AMERICAN MUTUAL LIFE ASSOCIATION

19424 South Waterloo Road Cleveland, Ohio 44119
216.531.1900 Fax: 216.531.8123

(Also designated as "Association")
A Fraternal Benefit Society Incorporated, Organized and Doing Business Under the Laws of the State of Ohio.

Addendum to Life Insurance Application
Form LF-08

A. The following questions are added as an addendum to the application form noted above and are part of the application:

1. Does any person named as Beneficiary or Contingent Beneficiary lack an insurable interest* in the person to be insured?

   Yes ___ No ___ If yes, please explain ____________________________________

2. Is any portion of the premium on the policy applied for, to be paid in whole or in part through an assumption; and/or forgiveness of a loan used to fund premiums?

   Yes ___ No ___ If yes, please explain ____________________________________

**Insurable interest - A connection by blood of the beneficiary to the insured or an economic connection under which the beneficiary stands to suffer financial loss by reason the death of the insured.*

B. AMERICAN MUTUAL LIFE ASSOCIATION IS LICENSED TO DO BUSINESS IN THE STATE OF OHIO. AS A TAX-EXEMPT ORGANIZATION, FRATERNAL BENEFIT SOCIETIES ARE NOT INCLUDED IN THE OHIO GUARANTY ASSOCIATION. THIS MEANS THAT FRATERNAL BENEFIT SOCIETIES CANNOT BE ASSESSED FOR THE INSOLVENCY OF OTHER LIFE INSURERS OR OTHER FRATERNAL BENEFIT SOCIETIES. BY LAW, A FRATERNAL BENEFIT SOCIETY IS RESPONSIBLE FOR ITS OWN SOLVENCY. IF THERE IS AN IMPAIRMENT OF RESERVES, A CERTIFICATE HOLDER MAY BE ASSESSED A PROPORTIONAL SHARE OF THE IMPAIRMENT. THIS PROCESS IS DESCRIBED IN THE CERTIFICATE ISSUED BY THE SOCIETY.

C. Those portions of the “Notice to Proposed Insured” and/or the authorization on application, Form LF-08 which make reference to “Medical Information Bureau or MIB” are deleted in their entirety and replaced with the following wording which will amend part of the application Form LF-08 through inclusion as part of amendment STOLI-2-16.

Notice to Proposed Insured:
I understand that information regarding insurability will be treated as confidential. The American Mutual Life Association or its reinsurer(s), may, however make a brief report of my personal health information to MIB, Inc., a not for profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. Should I 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 it my have about you in its files. The American Mutual Life Association or its reinsurer(s) may also release information in 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.

Upon receipt of a request from you, MIB will arrange disclosure to you of any information in your file. If you question the accuracy of the information in the 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. The telephone number is (866) 692-6901. Information for consumers about MIB, Inc. may be obtained on its website www.mib.com.

D. I hereby authorize any licensed physician, medical practitioner, hospital, clinic or medical or medically related facility, insurance company, or other organization, institution or person, that has any records or knowledge of me or my health, to give the American Mutual Life Association, or its representatives, including Equifax or bearer, or reinsurer, any such information. I authorize MIB, Inc. to give to AMLA or its reinsurer any records of me or my health. American Mutual Life Association may disclose such information to its reinsurer(s) and to MIB, Inc. The applicant or duly authorized representative of the applicant is entitled to a copy of this authorization.

Duration and revocation: This authorization is valid for 24-30 months after the date shown below, but I understand that I may revoke it at any time by giving written notice to AMLA at the above address. I understand that there are limitations on my right to revoke this authorization. Any action taken in reliance on this authorization will be valid if such action has been taken prior to receipt of notice of revocation. If this authorization is used to collect information in connection with a claim for benefits, it will be valid for the duration of the claim. If the law of my state so provides, my authorization may not be revoked during a contestable investigation. I also understand that my revocation of this authorization will not result in the deletion of codes in the MIB database if such codes are reported by AMLA (or AMLA becomes obligated to report such codes to MIB) while this authorization is in force.

A photographic copy of this authorization shall be as valid as the original.

Signed at __________________________ this ______ day of ___________, 20____

___________________________________ ___________________________________

Signature of Proposed Insured (Parent or Guardian, if Proposed Insured is under age 16).

Signature of Applicant if not Proposed Insured