APPLICATION FOR LIFE INSURANCE

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

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 per $1000	Total Premium
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

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. Is Proposed Insured a member of the American Mutual Life Association? Yes ☐ No ☐. If no, apply for membership.
7. If Proposed Insured is not the Applicant, describe relationship of Applicant to Proposed Insured: ________________________________

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

9a. Does the Proposed Insured currently have life insurance on his/her life? ☐ Yes ☐ No.
9b. If yes, is discontinuing premium payments, surrendering, forfeiting, assigning to the insurer or otherwise terminating the existing policy or contract being considered? ☐ Yes ☐ No. Is using funds from the existing policy or contract to pay premiums due on the insurance applied for herein being considered? ☐ Yes ☐ No.
10. Within the past 5 years, has Proposed Insured used tobacco in any form? Yes ☐ No ☐.
11a. Within the past 5 years, has Proposed Insured been hospitalized; or received medical treatment or been diagnosed with any illness, disease, injury or physical condition? Yes ☐ No ☐.
11b. Does Proposed Insured have any physical or mental handicaps? Yes ☐ No ☐.
11c. Give details of YES answers to 10, 11a, and 11b (Tobacco use; Illness or handicap; dates, duration; physicians; and/or hospital):
____
____

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 (list city or town): ___________________________________ this: ________ day of: ________________ 20____.

____
Signature of Agent/Home Office Representative

____
Applicant

Identity verified by: ☐ Driver's License # _______________ or
☐ Other ________________________

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

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.

AUTHORIZATION

I hereby authorize any licensed physician; medical practitioner; hospital; clinic other medical or medically related facility; insurance company; MIB, Inc ("MIB"); 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 ____