

# American Memorial Life Insurance

A wholly-owned subsidiary of



## CANCER – All Types

No treatment in last **12 months**

## CARDIAC

No treatment in last **24 months**

## DIABETES

No Insulin **prior to age 40** and **no control questions** asked

## KEY FEATURES

- Immediate benefit
- A – Rated Company
- Issue ages are 0 – 85
- Face amounts up to \$75k (depending on age)
- Age Last

## OTHER MARKETS

- Foreign Travel (including Missionaries )
- Multiple Sclerosis
- Parkinson's Disease
- Lupus
- Hazardous Sports/Hobbies
- Dangerous Occupations

PO Box 11767, Knoxville, TN 37939  
800-624-4502 / 865-588-9555  
[www.tba.com](http://www.tba.com)



# Rate Pages

Annual Rates per \$1,000 plus \$30 annual policy fee.

Preferred (Age 0-42)					
Age	Female		Male		Policy Size
	Non-Smoker	Smoker	Non-Smoker	Smoker	
0	15.17		17.50		\$5K - \$20K
1	15.28		17.61		
2	15.39		17.72		
3	15.50		17.83		
4	15.61		17.94		
5	15.72		18.06		
6	15.83		18.17		
7	15.94		18.28		
8	16.06		18.39		
9	16.17		18.50		
10	16.39		18.83		
11	16.72		19.17		
12	17.06		19.39		
13	17.28		19.61		
14	17.50		20.06		
15	17.72	19.72	20.50	23.50	\$5K - \$30K
16	17.83	19.94	20.83	23.94	
17	18.06	20.28	21.28	24.50	
18	18.28	20.50	21.72	25.06	
19	18.50	20.83	21.72	25.06	
20	18.72	21.17	21.72	25.06	
21	19.06	21.39	21.83	25.06	
22	19.28	21.72	21.83	25.06	
23	19.50	22.06	21.83	25.06	
24	19.83	22.50	22.17	25.50	
25	20.28	23.06	22.61	25.94	
26	20.61	23.50	22.94	26.28	
27	21.06	24.06	23.39	26.72	
28	21.39	24.50	23.72	27.17	
29	21.39	24.50	23.72	27.17	
30	21.39	24.50	23.72	27.17	
31	21.39	24.50	23.72	27.28	
32	21.39	24.50	23.83	27.28	
33	21.39	24.72	23.83	27.28	
34	21.94	25.61	24.61	28.39	
35	22.39	26.39	25.39	29.61	
36	22.94	27.28	26.17	30.72	
37	23.39	28.06	26.94	31.94	
38	23.94	28.94	27.72	33.06	
39	24.94	30.17	28.94	34.61	
40	25.83	31.28	30.28	36.06	\$5K - \$75K
41	26.83	32.50	31.50	37.61	
42	27.72	33.61	32.83	39.06	

Preferred (Age 43-85)					
Age	Female		Male		Policy Size
	Non-Smoker	Smoker	Non-Smoker	Smoker	
43	28.72	34.83	34.06	40.61	\$5K - \$75K
44	29.72	36.06	35.72	42.72	
45	30.72	37.17	37.39	44.83	
46	31.72	38.39	39.17	46.83	
47	32.72	39.50	40.83	48.94	
48	33.72	40.72	42.50	51.06	
49	33.83	41.17	42.83	51.94	
50	33.94	41.61	43.17	52.83	
51	34.06	41.94	43.39	53.83	
52	34.17	42.39	43.72	54.72	
53	34.28	42.83	44.06	55.61	
54	35.61	44.50	45.94	58.06	
55	36.94	46.17	47.83	60.50	
56	38.39	47.83	49.61	62.94	
57	39.72	49.50	51.50	65.39	
58	41.06	51.17	53.39	67.83	
59	42.72	53.50	55.50	71.17	
60	44.39	55.83	57.61	74.50	
61	46.06	58.06	59.61	77.94	
62	47.72	60.39	61.72	81.28	
63	49.39	62.72	63.83	84.61	
64	51.39	65.61	67.94	91.39	
65	53.39	68.50	72.06	98.28	
66	55.28	71.50	76.06	105.06	
67	57.28	74.39	80.17	111.94	
68	59.28	77.28	84.28	118.72	
69	63.28	83.39	90.06	128.94	
70	67.28	89.39	95.83	139.17	
71	71.39	95.50	101.61	149.39	
72	75.39	101.50	107.39	159.61	
73	79.39	107.61	113.17	169.83	
74	84.61	116.06	120.17	182.94	
75	90.28	125.39	127.61	197.39	
76	90.94	126.94	128.39	199.50	
77	91.61	128.50	129.06	201.61	
78	92.28	130.06	129.83	203.72	
79	92.94	131.61	130.50	205.83	
80	98.83	141.61	131.28	207.94	
81	102.72	146.94	135.28	213.83	
82	106.61	152.17	139.39	219.61	
83	106.83	156.06	142.39	222.28	
84	113.83	159.94	145.50	224.83	
85	121.39	172.17	153.83	240.28	

**Example: \$20,000 Policy - Female Preferred Non-smoker Age 65**

Annual Rate per \$1,000      \$53.39  
 Amount of insurance      \$20,000  
 Policy Fee      \$30.00

**Annual Premium calculation**

*(Annual Rate x (Amount of insurance / 1000)) + Policy Fee*  
 $53.39 \times (\$20,000 / 1000) + \$30 = \$1,097.80$

Annual premium      \$1,097.80

**Payment mode calculation**

Payment Frequency	Factor
Monthly	0.09
Quarterly	0.26
Semi-Annual	0.51

*Annual Premium x Factor*

Monthly Premium      98.80  
 Quarterly premium      285.43  
 Semi-annual premium      570.86

# Height & Weight Chart

The maximum weight is a major co-mortality factor. The minimum weight is a major co-mortality factor as well – underweight may be due to a recent illness or modified diet. Serious causes may exist, especially in the elderly, when low BMI appears to be a marker of disease. Underweight is less common than obesity, however it still gives rise to significant mortality.

If an applicant exceeds maximum weight – it is a decline.

If applicant goes below the minimum weight – it is a decline.

Height	Minimum weight	Maximum weight
	Unisex	Unisex
4'8	74	185
4'9	76	192
4'10	79	199
4'11	82	206
5'0	84	213
5'1	87	220
5'2	90	228
5'3	93	235
5'4	96	243
5'5	99	250
5'6	102	258
5'7	105	266
5'8	109	274
5'9	112	282
5'10	115	291
5'11	118	299
6'0	122	308
6'1	125	316
6'2	129	325
6'3	132	334
6'4	136	343
6'5	139	352
6'6	143	361
6'7	146	371

# Appointment with AMLIC

## Managers

Complete the appointment application and commission hierarchy for each business entity and each individual requesting appointment and include your name (printed), your signature, and your phone and fax numbers.

## Applicant

1. Complete American Memorial Life Insurance Company's (AMLIC) "Application For Appointment"
2. If you are currently licensed, include a copy of your resident insurance license and non-resident insurance license from each state that you intend to sell in.
3. If you do not have your life license, please call Agent Services at (800) 742-7021 for instructions on appropriate state forms for a new license application.

*Please see the "Application for Appointment" included in this sales kit for complete instructions.*

*Please send all above to:*

Workers & Family Insurance  
Isidore "Izzy" Grossman RHU, Founder  
1250 Easton Road Suite 160  
Horsham, PA 19044

*Appointment Contact Information:*

Tel: 215-674-5800  
Fax: 215-674-5898

## Details:

No E and O coverage is required for appointment, but if such insurance exists, send it as part of the application.

The new agent can send his or her appointment paperwork and the first application for insurance together.

Appointment fees will not be paid by American Memorial Life in the agent's home state or in all other states where the agent is licensed and actively selling, unless the Application for Appointment is submitted along with the first insurance application.

A background check will include criminal, credit, and a Vector One report.

# Point of Sale Process

**(888) 801-5118**

**Call center office hours (CST):**

Monday	8:00 am to 9:30 pm
Tuesday	8:00 am to 9:30 pm
Wednesday	8:00 am to 9:30 pm
Thursday	8:00 am to 9:30 pm
Friday	8:00 am to 5:00 pm

**Applicant Status:**

The phone interviewer will re-ask the Health Questions.

The phone interviewer will inform the applicant of the underwriting decision.

If the sale is non-seen, please leave the best time to do the interview and the desired language on your recorded message.

**Foreign Language:**

Please inform the phone interviewer the desired language at the beginning of your call.

**Busy Line or Phone Issues:**

In the rare instance that the phone interview line is busy, please leave a voice mail message including the proposed insured's phone number.

**After Hours or Non-Seen:**

Please leave your name, phone number, and the best time to call.

**Note:**

If sending appointment paperwork and the first application for insurance at the same time, the writing agent should inform the phone interview person that there is no existing number yet established for the agent.

Each application will have a "Form #" printed on it. This # is to be given to the ESP Interviewer by the agent for every interview. When the agent leaves a message for a call back to the applicant, the agent needs to leave this "Form #" as part of the message.

Some states require a delivery receipt please follow state guidelines.

# Completing an Application

## Step 1 Pre-Qualify

- Pre-qualify the applicant by completing the application.
- Confirm that the applicant is able to participate without assistance in the phone interview.
- Decline - If any question in Section 9 is "Yes."

## Step 2 Phone Interview

Call (888) 801-5118

- Verbal recorded MIB authorization from applicant.
- The applicant verifies the information on the application.

## Step 3 Close

- Agent will speak to the interviewer.
- Preferred Rates – if questions are all answered "No."
- There are three possibilities.
  - a. Accepted: Collect correct premium and forward application and premium to AML.
  - b. Declined: Do not collect premium, notify applicant, send application to AML, and a decline letter will be sent.
  - c. Incomplete/Cancel: If application cannot be completed or applicant stops interview, then Decline – Do not collect premium, notify applicant, send application to AML, and a decline letter will be sent.
- Add premium options, model factors, and various methods to submit the first premium.
- Complete other applicable forms
- Complete the agent checklist

**Note: See additional instructions on the "seen" and "non-seen" forms.**

# Partner Information



ASSURANT  
Solutions®

Assurant Solutions is partnered with the largest funeral home organization in North America, Service Corporation International (SCI). Assurant Solutions is a part of Assurant, a premier provider of specialized insurance products and related services in North America and selected other markets. Assurant, a Fortune 500 company and a member of the S&P 500, is traded on the New York Stock Exchange under the symbol AIZ. Assurant has over \$25 billion in assets and \$8 billion in annual revenue. Assurant has approximately 15,000 employees worldwide and is headquartered in New York's financial district.

American Memorial Life Insurance Company (AML) is a legal entity of Assurant Solutions. AML is licensed in 49 states and rated "A-" (Excellent) by the A.M. Best Company, a leading provider of insurance ratings.



Dignity Planning® is a free needs analysis and suitability tool that allows financial service professionals to provide their clients with a complete solution for end-of-life planning. With Dignity Planning, clients have a simple, secure way to plan, record and share their final wishes while agents benefit from increased policy persistency and face amounts, up-sell and cross-sell opportunities and lead generation.

# Application for Life Insurance

American Memorial Life Insurance Company

P.O. Box 2730 • Rapid City, SD 57709

HOME OFFICE USE ONLY

# \_\_\_\_\_

Agent Present  Yes  No

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.

## 1. Proposed Insured

Address: \_\_\_\_\_  
First Middle Initial Last  
Street  
City State Zip

Telephone Number: (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_ (Work) \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Current Age: \_\_\_\_\_ Birth State: \_\_\_\_\_  Male  Female

## 2. Owner Information (If different from Proposed Insured)

Owner's Name: \_\_\_\_\_ Email Address: \_\_\_\_\_

Owner's Address: \_\_\_\_\_

Relationship to Proposed Insured: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Telephone Number: (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_ (Work) \_\_\_\_\_

## 3. Primary Beneficiary

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: (Home) \_\_\_\_\_  
(Cell) \_\_\_\_\_ (Work) \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Relationship to Proposed Insured: \_\_\_\_\_

## 4. Contingent Beneficiary

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: (Home) \_\_\_\_\_  
(Cell) \_\_\_\_\_ (Work) \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Relationship to Proposed Insured: \_\_\_\_\_

5. Face Amount: \$ \_\_\_\_\_

6. Preferred Plan

## 7. Additional Required Information for Proposed Insured:

A. Has the Proposed Insured used nicotine based products in the past 12 months?  Yes  No

B. Current Physician and Address: \_\_\_\_\_

C. Drivers License Number: \_\_\_\_\_ State: \_\_\_\_\_

D. Are you a U.S. citizen?  Yes  No

If not, do you have an immigration card?  Yes  No Card Number: \_\_\_\_\_



**8. Payment Options**

**Initial Payment Method:**

- PAC (Pre-Authorized Check)       Check\* (Payable to AML)
- Credit Card (Initial payment only)       VISA       MasterCard

Account Number \_\_\_\_\_ Expiration Date \_\_\_\_\_

Cardholder's Printed Name \_\_\_\_\_ Cardholder's Signature \_\_\_\_\_

Premium Amount \$ \_\_\_\_\_

**Subsequent Premium Payment Frequency and Method of Payment:**

**Billing Frequency**

- Monthly
- Quarterly
- Semi-Annual
- Annual

**Payment Method**

PAC (Pre-Authorized Check) (Must choose PAC if Initial Payment Method above is PAC)

Check \*(Payable to AML)

If you selected PAC (Pre-Authorized Check), indicate subsequent premium withdrawal date \_\_\_\_\_

- Checking       Savings

Name of Financial Institution \_\_\_\_\_

Routing Number \_\_\_\_\_ Account Number \_\_\_\_\_

Account Holder's Printed Name \_\_\_\_\_ Signature of Account Holder \_\_\_\_\_

\*When you provide a check as payment, you authorize us either to use information from your check to make a one-time electronic fund transfer from your account or to process the payment as a check transaction. When we use information from your check to make an electronic fund transfer, funds may be withdrawn from your account as soon as the same day you make your payment, and may not receive your check back from your financial institution. For inquiries please call 1-800-585-8385, press zero.

**9. Health Questions:** If the Proposed Insured answers "YES" to any question in this section or does not meet the height and weight requirements for the product, they are not eligible for coverage.

1. Height \_\_\_\_\_ Weight \_\_\_\_\_

YES NO

2.   Do you need assistance with the normal activities of daily living (eating, bathing, dressing, taking medications, etc.), or are you currently hospitalized, confined to a bed or nursing facility, or receiving hospice care?

3. Within the past 12 months have you

a.   Been diagnosed with internal cancer, leukemia, lymphoma, or melanoma or have had more than one occurrence of any cancer in your life time (excluding basal or Squamous cell skin cancer), had a recurrence of any cancer, or currently being treated for cancer or had an amputation caused by any disease or cancer?

b.   Been medically diagnosed, treated, or taken medication for stroke or transient ischemic attack (TIA/mini-stroke)?

4. Within the past 24 months have you

a.   Been medically diagnosed, treated or taken medication for cirrhosis, liver disease, angina, chronic obstructive pulmonary or lung disease (COPD/COLD), emphysema, chronic bronchitis, required oxygen to assist in breathing, or uncontrolled high blood pressure?

b.   Been diagnosed as having, been treated for or hospitalized for heart disease, Hodgkin's Disease, heart attack, heart or circulatory vascular surgery (including coronary artery bypass, pacemaker or replacement pacemaker, heart valve replacement, abdominal aortic aneurysm, but excluding angioplasty or stent placement) cardiomyopathy, or any procedure to improve circulation to the heart or brain?

5. Within the past 36 months have you

a.   been convicted of a felony or are you currently incarcerated or on probation, been treated for or been advised to have treatment for alcohol or any drugs of abuse, attempted suicide, or been convicted of operating a vehicle while intoxicated or impaired?

6. Have you ever

a.   Been treated for insulin shock, diabetic coma, or have you taken insulin injections or by other methods prior to age 40?

b.   Been medically treated or diagnosed by a medical professional as having Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC), or any immune deficiency related disorder or tested positive for the human immunodeficiency virus (HIV)?

c.   Had, or been medically advised to have, an organ transplant, or been diagnosed as having a terminal medical condition that is expected to result in death within the next 12 months.

d.   Been medically diagnosed, treated, or taken medication for chronic kidney disease (including dialysis), kidney or liver failure, congestive heart failure, Alzheimer's, dementia, Lou Gehrig's disease (ALS), schizophrenia, bipolar disorder, or mental incapacity?

**Conditions Relating to the Application:** I have read the questions and answers in all parts of this Application. I agree that they are complete and true to the best of my knowledge and belief. I agree that this Application and any supplement to the Application, if required, shall be attached to and form a part of any policy issued.

**Acknowledgement:** I have read and understand the Conditions Relating to the Application, the Medical Authorization information, and this Acknowledgement. I acknowledge receipt and review of the Notice to the Applicant and (where required by law) a Buyer's Guide and any other required preliminary cost information.

I understand and agree that no insurance agent has the authority to waive an answer to any question in the Application, pass on insurability, make or alter any contract, or waive any of the Company's rights or requirements. I understand and agree that any policy applied for shall not take effect (except as provided in the Conditional Premium Receipt bearing the same name as this Application) unless and until the policy has been issued and delivered and the first full premium, according to the mode of payment selected by the applicant and as permitted by the Company and stated in the policy, has been paid and accepted by the Company during the lifetime and condition of health of the Proposed Insured as stated in this Application. I understand that I (or my authorized representative) may receive a copy of this Authorization.

**SIGNATURES:**

Signed at: \_\_\_\_\_  
City State

**Proposed Insured** \_\_\_\_\_ Date \_\_\_\_\_

Will the policy that you are applying for replace any existing life insurance or annuity policy?  Yes  No

If yes, give name and address of the existing insurer and policy number, if available: \_\_\_\_\_

**Applicant/Owner** \_\_\_\_\_ Date \_\_\_\_\_  
(If different from Proposed Insured)

**Witness - Licensed Agent** \_\_\_\_\_ Date \_\_\_\_\_

**Agent's Statement**

Did you see the Proposed Insured at the time this application was completed?  Yes  No

Is the insurance applied for intended to replace or change an existing life insurance or annuity policy?  Yes  No

If a replacement is involved, I certify that I only used company approved sales materials.

Licensed Agent's Signature \_\_\_\_\_

Name of Agency Office \_\_\_\_\_

Agent's State License ID Number \_\_\_\_\_ Expiration Date \_\_\_\_\_

Print Agent Name \_\_\_\_\_

Agent Number \_\_\_\_\_ Agent Telephone Number ( \_\_\_\_\_ ) \_\_\_\_\_

**Medical Authorization**

For use with Life Insurance Applications.

This Authorization complies with the HIPAA Privacy Rule.

\_\_\_\_\_  
Name(s) of primary proposed insured/patient

\_\_\_\_\_  
Date(s) of birth

\_\_\_\_\_  
Name(s) of unemancipated minors

\_\_\_\_\_  
Date(s) of birth

I authorize any health plan, physician, medical practitioner, health care professional, hospital, clinic, pharmacy benefit manager, pharmacy, MIB, Inc., laboratory, medical facility, insurance company, insurance support organization (or any of its members or affiliates), the Veteran’s Administration, my employer, consumer reporting agency, or any other health care provider that has provided payment, treatment or services to me or on my behalf or on the behalf of my unemancipated minor children (collectively, “My Providers”) to disclose the entire medical record and any other protected health information concerning me or my above named unemancipated minor children to American Memorial Life Insurance Company (“the Company”) or its reinsurers, their agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes. I acknowledge receipt of the MIB, Inc. Pre-Notice and Fair Credit Reporting Act Pre-Notice.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information or that of my unemancipated minor children do not apply to this authorization and I instruct My Providers to release and disclose the entire medical record without restriction.

This protected health information is to be disclosed under the authorization at my request, as permitted by § 164.508 of the privacy regulations issued pursuant to the Health Insurance Portability and Accountability Act (“HIPAA Privacy Rule”).

This authorization shall remain in force for 24 months following the date of my signature below, regardless of my condition and whether living or deceased, and a copy of this authorization is as valid as the original. I understand that I have the right to obtain a copy of this authorization and to revoke this authorization in writing, at any time, by sending a written request for revocation to the Company at Attention: Privacy Task Force, P.O. Box 2730, Rapid City, SD 57709. I understand that a revocation is not effective to the extent that any of My Providers has relied on this authorization or to the extent that the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal regulations governing privacy and confidentiality of health information (such as the HIPAA Privacy Rule). However, the company will protect the privacy of health information in accordance with other applicable state and/or federal privacy laws and its own privacy policies.

I understand that My Providers may not refuse to provide treatment or payment for health care services because I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record or that of my unemancipated minor children, the Company may not be able to process my application, or if coverage has been issued, may not be able to make any benefit payments. I acknowledge that I (or my authorized representative) have received a copy of this authorization.

\_\_\_\_\_  
Signature of Primary Proposed Insured/Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Primary Proposed Insured/Personal Representative

\_\_\_\_\_  
Date

If signed by an individual’s Personal Representative, describe authority to sign on behalf of individual:

Parent       Power of Attorney       Legal Guardian       Other \_\_\_\_\_

## Notice to the Applicant

You have made a wise decision to apply for life insurance. The possibility exists that premiums paid over several years may exceed the death benefit. This notice is given to you at the time you apply for life insurance to tell you about that type of information the Company may obtain in connection with your application. We will treat all personal information about you as confidential.

**Underwriting.** Your application, together with the medical history you give, provides the initial basis for evaluation. The Company relies on the accuracy and completeness of your answers and may make inquiries, both before and after a policy is issued, to verify this information.

**Sources of Information.** The Company may request additional information from your physician(s) or hospital(s) or other medical professionals, or medical care institutions, the Medical Information Bureau (MIB), other insurance institutions to which you have applied for insurance, your employers, agents of the Company, business associates, a governmental entity, financial institution, or consumer reporting agency. Your signature on the Acknowledgement and Medical Authorization Form permits the Company to make these inquiries. Such inquiries may be made by telephone, written correspondence, or personal interview. If the Company requests information from another insurance company, it will not request underwriting action. You have the right to know what information we have about you, to copy it, and if it is incorrect, to have it corrected. If the Company received information about you from an insurance support organization, such information may be retained by the organization and released to others. In this connection, the following notice is given to you as required by the federal and various state Fair Credit Reporting Acts. You have the right to access and correction with respect to this information. If you wish a more detailed explanation of information practices, please send your written request to American Memorial Life Insurance Company, P.O. Box 2730, Rapid City, SD 57709.

**Fair Credit Reporting Act Pre-Notice.** In some cases, the Company may ask an independent agency to prepare an investigative consumer report for you. This report may include information about your character, general reputation, personal characteristics such as health, finances, and mode of living, except as may be related directly or indirectly to your sexual orientation. Any information obtained by an investigative agency may be kept in its file and later given to others who have a business need for it. If an investigative consumer report is ordered by the Company, the report will include information obtained through interviews with your neighbors, friends, or others with whom you are acquainted. You may request to be interviewed in connection with the preparation of the investigative consumer report. You may request, in writing, to receive information from the Company about the nature and scope of an investigative consumer report. Within five (5) business days of receipt of such request, the Company will provide you with the name, address, and phone number of any agency the Company asks to prepare such a report. You should contact them to obtain a copy of the report.

**Medical Information Bureau, Inc. Pre-Notice.** Information regarding your insurability will be treated as confidential. American Memorial Life Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you 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 about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the information in 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.

American Memorial Life Insurance Company, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life and health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at [www.mib.com](http://www.mib.com).

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## Conditional Premium Receipt

THIS RECEIPT PROVIDES COVERAGE ONLY IF CONDITIONS BELOW ARE MET.

The Company hereby acknowledges receipt of the initial premium from the Proposed Insured for which an application for insurance is made to American Memorial Life Insurance Company on the date of application and for the premium collected as stated on the application for insurance.

Life insurance and any additional benefits in the amount applied for shall be deemed to take effect as of the date of this application, subject to the terms and conditions printed below.

### Conditions of Life Insurance Coverage (Please read carefully).

Subject to the limitations of this receipt and the terms and conditions of the policy that may be issued by the Company on the basis of the application, the life insurance and any additional benefits applied for will not be deemed to take effect unless the Company, after investigation and such medical examination (if any) as it may require, is satisfied that on the date of the application the person proposed for insurance was insurable for the amount of life insurance and any additional benefits applied for according to the Company's rules and practice of selection; provided, however, that approval by the Company of the insurability of the Proposed Insured for a plan of insurance other than that applied for shall not invalidate the terms and conditions for the receipt relating to life insurance and any other additional benefit applied for.

The amount received shall be refunded if the application is declined or if a policy is issued other than as applied for and is not accepted. Any check, draft or money order is received subject to collection.

American Memorial Life Insurance Company or its reinsurers may also release limited information in its file to other properly authorized life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted.

# Agent Guide

## Section #1 and #2

Proposed Insured/Owner

- Verify age and birth date match
- Provide SSN if available
- The owner receives all correspondence from AML (Welcome Letter, Benefit Summary) the Policy is sent to the agent (unless requested differently).
- **Insured must sign application and answer health questions.**

Individuals AML considers to have insurable interest	Legal Authority to sign on behalf of the insured - needs paperwork
<ul style="list-style-type: none"><li>• Spouse</li><li>• Mother/Father</li><li>• Sister/Brother</li><li>• Child</li><li>• Grandparent</li><li>• Grandchild</li></ul>	<ul style="list-style-type: none"><li>• Power of Attorney</li><li>• Guardianship</li><li>• Conservator</li><li>• Parent of Minor Child</li></ul>

## Section #5, #6,

5. Face Amount: \$ _____	6. Preferred Plan
--------------------------	-------------------

Face Amount Must Be Completed.

## Section #7

<b>7. Additional Required Information for Proposed Insured:</b>	
A. Has the Proposed Insured used nicotine based products in the past 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
B. Current Physician and Address: _____ _____	
C. Drivers License Number: _____	State: _____
D. Are you a U.S. citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If not, do you have an immigration card? <input type="checkbox"/> Yes <input type="checkbox"/> No Card Number: _____	

- **Consider** the application if applicant is a USA citizen or legal permanent resident with immigration card.
- **Decline** the application if applicant is not a USA citizen or legal permanent resident with immigration card.

## Additional Note:

Please leave the last page of the application titled “Notice to Applicant” with the customer.

**9. Health Questions:** If the Proposed Insured answers “YES” to any question in this section or does not meet the height and weight requirements for the product, they are not eligible for coverage.

1. Height See Height Chart

Weight See Weight Chart

YES NO

2.   Do you need assistance with the normal activities of daily living (eating, bathing, dressing, taking medications, etc.), or are you currently hospitalized, confined to a bed or nursing facility, or receiving hospice care?

3. Within the past 12 months have you

a.   Been diagnosed with internal cancer, leukemia, lymphoma, or melanoma or have had more than one occurrence of any cancer in your life time (excluding basal or Squamous cell skin cancer), had a recurrence of any cancer, or currently being treated for cancer or had an amputation caused by any disease or cancer?

b.   Been medically diagnosed, treated, or taken medication for stroke or transient ischemic attack (TIA/mini-stroke)?

4. Within the past 24 months have you

a.   Been medically diagnosed, treated or taken medication for cirrhosis, liver disease, angina, chronic obstructive pulmonary or lung disease (COPD/COLD), emphysema, chronic bronchitis, required oxygen to assist in breathing, or uncontrolled high blood pressure?

b.   Been diagnosed as having, been treated for or hospitalized for heart disease, Hodgkin’s Disease, heart attack, heart or circulatory vascular surgery (including coronary artery bypass, pacemaker or replacement pacemaker, heart valve replacement, abdominal aortic aneurysm, but excluding angioplasty or stent placement) cardiomyopathy, or any procedure to improve circulation to the heart or brain?

5. Within the past 36 months have you

a.   been convicted of a felony or are you currently incarcerated or on probation, been treated for or been advised to have treatment for alcohol or any drugs of abuse, attempted suicide, or been convicted of operating a vehicle while intoxicated or impaired?

6. Have you ever

a.   Been treated for insulin shock, diabetic coma, or have you taken insulin injections or by other methods prior to age 40?

b.   Been medically treated or diagnosed by a medical professional as having Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC), or any immune deficiency related disorder or tested positive for the human immunodeficiency virus (HIV)?

c.   Had, or been medically advised to have, an organ transplant, or been diagnosed as having a terminal medical condition that is expected to result in death within the next 12 months.

d.   Been medically diagnosed, treated, or taken medication for chronic kidney disease (including dialysis), kidney or liver failure, congestive heart failure, Alzheimer’s, dementia, Lou Gehrig’s disease (ALS), schizophrenia, bipolar disorder, or mental incapacity?

**(4. a.) COPD/COLD:** (Chronic obstructive lung disease or pulmonary disease), this health condition includes chronic bronchitis, emphysema, pulmonary fibrosis, pulmonary granulomatosis, pulmonary edema, **active** tuberculosis, pneumoconiosis (black lung, farmer’s lung, asbestosis, silicosis), bronchiectasis, pulmonary sarcoidosis, histoplasmosis, and cryptococcosis.

Asthma by itself is **not considered** COPD/COLD and is an acceptable risk factor.

**(4. b.) NEW Heart Disease or Disorder:** The following are considered diseases or disorders of the heart occurring / discovered within the last **24 months**. Heart attack, heart blocks, PVD (peripheral vascular disease), valvular surgery, (angioplasty and stent placement are excluded from question 4b only), pacemaker, cerebral vascular disease, arrhythmias, carditis, **abnormal** resting and exercise EKG’s, cardiac ischemia, enlarged heart, angina, coronary artery aneurysm, coronary artery bypass grafting, heart replacement, murmurs of any kind, cardiomyopathy, coronary artery disease of any type. Issues such as a heart attack five years ago without any further episodes continue to be underwriting acceptable.

**Prescription drug use for maintenance of health conditions originally diagnosed over 24 months ago, does not apply to question 4b.**

**Prescription drug use for maintenance of health conditions originally diagnosed over 12 months ago, does not apply to question 3a.**

**Uncontrolled Blood Pressure:** If the applicant feels blood pressure is uncontrolled, they should answer the question “Yes.” If confident that it is controlled they should respond “No.” The applicant can determine whether their blood pressure condition is controlled by what their doctor has told them. If they are **taking their medication** and if the average reading does not exceed **140/90** they can consider their blood pressure under control.

**Treatment:** Treatment is defined as receipt of medical services, surgery, or therapeutic care due to disease or injury; this does not include routine checkups.

## Payment Options Section:

<b>8. Payment Options</b>	
<b>Initial Payment Method:</b>	
<input type="checkbox"/> PAC (Pre-Authorized Check)	<input type="checkbox"/> Check* (Payable to AML)
<input type="checkbox"/> Credit Card (Initial payment only)	<input type="checkbox"/> VISA <input type="checkbox"/> MasterCard
Account Number _____	Expiration Date _____
Cardholder's Printed Name _____	Cardholder's Signature _____
Premium Amount \$ _____	
<b>Subsequent Premium Payment Frequency and Method of Payment:</b>	
<b>Billing Frequency</b>	<b>Payment Method</b>
<input type="checkbox"/> Monthly	PAC (Pre-Authorized Check) (Must choose PAC if Initial Payment Method above is PAC)
<input type="checkbox"/> Quarterly	Check *(Payable to AML)
<input type="checkbox"/> Semi-Annual	
<input type="checkbox"/> Annual	
If you selected PAC (Pre-Authorized Check), indicate subsequent premium withdrawal date _____	
<input type="checkbox"/> Checking	<input type="checkbox"/> Savings
Name of Financial Institution _____	
Routing Number _____	Account Number _____
Account Holder's printed name _____	Signature of Account Holder _____

- Do not accept cash
- Indicate billing frequency: (Monthly, Quarterly, Semi-Annual, and Annual)
- Indicate PAC date (if selected)
  - A void check or savings withdraw slip is not required
  - Can't choose the 29th, 30th, or 31st
  - Left blank - default to 30 days on monthly
  - PAC date must be set by the 28th of next month if on a monthly schedule
- If credit card, ensure credit card information is complete
  - Cardholder's signature could be different from proposed insured or owner
  - VISA & MasterCard (Initial Payment Only)
  - Single pay or initial premium payment only
- Indicate Banking information
  - Indicate bank name
  - Indicate checking or savings
  - Complete the routing and account numbers
  - Have the account holder sign

### Premium Note:

The Premium Amount represents the amount of initial payment and the amount of each subsequent payment. *For example*, if an Annual Billing Frequency is selected for subsequent premiums, the initial payment will be the annual premium amount.

## Health Question Section

### Health Questions

- Do not interpret questions
- Applicant should answer questions
- Policies are contestable for 24 months

## Signature Section

### INCLUDE:

- |   |  |
|---|--|
| <input type="checkbox"/> Signed at City, State              | <input type="checkbox"/> Proposed Insured and Date |
| <input type="checkbox"/> Replacement Question, "Yes/ No"    | <input type="checkbox"/> Applicant/ Owner and Date |
| <input type="checkbox"/> Witness or Licensed Agent and Date |  |

## Agent's Statement Section

### INCLUDE:

- |  |  |
|--|--|
| <input type="checkbox"/> Licensed Agent's Signature      | <input type="checkbox"/> Name of Agency Office |
| <input type="checkbox"/> Agent's State License ID Number | <input type="checkbox"/> Expiration Date       |
| <input type="checkbox"/> Agent's Printed Name            | <input type="checkbox"/> Agent Number          |
| <input type="checkbox"/> Agent Telephone Number          |  |

## To Review:

1. **Decline** - If any question in PART 9 is "Yes."

## General Rules for All Forms:

- Never** use white out!
- Cross out error(s) with one line and have purchaser or owner and agent initial and date the correction.
- If there are more than three errors, complete a new form.
- Faxed changes are not accepted. American Memorial Life must have the original document.
- Do not use rubber stamps.
- Print** by hand legibly.
- Do not type!**
- The form should be completed by only one agent and that agent must be licensed and appointed with American Memorial Life in the state the form was signed. **Note:** If your state allows, writing agent can send the AML Application for Agent Appointment paperwork in with the first insurance application.