APPLICATION FOR LIFE INSURANCE

American Mutual Life Association
(A Fraternal Benefit Society)
19424 S. Waterloo Road, Cleveland, OH 44119
216-531-1900

Note: If Proposed Insured is not a member of American Mutual Life Association, complete Application for Membership

Home Office Use Only

App. Status: _____	Lodge # _____
Plan Code: _____	Contract # _____
Premium: $_____	Issue Date: _____
Mode: _____	Issue Age: _____
☐ Male ☐ Female	☐ Smoker ☐ Non-Smoker

Plan	Code	Ins. Amt.	Prem/$1000	Tot. Prem
W.L.				
20 PL				
3 PL				
SPWL				
Term				
Rider(s)				
Totals				
Paid With Application:				
Div Opt ☐ Pur Pd-up Add ☐ Pay in Cash ☐ Acc at Int. ☐ Red Prem				

A. Proposed Insured

1. Full Name (print): _____
2. _____
   (Address) (City) (State) (Zip)
3. Birth date (MM/DD/YY):_____Phone #: _____
   Birthplace:_____ Email:_____
4. Sex: M ☐ F ☐. Height: ____ft ____in. Weight: _____
5. Social Security #: _____ Occupation:_____
6. a. Name of employer: _____
   b. Employer's address and phone #: _____ c. Length of employment: Years: _____ Months: _____
   d. Describe duties:_____
7. If Proposed Insured is not the Applicant, describe relationship of Applicant to Proposed Insured: _____
8. Name, address and Social Security # of Owner of insurance applied for, if not Proposed Insured: _____
   _____
9. Face Amount of Insurance applied for: _____ Plan of Insurance: _____
   Rider(s):_____ Premium:_____

Method of Payment: ☐ Single Premium ☐ Annual ☐ Semi-Annual ☐ Quarterly
Dividend Option: ☐ Purchase paid up adds ☐ Pay in cash ☐ Accum. at interest ☐ Reduce premiums

B. Beneficiary

	Name and address of Beneficiary:	Social Security #	Relationship:	Share %:
Primary:				
Contingent:				

C. Medical Information

1. During the past seven years has the Proposed Insured been examined or prescribed medication by a physician or medical practitioner? ☐ Yes ☐ No
2. Has the Proposed Insured **ever** been treated for, or been diagnosed by a physician as having:
   a. Cancer, diabetes or high blood pressure? ☐ Yes ☐ No
   b. Disease or disorder of the heart or blood? ☐ Yes ☐ No
   c. Nervous or mental condition, or any abnormality of the brain or nervous system? ☐ Yes ☐ No
   d. Any disease or abnormality of the lungs or respiratory system? ☐ Yes ☐ No
   e. Disease or abnormality of the kidneys, liver, prostate or genitourinary system? ☐ Yes ☐ No
   f. Disease or abnormality of the gastrointestinal system? ☐ Yes ☐ No
   g. Disorder of the muscles, bones or joints? ☐ Yes ☐ No
3. Has the Proposed Insured ever been advised to seek treatment or counseling, been treated for or received counseling, or joined a support group for the use of alcohol? ☐ Yes ☐ No
4. During the last 5 years has the Proposed Insured been hospitalized or had surgery of any kind? ☐ Yes ☐ No
5. Has the Proposed Insured:
   a. Used barbiturates, heroin, cocaine, marijuana or any illegal, restricted or controlled substance except as prescribed by a physician? ☐ Yes ☐ No
   b. Been advised to seek or received treatment for drug use, or been arrested for drug use or distribution? ☐ Yes ☐ No
6. Has the Proposed Insured used any nicotine products (cigarettes, cigars, chewing tobacco, pipe, nicotine gum patch or other)
   a. In the past 12 months? ☐ Yes ☐ No
   b. In the past 36 months? ☐ Yes ☐ No
7. If female, is Proposed Insured pregnant? ☐ Yes ☐ No
8. Is any medication currently prescribed for the Proposed Insured? ☐ Yes ☐ No

Give Details for all YES answers to Questions 1 through 8 above.

Question #	Dates	Medical Condition	Name & Address of Doctor(s)

D. **Family History**

Family Record	Living		Dead	
	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers/ Sisters				

Have any of your parents, brothers, or sisters ever had heart disease, diabetes or mental illness? ☐ Yes ☐ No If YES explain:

E. General Information

1. Foreign Travel, Aviation, and Military

a Does the Proposed Insured intend to travel outside the U.S. or Canada within the next two years? ☐ Yes ☐ No

b Except as a passenger on a regularly scheduled flight, does the Proposed Insured intend to fly or has he/she flown within the past two years? ☐ Yes ☐ No

c Is the Proposed Insured a member, or does he/she intend to become a member of the Armed Forces (including Reserves and National Guard)? ☐ Yes ☐ No

2. Avocation and Sports

In the past three years, has the Proposed Insured participated in any form of racing, skin or scuba diving, parachuting, hang gliding, rock climbing or any similar sport or avocation? ☐ Yes ☐ No

3. Driving Information

a Proposed Insured's driver's license #:_____ State:_____

b. Has the Proposed Insured been charged with any moving violation or accident, had driving license suspended or been convicted of driving under the influence of drugs or alcohol within the last five years? ☐ Yes ☐ No

4. Has any company declined to issue, renew or reinstate, rated, modified or postponed or cancelled any life or health insurance on the life of the Proposed Insured? ☐ Yes ☐ No

If YES, explain: When?_____ What Company? _____

5. a. Does the Proposed Insured currently have life insurance on his/her life? ☐ Yes ☐ No. If YES, in what amount:_____

b. If YES, is discontinuing premium payments, surrendering, forfeiting, assigning to the insurer or otherwise terminating the existing policy or contract being considered? ☐ Yes ☐ No.

c. Is using funds from the existing policy or contract to pay premiums due on the insurance applied for herein being considered? ☐ Yes ☐ No.

I AGREE THAT NO INSURANCE SHALL TAKE EFFECT UNLESS AND UNTIL: (1) the first premium shall have been paid; (2) a contract is delivered to the Applicant during the Proposed Insured's lifetime; (3) the health of the Proposed Insured is as described in the Application; and (4) all requirements of the Constitution and Bylaws of the American Mutual Life Association have been complied with.

Signed at: _____ this: _____ day of: _____ 20____.

Based upon the information provided, it is my understanding that the insurance applied for herewith will not change or replace any existing insurance or annuities.

_____
Applicant

_____
Proposed Insured's Signature Required if not Applicant
(Parent or Guardian if Proposed Insured is under age 16)

_____
Signature of Agent/Home Office Representative

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

NOTICE TO PROPOSED INSURED

I understand that information regarding my insurability will be treated as confidential. The American Mutual Life Association may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies which operates as an information exchange in behalf of its members. Should I apply to another Bureau member company for life or health insurance coverage, or if a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information it may have in its files.

Upon receipt of a request from me, the Bureau will arrange disclosure of any information it may have in my file. (Medical information will be disclosed only to my attending physician.) Should I have a question regarding the accuracy of information in the Bureau's file, I may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3360.

The American Mutual Life Association may also release information in its file to the other life insurance companies to whom I may apply for life or health insurance, or to whom a claim for benefits may be submitted.

I further understand that in connection with this application for insurance an investigative consumer report may be made as to my insurability, whereby information may be obtained through interviews with neighbors, friends and associates, and which may include, if applicable, information to character, general reputation, personal characteristics and mode of living. Additional detailed information as to the nature and scope of any investigation will be furnished upon written request.

AUTHORIZATION

I hereby authorize any licensed physician; medical practitioner; hospital; clinic other medical or medically related facility; insurance company; MIB, Inc ("MIB"); state Bureau of Motor Vehicles; or other organization; institution or person that has any record or knowledge of me or my health; to give to American Mutual Life Association or its representatives; or bearer; or its reinsurers; any such information. Authorization is valid for no longer than thirty months. A photocopy of this authorization shall be as valid as the original.

Date _____ 20_____.

_____
Proposed Insured's Signature (Parent or Guardian if Proposed Insured is under age 16)

For Home Office Use

☐ Approved Remarks: _____

☐ Disapproved _____

Dated:_____ Signed _____