Not for use in CA, FL, NY, PA, and VT.

Policy Number: ☐☐☐☐☐☐☐☐☐☐

Eagle Premier Series TeleApplication Worksheet

This worksheet is for reference only and is NOT an application for coverage. DO NOT sign and return to Americo.

Use this worksheet to help save time with the TeleApplication process. Gather the information prior to contacting Americo. This worksheet contains sensitive information and should be kept in a secure location for your records or destroyed. When ready, contact Americo's Call Center at 855.248.8327. All participants (Agent, Proposed Insured, Owner, and Payor) must be on the phone at the time of the call. All calls are recorded.

Agent Information

Name:_____ Agent ID #:_____

Proposed Insured Information

Issue State:_____ Date of Birth: ____ / ____ / ____ ☐ Male ☐ Female

Name (First, MI, Last): _____

Mailing Address:_____

Street Address (If Mailing Address is a PO BOX): _____

If less than 5 years at current address, list prior address:_____

Email Address:_____ Phone Number: ( ) _____- _____ SSN or Taypayer ID: _____

Place of Birth (City, State, Country): _____

Owner Information *(If different than the Proposed Insured)*

Name (First, MI, Last): _____ Relationship to Proposed Insured: _____

SSN or Taypayer ID: _____ Email Address: _____

Mailing Address:_____

Street Address (If Mailing Address is a PO BOX): _____

Beneficiary Information *(% of Share must total 100%. If shares are not given, they will be equal.)*

☐ Primary ☐ Contingent % of Share: _____ Name (First, MI, Last): _____

Date of Birth: ____ / ____ / ____ Phone Number: ( ) _____- _____

Relationship to Proposed Insured:_____

☐ Primary ☐ Contingent % of Share: _____ Name (First, MI, Last): _____

Date of Birth: ____ / ____ / ____ Phone Number: ( ) _____- _____

Relationship to Proposed Insured:_____

Product Information *(Not all products are available in all states. See Product Availability Guide for state availability.)*

☐ Eagle Premier ☐ Eagle Guaranteed Face Amount $_____ Monthly Premium $_____

Effective Date (If Not Current Date): ____ / ____ / ____ ☐ Automatic Premium Loan

If applying for Eagle Premier, complete the following information:

1. ☐ Smoker ☐ Nonsmoker 2. Height _____' _____" 3. Weight _____ (in pounds)

Payor Information *(Complete only when the Payor is different than the Proposed Insured and Owner.)*

Name (First, MI, Last): _____ Relationship to Proposed Insured:_____

Mailing Address:_____

Street Address (If Mailing Address is a PO BOX): _____

Bank Information

Name of Financial Institution: _____

☐ Checking ☐ Savings Routing Number:_____ Account Number: _____

Notes:

AMERICO

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Replacement Information

IMPORTANT NOTE: *Internal Replacements are not allowed and External Replacements can only be completed using the eApplication.*

1. Is there any existing life insurance or annuity coverage on the life of any proposed Insured? *If Yes, provide the information below.*

Proposed Insured's Name (First, MI, Last)	Company	Owner (First, MI, Last)	Amount	Accidental Death Benefit	Policy Date

2. Will the life insurance applied for replace, or otherwise reduce in value any existing life insurance or annuity now in force?

Proposed Insured Health Information

Any **YES** answer to questions 4 - 11 will disqualify your client from receiving an Eagle Premier Policy.

1. Have You used any nicotine products (including, but not limited to, cigarettes, cigars, pipes, chewing tobacco, snuff, alternative nicotine delivery devices such as nicotine chewing gum or lozenges, nicotine patches or e-cigarettes or any device used for the vaporization of liquid nicotine) within the last 12 months?
2. Height?
3. Weight?
4. Have You ever been diagnosed, treated, tested positive, or been given medical advice, or prescribed medication by a licensed member of the medical profession for:
   a. Alzheimer's disease, dementia, memory loss, muscular dystrophy, or ALS (Lou Gehrig's disease)?
   b. Congestive heart failure, defibrillator placement, cardiomyopathy, chronic kidney disease or kidney failure, or received kidney dialysis?
   c. Cirrhosis of the liver, Hepatitis (all forms, excluding recovered Hepatitis A), or liver failure?
   d. Emphysema, chronic obstructive pulmonary disease (COPD), or any other chronic respiratory or lung problem, excluding allergies or asthma?
   e. Metastatic cancer (cancer that has spread to other parts of the body)?
   f. Two or more occurrences of cancer of any kind or a reoccurrence of a previous cancer?
   g. AIDS, ARC, or HIV?
5. In the past 24 months, have You been diagnosed, treated, tested positive, or been given medical advice by a licensed member of the medical profession for:
   a. Internal cancer, brain tumor, or malignant melanoma (excluding basal cell skin cancer)?
   b. Complications of diabetes, including amputation, retinopathy (eye disease), nephropathy (kidney disease), neuropathy, insulin shock, or diabetic coma?
6. In the past 24 months, have You been diagnosed, treated, tested positive, received medical advice, counseling, or been prescribed medication by a licensed member of the medical profession for drug or alcohol abuse/dependency or addiction?
7. Within the last 12 months, have You been advised, by a licensed member of the medical profession, to have tests, surgery or hospitalization (except for those related to HIV or AIDS), which have not been completed, or are You waiting for a medical diagnosis or results of medical tests or procedures which have not been received?
8. In the past 12 months, have You been diagnosed, treated, tested positive, been given medical advice or prescribed medication by a licensed member of the medical profession for:
   a. Angioplasty (balloon procedure), stent placement, or heart bypass surgery?
   b. Stroke; heart attack, heart valve disease, coronary disease, angina (chest pain), or heart disorder (excluding hypertension)?
9. Have You received advice from a licensed member of the medical profession to have, are You waiting for, or have You ever received, an organ or tissue transplant?
10. Are You now or within the past 6 months have you been:
    a. Hospitalized for 48 hours or more, bedridden or confined to or living in a nursing facility or correctional facility?
    b. Receiving or been advised by a member of the medical profession to receive hospice care?
    c. Receiving home health care for a chronic or debilitating condition?
    d. Receiving assistance with activities of daily living, including eating, bathing, toileting, or dressing due to a chronic or debilitating condition?
    e. Confined to a wheelchair or using a walker for assistance (except in the case of a temporary condition immediately following injury or medical treatment) not to exceed 3 months' time?
    f. Using oxygen to assist in breathing?
11. Have You been diagnosed with a terminal illness that is expected to result in death within 24 months?