

**UNITED AMERICAN INSURANCE COMPANY**  
**A LEGAL RESERVE STOCK COMPANY \* Administrative Office: McKinney, Texas 75070**

Application for Accidental Death Policy

**Benefit Amount**  
**\$3,000**  
**(\$3,000 spouse, \$1,000 each child)**

**Annual Mode of Premium**

**Mode of Premium Payment**

- Send Premium Notices
- Automatic Payment Plan

Day (01-28) of the Month  
to Draft Bank Account

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**Proposed Insured/Applicant**

First Name	<input type="text"/>	M.I.	<input type="text"/>
Last Name	<input type="text"/>		
Address	<input type="text"/>		
City	<input type="text"/>	State	<input type="text"/>
		Zip Code	<input type="text"/>
Age Last Birthday	<input type="text"/>	Date of Birth (mm-dd-yyyy)	<input type="text"/> - <input type="text"/> - <input type="text"/>
		Sex	<input type="radio"/> Male <input type="radio"/> Female
Home Phone No.	<input type="text"/> - <input type="text"/> - <input type="text"/>	Work Phone No.	<input type="text"/> - <input type="text"/> - <input type="text"/>
SS #	<input type="text"/> - <input type="text"/> - <input type="text"/>	E-mail Address of Proposed Insured/Applicant	<input type="text"/>

Beneficiary Name	Relationship
<input type="text"/>	<input type="text"/>

<b>Spouse</b>	First Name <input type="text"/>	M.I.	<input type="text"/>
	Last Name <input type="text"/>		
	SS # <input type="text"/> - <input type="text"/> - <input type="text"/>	Date of Birth (mm-dd-yyyy)	<input type="text"/> - <input type="text"/> - <input type="text"/>

<b>Child 1</b>	First Name <input type="text"/>	M.I.	<input type="text"/>
	Last Name <input type="text"/>		
	SS # <input type="text"/> - <input type="text"/> - <input type="text"/>	Date of Birth (mm-dd-yyyy)	<input type="text"/> - <input type="text"/> - <input type="text"/>

<b>Child 2</b>	First Name <input type="text"/>	M.I.	<input type="text"/>
	Last Name <input type="text"/>		
	SS # <input type="text"/> - <input type="text"/> - <input type="text"/>	Date of Birth (mm-dd-yyyy)	<input type="text"/> - <input type="text"/> - <input type="text"/>

<b>Child 3</b>	First Name <input type="text"/>	M.I.	<input type="text"/>
	Last Name <input type="text"/>		
	SS # <input type="text"/> - <input type="text"/> - <input type="text"/>	Date of Birth (mm-dd-yyyy)	<input type="text"/> - <input type="text"/> - <input type="text"/>



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<b>Child 4</b>	First Name <input type="text"/>	M.I. <input type="text"/>	
	Last Name <input type="text"/>		
	SS # <input type="text"/> - <input type="text"/> - <input type="text"/>	Date of Birth (mm-dd-yyyy) <input type="text"/> - <input type="text"/> - <input type="text"/>	
<b>Child 5</b>	First Name <input type="text"/>	M.I. <input type="text"/>	
	Last Name <input type="text"/>		
	SS # <input type="text"/> - <input type="text"/> - <input type="text"/>	Date of Birth (mm-dd-yyyy) <input type="text"/> - <input type="text"/> - <input type="text"/>	
<b>Child 6</b>	First Name <input type="text"/>	M.I. <input type="text"/>	
	Last Name <input type="text"/>		
	SS # <input type="text"/> - <input type="text"/> - <input type="text"/>	Date of Birth (mm-dd-yyyy) <input type="text"/> - <input type="text"/> - <input type="text"/>	

**Is the insurance applied for intended to replace or change any coverage now in force with this or any other company? If "Yes," comply with the application Replacement Regulation or Rule.**     Yes     No    **This policy is not to be used to replace other coverage.**

DECLARATION AND AUTHORIZATION

I hereby declare that the statements recorded above are true and complete to the best of my knowledge and belief with respect to any proposed insured. I agree that: (1) no policy will be binding upon the Company unless upon its date of issue and delivery each proposed insured is alive; (2) no agent has authority to accept risks or make or change contracts or waive the Company's rights or requirements. I understand and agree that the Company reserves the right during the first year the policy is in force, to restrict beneficiaries to designations acceptable to the Company. Except with respect to a minor child of mine, this application is made with the knowledge and consent of the proposed insured.

I, HEREBY AUTHORIZE the MIB, Inc., any insurance company, hospital, physician or other practitioner having any information available as to my diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment, to disclose such information to United American Insurance Company for the purpose of determining my eligibility for insurance and eligibility for benefits under this policy. I understand that I or an authorized representative may request a copy of this authorization. Information for consumers MIB, Inc. may be obtained on its website at [www.mib.com](http://www.mib.com).

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

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

State

\_\_\_\_\_  
**Agent's Signature**

\_\_\_\_\_  
**Proposed Insured**

Last Name     Agent No.

\_\_\_\_\_  
**Applicant (If other than the Proposed Insured)**

**Print First 5 Letters of Agent's Last Name**

SEND POLICY TO:     Agent     Insured    The Policy will be sent to insured unless otherwise instructed.

