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 # _____
Issue Age: _____ Issue Date: _____
☐ 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:				

A. Proposed Insured

1. Full Name (print): _____
2. Full Address: _____
   (Address) (City) (State) (Zip)
3. Birth date (MM/DD/YY):_____Phone #: _____
   Birthplace:_____ Email:_____
4. Sex: M ☐ F ☐ Height: ____ft ____in. Weight: _____
5. Social Security #: _____
6. Occupation: _____
   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 ☐ Monthly
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. 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. 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 to part 5a. or if this contract is issued, will the discontinuing of premium payments, surrendering, forfeiting, assigning to the insurer or otherwise terminating an 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
6. 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 _____
7. Is there an arrangement or an intent to sell or transfer ownership to a third-party on the policy applied for, in whole or in part?
   ☐ 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.*

D. Medical Information

Part 1- Please Answer the Following Questions. If Questions 1 or 2-C are Answered "Yes", Skip Part 2 and Complete Part 3.

1. Is Proposed Insured a member of the American Mutual Life Association? If no, apply for membership. ☐ Yes ☐ No
2. 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
   c. In the past 60 months? ☐ Yes ☐ No

Part 2- If Any Question Below is Answered "Yes", Please Complete Part 3.

3. 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
4. Does Proposed Insured have any physical or mental handicaps? ☐ Yes ☐ No

Part 3- Please Complete the Following Questions

5. During the past seven years has the Proposed Insured been examined or prescribed medication by a physician or medical practitioner? ☐ Yes ☐ No
6. 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
7. 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
8. During the last 5 years has the Proposed Insured been hospitalized or had surgery of any kind? ☐ Yes ☐ No
9. 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
10. If female, is Proposed Insured pregnant? ☐ Yes ☐ No
11. Is any medication currently prescribed for the Proposed Insured? ☐ Yes ☐ No

Give Details for all YES answers to Questions 2 through 11 above.

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

E. 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:

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 AMLA 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.

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.

NOTICE TO PROPOSED INSURED

I understand that information regarding insurability will be treated as confidential. The American Mutual Life Association (AMLA) 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 may have about you in its files. AMLA 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.

AUTHORIZATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, medical or medically related facility, or other health care provider, insurance or reinsuring company, consumer reporting agency, the MIB, Inc., or other organization, institution or person, that has any records or knowledge of me or my health, to give the AMLA or its representatives or its reinsurer, any such information it may require to determine eligibility for insurance. I authorize MIB, Inc. to give to the AMLA or its reinsurer any records of me or my health. AMLA 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 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 _____ on this _____ day of _____, 20_____.

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

_____
Signature of Applicant if not Proposed Insured

For Home Office Use

☐ Approved Remarks: _____
☐ Disapproved _____

Dated:_____ Signed _____