AMERICO

AdvantageWL®

Application Packet

This packet contains the basic forms needed to write Americo AdvantageWL. For additional information, contact Sales Support at 800.231.0801 or log on to www.americo.com.

Forms included in this packet:

- **Application for Life Insurance (series 5098)**
- **Disclosure Statement for Accelerated Benefit Payment Rider (series 8386) –** *Disclosure must be dated the same day as the application.*
- **Bank Draft Authorization Form (AF55019)**

Additional forms that may be required:

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

- **Health Questionnaires** – *May be required due to underwriting. 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. Contact Sales Support for additional information. State variations apply.*
- **HIV Consent Forms (series 8285)** – *May be required in applicable states due to underwriting. State variations apply.*
- **Authorization to Transfer Funds** – *Required for full or partial surrender of an annuity or other financial account(s) if the client plans to have funds transferred directly from their financial institution to Americo.*

AMERICO®

For Use in Indiana
11-195-1-IN (03/17)

Application/Document

Transmittal Form

AFSFAX2002 (01/16)

Your application(s)/document(s) can be submitted through the following methods:

- Toll Free Fax Numbers:
  800.395.9261, 800.395.9238, or 877.388.3448
- E-mail: submit@americo.com
- Web Upload: www.americo.com

If this form is completed and used as your cover sheet for a new policy application, you will receive a confirmation message with the policy number by fax or e-mail. Confirmation will be delivered the same day if the application is received by 5 p.m. CST/CDT or the next business day if received after 5 p.m. CST/CDT. If you have any questions or need assistance with the submission process, please feel free to call the Agent Contact Center at 800.231.0801.

When submitting applications via web upload or e-mail, please note that the maximum file size we can accept is 25MB. In addition, we accept the following file types: PDF, TIFF, or JPEG.

PLEASE PRINT LEGIBLY

Agent / Agency Name:	Agent / Agency Phone Number:	Total No. of Pages Sent:
Fax Number and/or Email Address to Send Confirmation to:	Agent Code:	

Policy Number (if Applicable)	Applicant / Insured Name	Notes

Application for

Individual Life Insurance

AIN5098 (06/11)

AMERICO

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

f. Primary Phone: ☐Home ☐Cell ☐Work	g. Alternate Phone: ☐Home ☐Cell ☐Work	h. Email Address

i. Social Security # or Taxpayer ID #	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. Employer and employer address *(Include City, State, and ZIP)*

q. Provide description of job duties:

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

a. ☐ AdvantageWL

☐ Other _____

b. Face Amount

$_____

c. Was premium collected with the application?

☐ Yes ☐ No

*If **Yes**, indicate amount collected:* $ _____

d. Planned Premium *(Subject to change upon underwriting review.)*

$_____

e. Effective Date *(If not checked, Effective Date will be Issue date. Cannot be the 29th, 30th, or 31st of the month.)*

☐ Issue Date

☐ Save Age of _____

☐ Specific Date _____

f. Death Benefit Option *(Select for UL Products only; will be Option A, if not checked.)*

☐ A- Level

☐ B- Increasing

☐ N/A

g. Initial Allocation Percentage *(LifeCrest Index only)*

Index Option _____%

Declared Interest Option _____%

Total must equal 100%

☐ N/A

h. Automatic Premium Loan *(AdvantageWL only)*

☐ Yes

☐ No

☐ N/A

i. Premium Mode *(Subject to availability)*

(Note: Additional charges may apply for modes other than Annual.)

Mode: ☐ Annual ☐ List Bill No. _____

☐ Semi-Annual ☐ FEDD

☐ Quarterly ☐ Military Allotment

☐ Monthly Bank Draft *(Drawn on a U.S. bank)*

☐ Other *(Provide source of funds)* _____

j. Premium Class applied for *(Standard if not checked; subject to availability)*

☐ Standard Non-nicotine

☐ Standard Nicotine

3. RIDERS *(Verify rider availability to avoid amendments.)*

☐ Accidental Death Benefit $_____ ☐ Waiver of Premium *(Not available on UL)* ☐ Other_____

☐ Children's Term* $ _____ ☐ Other _____

*Complete Additional Proposed Insured(s) section of this application.

4. 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 # or Taxpayer ID #	Date of Birth	Relationship	% of Share *(Must total 100%)*
☐Primary					
☐Primary ☐Contingent					
☐Primary ☐Contingent					

5. ADDITIONAL PROPOSED INSURED(S) *(To include Spouse and Children's Term rider.*

Name of Additional Proposed Insured *(Last, First, MI)*	Date of Birth *(MM/DD/YYYY)*	Place of Birth (City, State, Country)	Sex	Height	Weight *(lbs.)*	Social Security # or Taxpayer ID #	Relationship to Proposed Insured
			☐M ☐F	' "			
			☐M ☐F	' "			
			☐M ☐F	' "			
			☐M ☐F	' "			
			☐M ☐F	' "			
			☐M ☐F	' "			

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.*)..... ☐ ☐

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

c. Will the life insurance applied for replace, or otherwise reduce in value, any existing life insurance or annuity now in force? ..... ☐ ☐
*(If **Yes,** complete the 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 a1035 exchange, indicate value to be transferred *(include Absolute Assignment form)*. .....$ _____ ☐N/A

f. If current life insurance or annuity is being replaced, indicate the amount of surrender charges that will be assessed. .....$ _____ ☐N/A

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

a. Owner's Name *(Last, First, MI)*	b. Relationship to Proposed Insured	c. Social Security # 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. Primary Phone: ☐Home ☐Cell ☐Work	g. Alternate Phone: ☐Home ☐Cell ☐Work	
h. Email Address	i. Date of Birth *(MM/DD/YYYY)*	j. 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. Social Security # 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. Primary Phone: ☐Home ☐Cell ☐Work	g. Alternate Phone: ☐Home ☐Cell ☐Work	
h. Email Address	i. Date of Birth *(MM/DD/YYYY)*	j. Place of Birth *(City, State, Country)*

9. FINANCIAL AND PURPOSE STATEMENT *(To be completed if amount applied for and in force with the Company is over $500,000.)*

a. Personal Finances | b. Business Finances

Total Assets	Total Liabilities	Net Worth	Income from Occupation	Income from Other Sources	Annual Sales	Total Liabilities	Net Income
$	$	$	$	$	$	$	$

c. What is the purpose of this insurance?

☐ Family Protection ☐ Key Man

☐ Buy/Sell *If checked, are partners applying for a like amount of coverage in force?* ..... ☐Yes ☐No

☐ Debt Protection *If checked, state loan amount and terms of agreement.* _____

☐ Other _____

d. Have you or your company ever filed for bankruptcy? ..... ☐Yes ☐No
(If Yes, provide full details in "Additional Comments/Special Requests" section and include discharge date, if applicable.)

10. ADDITIONAL COMMENTS/SPECIAL REQUESTS

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

	Proposed Insured		Additional Proposed Insured(s)	
	Yes	No	Yes	No
a. Within the past two (2) years, has any Proposed Insured:				
1. made any flights as a pilot, student pilot, or member of a flight crew? ***(If Yes, complete Aviation questionnaire.)***	☐	☐	☐	☐
2. engaged in the following hazardous sports: bungee or base jumping, parachuting, hang gliding; competitive skiing/snowboarding (such as heli-skiing or ski jumping); diving activities (such as scuba, cave diving, or underwater photography); canyoning, kayaking, or white water rafting; organized racing (such as automobiles, drag racers, or motorcycles); rock or mountain climbing, rodeo riding, or any other hazardous sport/activity? ***(If Yes, complete Sports Activities questionnaire.)***	☐	☐	☐	☐
b. Has any Proposed Insured:				
1. been convicted of reckless driving or driving under the influence of alcohol or drugs in the past five (5) years?	☐	☐	☐	☐
2. had a driver's license suspended or revoked within the past five (5) years or is currently under license suspension or revocation?..	☐	☐	☐	☐
3. been convicted of or plead guilty to more than two (2) moving violations in the past five (5) years?	☐	☐	☐	☐
4. been convicted of or plead guilty to more than three (3) moving violations in the past three (3) years?	☐	☐	☐	☐

c. 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

d. Within the past seven (7) years, has any Proposed Insured been convicted of, plead guilty to, or entered a plea of no contest to any felony?	☐	☐	☐	☐
e. Is any Proposed Insured currently on probation or been placed on probation within the last twelve (12) months?	☐	☐	☐	☐
f. Has any Proposed Insured ever been declined, postponed, rated, or modified for insurance?	☐	☐	☐	☐
g. Within the next two (2) years, does any Proposed Insured intend to work, travel, or reside outside of the United States for more than thirty (30) days? ***(If Yes, where? Provide details below.)***	☐	☐	☐	☐

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

PERSONAL HISTORY DETAILS

Question #	Proposed Insured's Name	Dates	Details

12. MEDICAL HISTORY

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

	Proposed Insured Yes	Proposed Insured No	Additional Proposed Insured(s) Yes	Additional Proposed Insured(s) No
c. Has any Proposed Insured used cigarettes, cigars, pipes, chewing tobacco, nicotine patches, snuff, nicotine chewing gum, or other products containing nicotine:				
1. within the last twelve (12) months?	☐	☐	☐	☐
2. within the last twelve (12) to thirty-five (35) months?	☐	☐	☐	☐
3. within the last thirty-six (36) months or more?	☐	☐	☐	☐
d. Within the past seven (7) years, has any Proposed Insured:				
1. been treated for or been advised or diagnosed by a medical professional to seek treatment for the use of alcohol or prescription drugs?	☐	☐	☐	☐
2. been advised to reduce or discontinue the intake of alcohol or prescription drugs? ***(If Yes to d.1. or d.2. above, complete the Alcohol Usage and/or Prescription Medication and Drug Use questionnaire.)***	☐	☐	☐	☐
3. 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, and/or 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.)***	☐	☐	☐	☐
4. been diagnosed with, been advised to have, or had treatment for: hypertension; heart disease/disorder; valve disorders; angina; cardiac arrhythmia; heart surgery, including bypass, angioplasty or stent placement; blood vessel or blood disorders; stroke; Transient Ischemic Attach (TIA); or circulatory disorder?	☐	☐	☐	☐
5. been diagnosed with, been advised to have, or had treatment for: chronic obstructive pulmonary disease (COPD); emphysema; lung or respiratory disorder; sleep apnea; current use of oxygen; or shortness of breath?	☐	☐	☐	☐
6. been diagnosed with, been advised to have, or had treatment for: cancer, in any form; pancreatic disorders; or diabetes?	☐	☐	☐	☐
7. been diagnosed with, been advised to have, or had treatment for: digestive disorder; gastrointestinal bleeding; bladder disorders; unexplained weight loss; kidney or liver disease, including hepatitis; Crohn's disease; or ulcerative colitis?	☐	☐	☐	☐
8. been diagnosed with, been advised to have, or had treatment for: Alzheimer's disease; dementia; memory loss; emotional or psychiatric disorder; nervous system disorder; or taken any prescription medication for Alzheimer's disease, dementia, or memory loss?	☐	☐	☐	☐
9. been diagnosed with, been advised to have, or had treatment for: paralysis; sexually transmitted diseases; lupus; birth defects; rheumatoid arthritis; or any disease or disorder of the bones or muscles?	☐	☐	☐	☐
10. been diagnosed with, been advised to have, or had treatment for any disease or disorder not mentioned above?	☐	☐	☐	☐
11. consulted any healthcare provider(s) not already identified, for any reason?	☐	☐	☐	☐
e. Within the past five (5) years, has any Proposed Insured consulted a physician to have tests performed, such as electrocardiogram (EKG), echocardiogram, X-ray, and/or blood tests; been hospitalized for any reason; or had tests, surgery, treatment or hospitalization recommended, but not completed?	☐	☐	☐	☐
f. Has any Proposed Insured ever been diagnosed as having, been told by a medical professional that they have, or been treated by a medical professional for Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or any immune deficiency-related disorder or tested positive for antibodies to the Human Immunodeficiency Virus (HIV)?	☐	☐	☐	☐
g. Does any Proposed Insured:				
1. currently use prescription medicines? ***(If Yes, list each medication and advise reason taking below.)***	☐	☐	☐	☐
2. currently have a personal physician? ***(If Yes, list name, address, and telephone number and provide date, reason and results of last consultation below.)***	☐	☐	☐	☐
h. Is any Proposed Insured currently disabled? ***(If Yes, provide reason for disability and details below.)***	☐	☐	☐	☐

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

MEDICAL HISTORY DETAILS

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 presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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 and/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 AND TO MEDICAL HISTORY QUESTIONS OF THIS APPLICATION, SIGNED AND DATED BELOW, ARE COMPLETE AND ACCURATE.**

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

X _____
Signature of Proposed Insured *(required)*

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

X _____
Signature of Additional Proposed Insured

X _____
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 annuity coverage on the life of any Proposed Insured?	☐	☐
8. Will the life insurance applied for replace, or otherwise reduce in value, any existing life insurance or annuity now in force? *(If **Yes,** complete the 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	% Split
	X		
	X		
	X		

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.

For use with Americo *Advantage*WL.

Disclosure Statement for
Accelerated Benefit Payment Rider

Rider Series 2146

AIN8386

GENERAL DESCRIPTION OF THE ACCELERATED BENEFIT

The Accelerated Benefit Payment Rider allows the Owner of the Policy to which the Rider is attached to receive an accelerated benefit following a Qualifying Event. A Qualifying Event is defined as a non-correctable medical condition of the Insured that, with reasonable medical certainty, will result in the death of the Insured in 12 months or less. The Company must receive a physician's written statement certifying the medical condition and the Insured's life expectancy.

The Owner may make only one request for an accelerated benefit payment. The Owner may request an accelerated payment of up to 50% of the death benefit amount after deducting all outstanding Policy loans. The minimum accelerated benefit the Company will pay is $5,000 and the maximum benefit is $250,000. The accelerated benefit will be paid only as a lump sum.

Request for an accelerated benefit payment must be in writing and the Company must receive the request while the Policy is in force (other than as extended term or paid-up insurance, if available). The Company must receive written approval by any irrevocable beneficiary under the Policy and a full release of any assignment of the Policy as collateral.

TAX CONSEQUENCES OF RECEIVING AN ACCELERATED BENEFIT PAYMENT

Depending on a number of factors, an accelerated benefit payment may be considered taxable income. The Owner should seek assistance from a qualified tax advisor before requesting an accelerated benefit.

COSTS OF THE ACCELERATED BENEFIT PAYMENT

There is no premium for the Rider. However, the Company will add an administrative fee not exceeding $250 to the accelerated benefit amount at the time of payment. The Company will charge interest on the accelerated benefit payment. Interest will accrue at the policy loan interest rate stated in the Policy on the portion of the benefit amount equal to the cash value. For the portion of the benefit amount that exceeds this amount, interest will accrue at a rate no more than the greater of: (a) the current yield on a 90-day treasury bill; or (b) the current maximum adjustable policy loan interest rated allowed by law.

EFFECT OF ACCELERATED BENEFIT PAYMENT

The accelerated benefit payment, the administrative fee and any accrued interest will be a lien against the Policy. The total amount of the lien and all Policy loans outstanding will reduce the amount otherwise available under the Policy's death benefit. As long as the lien is outstanding, access to the Policy's cash value, whether by surrender, partial withdrawal or policy loan, is limited to any excess of the cash value over the sum of any outstanding Policy loans and a pro rata portion of the cash value. At any point in time, such pro rata portion of the cash value shall be the cash value at that point times the ratio of the lien at that point divided by death benefit at that time.

The Rider provides that the Company will waive all premiums under the Policy and riders, if any, for up to 12 months immediately following the payment of an accelerated benefit. If the Insured is living following the twelfth month, the waiver provided by the Rider will no longer apply and premiums will be due.

Except as stated in the waiver provision of the Rider, Policy and rider premiums will remain payable and will not be reduced or eliminated as a result of an accelerated benefit payment. Any accidental death benefit provision of the Policy or any other rider attached to it will not be affected by the payment of an accelerated benefit payment.

ACKNOWLEDGMENT

I, the undersigned Insured (and Policy Owner, if other than the Insured), acknowledge that I have read and received this Disclosure Statement for Accelerated Benefit Payment Rider at the time of application for the Rider.

Proposed Insured's Signature	Date*	Owner's Signature (if other than Proposed Insured)	Date*	Agent or Broker's Signature	Date*

***Important Note:** signed date must be the same as the signed date on the application.

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 _____, _____.

X _____ **X** _____

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 _____, _____ .

X _____ **X** _____

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.

Important
Consumer Notices

AMERICO

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. You have the right to receive, in writing, the specific reason for an adverse underwriting decision. 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, MA 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. 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 (08/15)

Important
Consumer Notices

AMERICO

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. You have the right to receive, in writing, the specific reason for an adverse underwriting decision. 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, MA 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. 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 (08/15)

Bank Draft
Authorization Form
AF55019 (12/13)

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 authorization will remain in effect until revoked by me or the Company. Notifications should be sent to PO BOX 410288, Kansas City, MO 64141-0288, Attention Customer Service. Our toll-free number is 1-800-231-0801.** 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 business days from the returned draft date.**

I understand that Americo requires a 5 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 EXISTING POLICIES: Unless otherwise requested, premium draft date will be the existing premium due date.

DRAFT DATE: ***(If no option is selected, Draft Date will default to the first option listed below)***

☐ Upon issue and on the policy's regular due date thereafter

☐ Specific start date: _____ / _____ *(must be within 10 days of the Due Date and cannot be on the 29th, 30th, or 31st of the month. It may take up to 4 business days from the day we initiate the draft for your bank to process this transaction.)*
Month Day

ACCOUNT TYPE: ***(If no option is selected, Account Type will default to the checking account option)***

☐ 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

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**