Manager

Code Number

Signed at City

State

ADDITIONAL SPECIAL INFORMATION OR REQUESTS

AGREEMENTS

It is understood and agreed as follows:

1. The statements and answers recorded in all parts of this application are true and complete, to the best of my knowledge and belief.
2. No information regarding any proposed Insured will be considered known by the Company unless explicitly set out in writing on this application.
3. This application and the answers to any required medical exam will become a part of any policy issued on it.
4. No agent has the authority to waive any of the Company's rights or rules or to make or change any contract.
5. The insurance applied for will take effect only after the following occur while the proposed Insured(s) is(are) living and his/her(their) health is as stated in this application: (1) the policy is delivered to, and accepted by, the Owner; and (2) the first full premium is paid in cash. The only exception to this is provided in the Conditional Receipt if it has been issued and the advance payment required by the Conditional Receipt has been made.
6. I(We) have received the Notice of Information Practices which explains my(our) rights under the Fair Credit Reporting Act.
7. I(We) have paid \$ _____ * to the agent in exchange for the Conditional Receipt and I(we) acknowledge that I(we) fully understand and accept its terms.

By signing on page 6 of this application, you certify that you have completely read and fully understand the above statements. Before signing, read and review your answers for accuracy.

AUTOMATED TECHNOLOGY CONSENT

Old American Insurance Company and its service partners, including ExamOne World Wide, use technology that includes automated telephone dialing systems and prerecorded messages ("Automated Technology") to improve the application process. I understand that I am not required to provide consent to use this Automated Technology as a condition of completing the application process or purchasing insurance or other products from Old American Insurance Company. Unless specified below, I consent to the parties indicated above contacting me at any of the phone numbers I have provided, including cell phones, using Automated Technology.

I do not consent to the parties indicated above contacting me using Automated Technology.

TAXPAYER IDENTIFICATION NUMBER CERTIFICATION

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2. above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2. does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN.

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Primary Insured's Signature (if age 18 or over)

Owner's Signature (if other than Primary Insured)

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien;
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States;
- An estate (other than a foreign estate); or
- A domestic trust (as defined in Regulations section 301.7701-7).

AUTHORIZATION FOR THE RELEASE OF PERSONAL AND MEDICAL INFORMATION

To obtain a copy of or to revoke this authorization, contact:

New Business Department
Old American Insurance Company
P.O. Box 219844
Kansas City, MO 64121

This authorization applies to all persons whose signatures appear below. The proposed Primary Insured and all other proposed Insureds must sign.

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 me or on my behalf within the past 10 years ("My Providers"); MIB, Inc.; insurers; reinsurers; government agencies; consumer reporting agencies and/or employers to disclose my entire medical record, prescription history, medications prescribed and any other personal, financial, or protected health information concerning me to Old American Insurance Company or any person acting on behalf of Old American Insurance Company. I authorize Old American Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB. "Information" means facts regarding my physical or mental condition (including the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection; sexually transmitted diseases; mental illness; the use of alcohol, drugs, and tobacco; but excluding psychotherapy notes); employment; other insurance coverage; financial status; or any other relevant information about me or my minor children. Information obtained will be released only to reinsurers; MIB, Inc.; persons and entities performing business duties as delegated or contracted for by Old American Insurance Company related to my application and subsequent insurance-related functions as permitted or required by law or as I further authorize. Some of the health information obtained may be disclosed to persons or organizations that are not subject to federal health information privacy laws, resulting in the information no longer being protected under such laws.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct 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 me or on my behalf within the past 10 years ("My Providers"); MIB, Inc.; insurers; reinsurers; government agencies; consumer reporting agencies and/or employers to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this authorization so that Old American Insurance Company may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with Old American Insurance Company.

This authorization shall remain in force for 24 months following the date of my signature below and a copy of this authorization is as valid as the original. This time limit complies with the time limit, if any, permitted by applicable law in the state where the policy is delivered or issued for delivery. I understand that I have the right to revoke this authorization in writing at any time by providing written notification to the entity identified above, and I understand that a revocation is not effective to the extent that any of My Providers has already relied on this authorization to disclose information about me or to the extent that Old American Insurance Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. 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 recipient except as authorized by me or as required by law.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization or otherwise condition my enrollment or eligibility for health benefits on my signing this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, Old American Insurance 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 understand that any authorized representative or I will receive a copy of this authorization upon request.

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Dated at _____ this _____ day of _____, 20____
City/State Month Year

Signature of Owner (if other than Primary Insured)

Proposed Insured's Signature (if age 18 or over)

Additional Signature (if age 18 or over)

Additional Signature (if age 18 or over)



Bank Draft Authorization

Please select only one option. Include a copy of a voided check for bank draft.

Available draft days are the 1st through the 28th. Withdrawals will be made on or about the premium draft date shown.

The Conditional Receipt is required in all cases.

- Draft my account for the first premium. Please draft subsequent premiums on the _____ of each month.
- Delay my first draft until: _____. All subsequent drafts will occur on this same day each month.
- The initial premium is attached, please draft subsequent premiums on the _____ of each month.

Please make check or money order payable to Old American Insurance Company.

Account Information

Bank Name													
Address		City	State										
Must fill in all boxes and start with a 0, 1, 2, or 3.		<input type="checkbox"/> Checking	Zip										
Routing Number	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table>											Account Number	<input type="checkbox"/> Savings

Agreement for Automatic Premium Payments and Authorization to Honor Checks Drawn by the Company

It is agreed that:

- 1) This bank draft authorization does not change any policy provisions. The payor's authorization is not in lieu of payment in cash of the first premium and does not constitute advance payment required by the Conditional Receipt.
- 2) Upon 30 days written notice, this bank draft authorization may be stopped or changed at any time by: the owner of any policy under this bank draft authorization, the Company, or the payor.
- 3) No premium notices or receipts will be sent. Debit entries or checks, when paid, will constitute receipts for premiums.
- 4) The privilege of paying premiums under this bank draft authorization may be revoked by the Company if any check or debit entry is not paid upon presentation.
- 5) The Company's rights in respect to each check and/or debit entry will be the same as if I signed it personally.
- 6) If any debit or check entry is dishonored, the Company will be under no liability whatsoever, even if such dishonor results in forfeiture of insurance.
- 7) I authorize the Company to pay and charge to my(our) account, debit entries or checks drawn by and payable to the order of the Company, provided there are sufficient collected funds present to pay same upon presentation. This authorization will remain in effect until revoked by me in writing, a copy of which will be sent to the Company. Until the Company receives such notice, I agree that the Company will be fully protected in honoring any such debit.

Print Premium Payor's Name: _____

Signature of Premium Payor: _____

Date: _____

PLEASE TAPE A VOIDED CHECK IN THIS BOX.



Conditional Receipt

If the proposed Insured in this application dies before coverage under this Receipt terminates, we will pay the Receipt benefit described below to the beneficiary named in the application, subject to the Conditions.

Please read this Receipt carefully. No coverage is in force other than as stated in this Receipt. No agent may change the terms of this Receipt. No coverage will be effective under this Conditional Receipt if advance payment is not made by check or bank draft.

Conditions

If the amount received by check or bank draft with the application is at least one month's premium for the policy applied for, the coverage will be in effect as of the date of this Receipt, BUT ONLY IF the proposed Insured is hereafter determined by the Company, according to the underwriting standards of the Company then in effect, to be insurable for the policy exactly as applied for.

Fraud or material misrepresentations invalidate this Receipt and the Company's only liability is for refund of any payment made. All parts of the application must be completed and received by the Company.

Benefit

The benefit under this Receipt is an amount equal to the lesser of the Face Amount applied for on the proposed Insured in the application or \$50,000. The benefit provided by this Receipt is further limited as follows:

- (1) the maximum total coverage provided under all Conditional Receipts of the Company in effect on the proposed Insured is limited to \$50,000;
- (2) for death due to suicide, the Company's liability is limited to return of any amount paid with the application;
- (3) this Receipt is not effective as to any rider or supplemental benefits to the policy;
- (4) if payment is made by check or bank draft, coverage is effective only if the check or bank draft is honored on first presentation for payment;
- (5) in no event may this Receipt and the policy applied for provide coverage at the same time.

Date Coverage Terminates

The coverage provided by this Receipt will end on the earliest of:

- (1) the date coverage becomes effective under the policy applied for;
- (2) the date the Company mails notice of termination of coverage to the Owner;
- (3) 60 days from the date of this Receipt; or
- (4) the date the Owner withdraws the application for insurance.

If the application is declined or withdrawn, the Company will immediately refund any amount paid with this application.

All premium checks must be payable to Old American Insurance Company. Do not make check payable to the agent or leave the payee blank.

Name of Proposed Insured: _____

Payment Amount: _____

Dated at: _____ this _____ day of _____, 20_____.
City/ State Month Year

Agent's Signature: _____



To obtain further information contact:
New Business Department
Old American Insurance Company
P.O. Box 219844
Kansas City, MO 64121

NOTICE OF INFORMATION PRACTICES

Including Fair Credit Reporting Act Notice and MIB, Inc. Notice

Thank you for your application. It is the major source of information about you which we use in evaluating your application and issuing your contract. However, we wish to inform you that an investigative consumer report may be ordered as to your insurability. If an investigative consumer report is prepared in connection with this application, you may request to be interviewed in connection with the preparation of this report. This report may include, if applicable, 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) as may be obtained through interviews with family members, friends, neighbors and associates. We may also order a credit report.

If you would like to know whether such a report was ordered and, if so, receive additional information as to its nature and scope, including the name, address and phone number of the reporting agency, we will be pleased to furnish this information upon your written request to our Home Office at the address above. You may receive a copy of such report by contacting the reporting agency. Our experience shows that information from investigative reports usually does not have any adverse effect on our underwriting decision. However, if it should, we will notify you in writing of this fact as well as provide you the identity by name and address of the reporting agency. You may then wish to discuss the matter with that agency.

We are committed to protecting the privacy of our customer's nonpublic personal information. We will only disclose our customer's nonpublic personal information: among the affiliated companies of Old American Insurance Company; to provide services to our customers and administer our business; to market products; and as otherwise permitted by law. We may disclose our customer's nonpublic personal information to our agents and representatives to provide services to our customers and for marketing purposes. When we contract with other entities to provide support or marketing services, we will require them to adhere to our privacy standards.

Sometimes we acquire medical information about our customers, for instance, to underwrite an insurance contract or to process an insurance claim. We will keep our customer's medical information confidential. We will not share our customer's medical information even among the affiliated companies of Old American Insurance Company without the customer's consent. We will only use or disclose our customer's medical information to underwrite insurance, process claims, administer our business, to comply with laws and regulations or as otherwise authorized by our customers.

You have the right to obtain access to certain items of information we have collected about you, and you have the further right to request correction of information if you feel it is inaccurate.

If you wish to have a more detailed description of our information practices, we will be pleased to furnish this information upon your written request to our New Business Department, Old American Insurance Company, P.O. Box 219844, Kansas City, MO 64121.

MIB, Inc. Notice

Information regarding your insurability will be treated as confidential. Old American 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. 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.

Old American Insurance Company, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

This page remains with the applicant.



How the Accelerated Benefit Prepayment Option Works:

If in a physician's best medical judgment an Insured will die within one year, the policy owner may request prepayment of up to 50% of the policy face amount. This amount, less the same percentage of any outstanding policy loan amount, will then be paid to the policy owner.

For example, if an Insured requests a 50% benefit prepayment on a \$10,000 policy with an outstanding policy loan of \$1,000, the accelerated benefit would be \$4,500 (\$5,000 less \$500). This same percentage will apply to other policy values as noted below:

- After payment of the accelerated benefit, the policy premium payment will be reduced by the accelerated benefit payment percentage. (An \$800 annual premium* payment would be reduced to \$400.)
- If the policy has built up cash value, the cash value at the time of the benefit prepayment will also be reduced by the accelerated benefit payment percentage requested. (A \$1,000 cash value would be reduced to \$500.)
- If there is a policy loan outstanding, the loan amount is also reduced by the accelerated benefit payment percentage. (A \$1,000 outstanding policy loan would be reduced to \$500.)

EXAMPLE: Male, Age 60 Policy Status Before Benefit	
Original Face Amount.....	\$ 10,000.00
Policy Annual Premium*.....	\$ 804.80
Outstanding Policy Loan.....	\$ 1,000.00
Policy Cash Value.....	\$ 1,000.00
Terminal Benefit Requested (50% of Face Amount).....	\$ 5,000.00
Less 50% of Policy Loan Amount.....	500.00
Benefit Prepayment Made to Insured.....	\$ 4,500.00
Policy Status After Benefit Prepayment	
Face Amount of Policy.....	\$ 5,000.00
Policy Annual Premium*.....	\$ 402.40
Policy Cash Value.....	\$ 500.00
Outstanding Policy Loan.....	\$ 500.00

*Does not include \$42.00 policy fee.

ANY ACCELERATED BENEFITS PAID UNDER THIS POLICY MAY BE TAXABLE. IF SO, YOU OR YOUR BENEFICIARY MAY INCUR A TAX OBLIGATION. AS WITH ALL TAX MATTERS YOU SHOULD CONSULT YOUR PERSONAL TAX ADVISOR TO ASSESS THE IMPACT OF THIS BENEFIT.

OLD AMERICAN



INSURANCE COMPANY
3520 Broadway, Kansas City, MO 64111

Authorization for Release of Information to Insurance Agent or Agency

I authorize Old American Insurance Company, or its authorized third-party vendor, to disclose personal and medical information about me to the insurance agent and/or agency stated in my application for life insurance.

Information that Old American Insurance Company or its authorized third-party vendor may disclose includes medical information and other personal information as it relates to actions Old American Insurance Company may have taken based on this information, such as charging me a higher premium for my insurance, changing benefits to something other than I applied for, or declining my application for insurance.

The information will be used to help me with the insurance application process or to find other insurance coverage options.

I understand that if the person or entity that receives the above information is not covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

I understand that I may refuse to sign this authorization. If I refuse to sign, it will not affect the issuance of the insurance for which I am applying.

Unless revoked earlier, this authorization will remain in effect for 24 months from the date I sign it. I understand that I may revoke this authorization at any time, by written notice to: Old American Insurance Company, New Business Department, P.O. Box 219844, Kansas City, Missouri 64121-9844.

I realize that my right to revoke this authorization is limited to the extent that Old American Insurance Company, or its authorized third-party vendor, has taken action in reliance on the authorization.

I understand that I will receive a copy of the authorization.

Proposed Insured's signature: _____

Date: _____

ID:SF571

Company Copy

Instructions to Agent

Client Copy must be given to the proposed Insured.
Forward the Company Copy to the Home Office.

LEAVE WITH CLIENT

COMPLETE THE FOLLOWING FORMS AND
LEAVE THESE COPIES WITH THE OWNER.



Conditional Receipt

If the proposed Insured in this application dies before coverage under this Receipt terminates, we will pay the Receipt benefit described below to the beneficiary named in the application, subject to the Conditions.

Please read this Receipt carefully. No coverage is in force other than as stated in this Receipt. No agent may change the terms of this Receipt. No coverage will be effective under this Conditional Receipt if advance payment is not made by check or bank draft.

Conditions

If the amount received by check or bank draft with the application is at least one month's premium for the policy applied for, the coverage will be in effect as of the date of this Receipt, BUT ONLY IF the proposed Insured is hereafter determined by the Company, according to the underwriting standards of the Company then in effect, to be insurable for the policy exactly as applied for.

Fraud or material misrepresentations invalidate this Receipt and the Company's only liability is for refund of any payment made. All parts of the application must be completed and received by the Company.

Benefit

The benefit under this Receipt is an amount equal to the lesser of the Face Amount applied for on the proposed Insured in the application or \$50,000. The benefit provided by this Receipt is further limited as follows:

- (1) the maximum total coverage provided under all Conditional Receipts of the Company in effect on the proposed Insured is limited to \$50,000;
- (2) for death due to suicide, the Company's liability is limited to return of any amount paid with the application;
- (3) this Receipt is not effective as to any rider or supplemental benefits to the policy;
- (4) if payment is made by check or bank draft, coverage is effective only if the check or bank draft is honored on first presentation for payment;
- (5) in no event may this Receipt and the policy applied for provide coverage at the same time.

Date Coverage Terminates

The coverage provided by this Receipt will end on the earliest of:

- (1) the date coverage becomes effective under the policy applied for;
- (2) the date the Company mails notice of termination of coverage to the Owner;
- (3) 60 days from the date of this Receipt; or
- (4) the date the Owner withdraws the application for insurance.

If the application is declined or withdrawn, the Company will immediately refund any amount paid with this application.

All premium checks must be payable to Old American Insurance Company. Do not make check payable to the agent or leave the payee blank.

Name of Proposed Insured: _____

Payment Amount: _____

Dated at: _____ this _____ day of _____, 20____.

City/ State Month Year

Agent's Signature: _____



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OLD AMERICAN



INSURANCE COMPANY

3520 Broadway
Kansas City, MO 64111
816-753-4900
www.oaic.com

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