HMS® *plus* Application Packet

Agents: When filling out applications, be sure to include your client's email address. This will allow us to better service your clients' policies.

Forms included in this packet:

- Application (Series 5146)
- HMS Plus ADB w/ROP Disclosure (18-010-1) – *Required when applying for HMS Plus ADB w/ROP. Not available in all states. See www.americo.com for updated state availability.*
- HMS Plus w/ADB Disclosure (11-149-9) – *Required when applying for HMS Plus w/ADB. Not available in Washington.*
- Accelerated Death Benefit Rider Disclosure (Series 8604) – *Required for all products except HMS Plus w/ADB, HMS Plus ADB w/ROP, and HMS Plus Payment Protector. Applicant's Acknowledgment must be signed and submitted with the application.*
- Consumer Disclosure and Authorization (Series 8480) – *Must be signed and submitted with the application.*

Additional forms that may be required:

These forms can be ordered or downloaded from Americo.com.

- **Supplemental Applications** – *Refer to Americo.com for additional information. State variations apply.*
- **Replacement Forms** – *Required in applicable states when replacing an existing life insurance policy or annuity contract. Important Note: States may require a completed replacement form even when an existing policy or contract is not being replaced. Refer to Americo.com for additional information. State variations apply.*
- **Buyer's Guide** – *Required in New Hampshire, Washington, and Wisconsin. Must be left with the applicant.*
- **Supplemental Summary (CTX8214)** – *Required in Texas for the 5-year guarantee periods for HMS Plus 125 and HMS Plus 100.*
- **HIV Consent Forms** – *May be required in applicable states due to underwriting. State variations apply.*
- **Transfer Funds Form** – *Required when transferring funds from another financial institution to Americo.*

Important Product Notes:

New Mexico: *The 15-year no-lapse guarantee period is not available for HMS Plus 100 CBO.*
Oregon: *The 15-year no-lapse guarantee period is not available for HMS Plus CBO products.*
Texas: *The 15-year no-lapse guarantee period is not available for HMS Plus CBO products.*

For additional information, contact Agent Services at 800.231.0801 or log on to www.americo.com.

AMERICO®

Application/Document
Transmittal Form AFSFAX2002 (01/16)

AMERICO

Your application(s)/document(s) can be submitted through the following methods:

- Toll Free Fax Numbers:
  800.395.9261, 800.395.9238, or 877.388.3448
- E-mail: submit@americo.com
- Web Upload: www.americo.com

If this form is completed and used as your cover sheet for a new policy application, you will receive a confirmation message with the policy number by fax or e-mail. Confirmation will be delivered the same day if the application is received by 5 p.m. CST/CDT or the next business day if received after 5 p.m. CST/CDT. If you have any questions or need assistance with the submission process, please feel free to call the Agent Contact Center at 800.231.0801.

When submitting applications via web upload or e-mail, please note that the maximum file size we can accept is 25MB. In addition, we accept the following file types: PDF, TIFF, or JPEG.

PLEASE PRINT LEGIBLY

Agent / Agency Name:	Agent / Agency Phone Number:	Total No. of Pages Sent:
Fax Number and/or Email Address to Send Confirmation to:	Agent Code:	

Policy Number (if Applicable)	Applicant / Insured Name	Notes

Application for Simplified Issue

Individual Life Insurance ICC15 5146

AMERICO

Americo Financial Life and Annuity Insurance Company

You are completing an application for life insurance. It is important that you understand each question below and answer them truthfully. The statements and answers you provide in the application are the basis for any policy issued by the Company. By providing answers and statements to the questions, you represent and warrant that you fully understand all questions asked. Consistent with state laws, any false answers may serve as a basis for denial of a claim and/or rescission of your policy. Any person who knowingly presents a false statement in an application for insurance may be found guilty of a criminal offense and subject to penalties under state law.

SECTION 1. PROPOSED INSURED INFORMATION

1. Proposed Insured's Name *(Last, First, MI)*

2. ☐ Single ☐ Married

3. ☐ Male ☐ Female

4. a. Height: _____' _____"
   b. Weight: _____ lbs.

5. Mailing Address *(Include City, State, and ZIP. If mailing address is a PO Box, a street address is also required.)*

6. Street Address *(Include City, State, and ZIP)*

7. How long at current address? _____ If less than 5 years at current address, prior address is required.

8. Phone Number: ☐ Home ☐ Cell ☐ Work

9. Email Address

10. Social Security Number

11. Date of Birth *(MM/DD/YYYY)*

12. Age

13. Place of Birth *(State, Country)*

14. Is the Proposed Insured a U.S. Citizen? *(If **No**, complete the Foreign National and Foreign Travel Questionnaire.)* ☐ Yes ☐ No

15. Is the Proposed Insured currently employed? ☐ Yes ☐ No

16. Employer

17. Occupation

18. Annual Salary

19. Description of Job Duties

SECTION 2. PRODUCT INFORMATION *(Verify that the product is available in the state where the application is being signed.)*

1. ☐ HMS Plus 125 ☐ HMS Plus 125 CBO ☐ HMS Plus Payment Protector ☐ HMS Plus w/ADB *(if selected, skip 2 & 3)*
   Base Face Amount: $1,000 ADB Rider: $_____
   ☐ HMS Plus 100 ☐ HMS Plus 100 CBO ☐ Other: _____ ☐ HMS Plus ADB w/ROP *(if selected, skip 2 & 3)*
   Base Face Amount: $1,000 ADB Rider: $_____

2. Guarantee Periods *(Level Period/Guarantee Period)*
   ☐ 15/15 ☐ 20/20 ☐ 25/25 ☐ 30/30
   ☐ 15/5 ☐ 20/5 ☐ 25/5 ☐ 30/5
   ☐ To Age 70 (HMS Plus Payment Protector Only)
   ☐ Other: _____
   IMPORTANT NOTE: 5-Year Guarantee Periods are NOT available with the HMS Plus CBO UL or Payment Protector products.

3. Payment Information
   Face Amount $ _____
   Monthly Income*: $_____
   **HMS Plus Payment Protector only.*

4. Mode Premium $ _____
   Mode: ☐ Monthly Bank Draft ☐ Annually

5. Effective Date *(If not checked, will be "Issue Date". Date cannot be the 29th, 30th, or 31st of the month.)*
   ☐ Issue Date
   ☐ Save Age of _____
   ☐ Specific Date _____

SECTION 3. RIDERS *(Verify rider availability. Riders are not available in all states or with all products. Please refer to your Agent Guide.)*

1. ☐ Accidental Death Benefit *(Payment Protector only)*: ☐ $10,000 ☐ $25,000
2. ☐ Additional Insured Term Insurance*.....$ _____
3. ☐ Children's Term* .....$ _____
4. ☐ Waiver of Premium
5. ☐ Disability Income*
   ☐ Primary Insured ☐ 1 Year ☐ 2 Year $ _____
   ☐ Additional Insured ☐ 1 Year ☐ 2 Year $ _____
6. ☐ Monthly Income Death Benefit: $ _____
   Income Period: ☐ 15 ☐ 20 ☐ 25 ☐ 30 ☐ To Age 70
7. ☐ Other _____

*Additional Insured, Children's Term, and Disability Income riders require supplemental applications.

SECTION 4. BENEFICIARY INFORMATION *(Include percentage shares. If shares are not given, they will be equal.)*

If not specified, all beneficiaries will be Primary.	Name	Social Security Number or Taxpayer ID	Relationship	Date of Birth	Phone Number	Email	% of Share *(Must total 100%)*
☐ Primary							
☐ Primary ☐ Contingent							
☐ Primary ☐ Contingent							
☐ Primary ☐ Contingent							
☐ Primary ☐ Contingent							
☐ Primary ☐ Contingent							

SECTION 5. LIFE INSURANCE IN FORCE AND REPLACEMENT INFORMATION

Include information for Proposed Insured and Additional Proposed Insured, if applicable.

1. Does any Proposed Insured have life insurance applications pending with other companies? *If **Yes**, provide details below.* ..... ☐ Yes ☐ No

Insured's Name	Insurance Type	Face Amount	Company	Paramed Exam/Fluids Required	App Signed Date *(mo/yr)*
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	

2. Is there any existing life insurance or annuity coverage on the life of any Proposed Insured? *If **Yes**, provide details below, including whether the life insurance applied for will replace or otherwise reduce in value any existing life insurance or annuity in force.* ..... ☐ Yes ☐ No

Insured's Name	Company	Owner's Name	Date *(mo/yr)*	Face Amount	Accidental Death Benefit	
						☐ Internal ☐ External ☐ Replacement
						☐ Internal ☐ External ☐ Replacement
						☐ Internal ☐ External ☐ Replacement

Complete the replacement form(s) in accordance with applicable state replacement regulation. **Replacement forms must be completed and signed on the same day, and submitted with the application.**

If an internal replacement, include a Surrender Form or Absolute Assignment form for the life insurance or annuity being replaced.

SECTION 6. OWNER INFORMATION *(If different from the Proposed Insured.)*

1. Owner's Name *(Last, First, MI)*	2. Relationship to Proposed Insured	3. SSN or Taxpayer ID

4. Mailing Address *(Include City, State, and ZIP. If mailing address is a PO Box, a street address is also required.)*

5. Street Address *(Include City, State, and ZIP)*

6. How long at current address? _____ If less than 5 years at current address, prior address is required.

7. Phone Number: ☐ Home ☐ Cell ☐ Work	8. Email Address	9. Date of Birth *(MM/DD/YYYY)*	10. Place of Birth *(State, Country)*

SECTION 7. MEDICAL HISTORY

If you are applying for HMS Plus w/ADB or HMS Plus ADB w/ROP, do not answer questions 1-13. | **Yes** | **No**

1. a. During the last 24 months, which of the statements below describes your Nicotine use *(check all that apply)*:
   - ☐ Occasional use of nicotine products ☐ Less than 10 cigarettes per day ☐ More than 10 cigarettes per day
   - ☐ Other nicotine products such as cigars, pipes, chewing tobacco, snuff, and alternative nicotine delivery devices such as nicotine chewing gum, nicotine patches, or electronic cigarettes
   - ☐ No nicotine products

   b. If you are not a current nicotine user, have you used any nicotine products in the past? ☐ ☐

   If **Yes**, what was your last date of use? _____

*If you answer **Yes** to questions 2 a.-b. or 3 a.-j. (below), you will not be eligible for coverage under this application; however, coverage may be available under a different Americo life insurance plan.*

	Yes	No
2. Have you ever been:		
a. Diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)?	☐	☐
b. Diagnosed or treated by a member of the medical profession for specified symptoms such as: immune deficiency, recurrent fever, unexplained weight loss, fever of unknown origin, severe night sweats, unexplained infections or skin lesions, unexplained swelling of the lymph glands, Kaposi's Sarcoma, or *Pneumocystis Carinii* Pneumonia?	☐	☐
3. Have you ever (1) been diagnosed with, or (2) received care or treatment, or (3) been advised by a member of the medical profession to seek treatment for, or (4) consulted with a health care provider regarding:		
a. Coronary Artery Disease, Heart Attack, Coronary Artery Bypass Surgery, Angioplasty, Stent Placement, Valvular Heart Disease, Cardiomyopathy, Congestive Heart Failure, Congenital Heart Disease, Stroke, Transient Ischemic Attack (TIA)/Mini Stroke, abnormal heart rhythm, Cerebral, Aortic or Thoracic Aneurysm, or Abdominal Aortic Aneurysm?	☐	☐
b. Chronic Lung Disease (except Asthma), including Chronic Obstructive Pulmonary Disease (COPD), Chronic Bronchitis, Emphysema, Sarcoidosis, or Cystic Fibrosis?	☐	☐
c. Major Depression, Bipolar Depression, Schizophrenia, Alzheimer's Disease, Dementia, Down Syndrome, Autism, mental incapacity, suicide attempt, or any other disease of the central nervous system?	☐	☐
d. Chronic Kidney Disease, End-Stage Renal Disease, Renal Insufficiency, or any condition within the last 5 years that required dialysis?	☐	☐
e. Parkinson's disease, Sickle Cell Anemia, Lou Gehrig's Disease (ALS), Muscular Dystrophy, Demyelinating Disease including Multiple Sclerosis, Huntington's Disease, Hydrocephalus, Quadriplegia, or Paraplegia?	☐	☐
f. ☐ Liver Disease, ☐ Cirrhosis, ☐ Hepatitis B or ☐ Hepatitis C, ☐ Crohn's Disease, or ☐ Ulcerative Colitis?	☐	☐
g. Cancer, Leukemia, Melanoma, any tumor (benign or malignant) of the brain, or any other cancer (except basal cell cancer)?	☐	☐
h. Rheumatoid Arthritis, Systemic Lupus, or Scleroderma?	☐	☐
i. An organ transplant?	☐	☐
j. Diabetes requiring insulin in any form or with complications such as Retinopathy (eye), Nephropathy (kidney), Neuropathy (nerve), or Peripheral Vascular Disease (PVD or PAD)?	☐	☐

	Yes	No
4. Do you currently have a primary care physician? *(If **Yes**, provide details below.)*	☐	☐

Name:_____ Phone Number:_____

Address:_____ Last Appointment:_____

5. Have you ever (1) been diagnosed with, or (2) received care or treatment for, or (3) been advised by a member of the medical profession to seek treatment for Diabetes? *(If **Yes**, complete questions below.)* ☐ ☐

   a. What was the original diagnosis date? _____

   b. Is physician different than your primary care physician? *(If **Yes**, provide details below.)* ☐ Yes ☐ No

Name:_____ Phone Number:_____

Address:_____ Last Appointment:_____

   c. Are you being treated with prescription medication(s)? *(If **Yes**, list any prescription medication for Diabetes.)* ☐ Yes ☐ No

Rx:_____	Dosage:_____	Frequency:_____	Rx:_____	Dosage:_____	Frequency:_____
Rx:_____	Dosage:_____	Frequency:_____	Rx:_____	Dosage:_____	Frequency:_____
Rx:_____	Dosage:_____	Frequency:_____	Rx:_____	Dosage:_____	Frequency:_____

   d. What was your most recent fasting blood sugar reading or A1c and the date it was recorded?_____ Date: _____

MEDICAL HISTORY CONTINUED **Yes** **No**

6. Have you ever (1) been diagnosed with, or (2) received care or treatment for, or (3) been advised by a member of the medical profession to seek treatment for Hypertension (High Blood Pressure)? *(If **Yes**, complete questions below.)* ☐ ☐

   a. What was the original diagnosis date? _____

   b. Is physician different than your primary care physician? *(If **Yes**, provide details below.)* ☐ Yes ☐ No

   Name:_____ Phone Number:_____

   Address:_____ Last Appointment:_____

   c. Are you being treated with prescription medication(s)? *(If **Yes**, list any prescription medication for Hypertension.)* ☐ Yes ☐ No

   Rx:_____ Dosage:_____ Frequency:_____ | Rx:_____ Dosage: _____ Frequency: _____

   Rx:_____ Dosage:_____ Frequency:_____ | Rx:_____ Dosage: _____ Frequency: _____

   Rx:_____ Dosage:_____ Frequency:_____ | Rx:_____ Dosage: _____ Frequency: _____

   d. What was the most recent blood pressure reading and the date it was recorded?.....Systolic:_____ Diastolic: _____ Date: _____

7. In the past 5 years, have you had or been advised by a member of the medical profession to have an echocardiogram, stress test, or cardiology or nephrology consultation due to symptoms? *(If **Yes**, provide details below.)* ☐ ☐

   Test/Consultation Date:_____ Results: _____

   Medical Professional Name:_____ Phone Number:_____

   Address: _____

8. In the past 5 years, have you ever (1) been diagnosed with, or (2) received care or treatment for, or (3) been advised by a member of the medical profession to seek treatment for Epilepsy or Seizure Disorder? *(If **Yes**, complete questions below.)* ☐ ☐

   a. What was the original diagnosis date? _____

   b. Is physician different than your primary care physician? *(If **Yes**, provide details below.)* ☐ Yes ☐ No

   Name:_____ Phone Number:_____

   Address:_____ Last Appointment:_____

9. In the past five (5) years, have you ever (1) been diagnosed with, or (2) received care or treatment, or (3) been advised by a member of the medical profession to seek treatment for, or (4) consulted with a health care provider regarding:

   a. Mild or Situational Depression or Anxiety? *(If **Yes**, complete questions below.)* ☐ ☐

      i. What was the original diagnosis date? _____

      ii. Is physician different than your primary care physician? *(If **Yes**, provide details below.)* ☐ Yes ☐ No

      Name: _____ Phone Number:_____

      Address: _____ Last Appointment Date: _____

      iii. Has this condition:

      (a) Required treatment with prescription medication(s)? *(If **Yes**, list any prescription medication for Mild Depression or Anxiety.)* ☐ Yes ☐ No

      Rx:_____ Dosage:_____ Frequency:_____ | Rx: _____ Dosage: _____ Frequency: _____

      Rx:_____ Dosage:_____ Frequency:_____ | Rx: _____ Dosage: _____ Frequency: _____

      Rx:_____ Dosage:_____ Frequency:_____ | Rx: _____ Dosage: _____ Frequency: _____

      (b) Required in-patient hospitalization? *If **Yes**, provide date:* _____ ☐ Yes ☐ No

      (c) Caused inability to work due to this condition? *If **Yes**, provide date:* _____ ☐ Yes ☐ No

   b. Asthma? *(If **Yes**, complete questions below.)* ☐ ☐

      i. What was the original diagnosis date? _____

      ii. Is physician different than your primary care physician? *(If **Yes**, provide details below.)* ☐ Yes ☐ No

      Name: _____ Phone Number:_____

      Address: _____ Last Appointment Date: _____

      iii. Does this condition:

      (a) Require daily medication to control? *(If **Yes**, list any prescription medication for Asthma.)* ☐ Yes ☐ No

      Rx:_____ Dosage:_____ Frequency:_____ | Rx: _____ Dosage: _____ Frequency: _____

      Rx:_____ Dosage:_____ Frequency:_____ | Rx: _____ Dosage: _____ Frequency: _____

      Rx:_____ Dosage:_____ Frequency:_____ | Rx: _____ Dosage: _____ Frequency: _____

      (b) Require steroid medication? *(If **Yes**, list any steroid medication for Asthma.)* ☐ Yes ☐ No

      Rx:_____ Dosage:_____ Frequency:_____ | Rx: _____ Dosage: _____ Frequency: _____

      Rx:_____ Dosage:_____ Frequency:_____ | Rx: _____ Dosage: _____ Frequency: _____

      Rx:_____ Dosage:_____ Frequency:_____ | Rx: _____ Dosage: _____ Frequency: _____

      iv. Has this condition required hospitalization or Emergency Department visits? *If **Yes**, provide date:* _____ ☐ Yes ☐ No

MEDICAL HISTORY CONTINUED **Yes** **No**

c. Sleep Apnea? *(If **Yes**, complete questions below.)* ☐ ☐

i. What was the original diagnosis date? _____

ii. Is physician different than your primary care physician? *(If **Yes**, provide details below.)* ☐ Yes ☐ No

Name: _____ Phone Number: _____

Address: _____ Last Appointment Date: _____

iii. Do you use CPAP or BIPAP for treatment of sleep apnea nightly, or as prescribed by your physician? ☐ Yes ☐ No

iv. Have you been advised by a member of the medical profession that your treatment has been successful in controlling your symptoms? ☐ Yes ☐ No

d. Psoriatic or other Inflammatory Arthritis? *(If **Yes**, complete questions below.)* ☐ ☐

i. What was the original diagnosis date? _____

ii. Is physician different than your primary care physician? *(If **Yes**, provide details below.)* ☐ Yes ☐ No

Name: _____ Phone Number: _____

Address: _____ Last Appointment Date: _____

iii. How many joints are involved? ☐ Less than 6 ☐ 6 or more

e. Any disease or disorder of the Bones or Muscles? *(If **Yes**, complete questions below.)* ☐ ☐

i. What was the original diagnosis date? _____

ii. Is physician different than your primary care physician? *(If **Yes**, provide details below.)* ☐ Yes ☐ No

Name: _____ Phone Number: _____

Address: _____ Last Appointment Date: _____

iii. Have you had surgery for any disorder of your bones or muscles? ☐ Yes ☐ No

*(If **Yes**, provide date and muscle or bone impacted.)* Date: _____ Muscle/bone: _____

If **Yes**, have you been released by your physician to return to normal activities and have all necessary follow-ups been completed? ☐ Yes ☐ No

10. In the past 12 months, have you been prescribed or have you taken prescription pain medication? *(If **Yes**, list prescription details below.)* ☐ ☐

Rx: _____ Dosage: _____ Frequency: _____ Date: _____ Reason: _____

Rx: _____ Dosage: _____ Frequency: _____ Date: _____ Reason: _____

Rx: _____ Dosage: _____ Frequency: _____ Date: _____ Reason: _____

11. In the past 12 months, other than for wellness visits, minor injuries, or illnesses for which a medical professional has deemed you fully recovered and requiring no further treatment or follow-up, have you consulted any member of the medical profession not already identified for any reason? *(If **Yes**, complete Medical History Details below.)* ☐ ☐

12. Are you, at the time of this application, confined to any hospital or other medical facility? *(If **Yes**, complete Medical History Details below.)* ☐ ☐

13. In the past 12 months, have you had or had recommended by a member of the medical profession, but not yet completed, any surgery, treatment or hospitalization? *(If **Yes**, complete Medical History Details below.)* ☐ ☐

SECTION 8. MEDICAL HISTORY DETAILS

Please provide details of all "Yes" answers to questions 11, 12, and 13 in the area below. *(Attach an Application Addendum if more space is needed in order to avoid amendments.)*

Question #	Date of Diagnosis or Onset of Treatment	Medical Diagnosis	Name, Address, and Telephone Number of Attending Physician or Medical Facility		Date of Last Visit
			Name:		
			Address:		
			Telephone:		

Details, including medications prescribed, and results of last visit.

			Name:		
			Address:		
			Telephone:		

Details, including medications prescribed, and results of last visit.

			Name:		
			Address:		
			Telephone:		

Details, including medications prescribed, and results of last visit.

SECTION 9. PERSONAL HISTORY

- Personal History questions are required for all products.
- Provide details of all "Yes" answers in the Personal History Details section below.

	Yes	No
1. Have you ever been declined, rated, or modified for life or health insurance?	☐	☐
2. Have you currently, or within the last 12 months, used any of the following: walker, wheelchair, electric scooter, oxygen, or catheter?	☐	☐
3. Within the past 2 years, have you made any flights as a pilot or student pilot? *(If **Yes**, complete Aviation Questionnaire.)*	☐	☐
4. In the next 2 years do you intend to engage in any motor sports racing; boat racing; parachuting/skydiving; hang gliding; base jumping; rock or mountain climbing; cave diving, underwater photography, canyoning, or Scuba diving over 100 ft.?	☐	☐
5. Within the past 10 years, have you been convicted of, or are you currently awaiting trial for, any felony?	☐	☐
6. Are you currently on or have you been released from probation, parole, or other court ordered supervision with the last 2 years?	☐	☐
7. Within the next 2 years, do you intend to work, travel, or reside outside of the United States for more than 30 days? *(If **Yes**, complete the Foreign National and Foreign Travel Questionnaire.)*	☐	☐
8. In the past 10 years, have you:		
a. Used heroin, morphine, other narcotics, ecstasy, opium derivatives, marijuana, cocaine, crack, barbiturates, amphetamines, methamphetamines, or hallucinogens or any other illegal, restricted or controlled substances; or been treated or been advised by a member of the medical profession to seek treatment for the intake of any drug?	☐	☐
b. Used alcohol to a degree that required treatment or been advised to limit or discontinue its use by a member of the medical profession?	☐	☐
c. Used or been convicted of possession of unlawful drugs or used prescription drugs other than as prescribed in any form?	☐	☐
9. Do you currently hold a valid driver's license? *(If **Yes**, provide information below. If **No**, provide details in Section 10. Personal History Details.)*	☐	☐

Name on Driver's License	Driver's License Number	State Issued

10. Within the past 5 years, have you been convicted, pled guilty, or entered into a plea agreement for driving under the influence of drugs or alcohol or reckless driving, or had 3 or more moving violations or had your driver's license suspended or revoked? ☐ ☐

*If **Yes**, provide license information below if different than current license and provide details of Yes answer under Section 10 Personal History Details (below).*

Name on Driver's License	Driver's License Number (if known)	State Issued

SECTION 10. PERSONAL HISTORY DETAILS

Question #	Date	Details

SECTION 11. SPECIAL REQUESTS

SECTION 12. AUTHORIZATION AND ACKNOWLEDGMENT

IMPORTANT FRAUD NOTICE: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

REQUEST FOR OWNER(S) TAXPAYER IDENTIFICATION NUMBER AND W-9 CERTIFICATION: Under penalties of perjury, I as the Owner certify that:

1. **I am a U.S. citizen or other U.S. person, and the number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and,**
2. **I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding.**

CERTIFICATION INSTRUCTIONS: You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return.

By providing Your Authorization and Acknowledgment, You:

- **AGREE** any policy issued on this application will be deemed to be delivered in and governed by the laws of the jurisdiction where the Owner resides at the time of the application, as evidence by the address provided in this application.
- **ACKNOWLEDGE** that the USA PATRIOT ACT requires all financial institutions, including insurance companies, to verify the identity of their customers. Providing your name, address, date of birth and taxpayer identification number allows Americo to verify your identity. Americo's verification process may include the use of third-party sources to verify the information you provide.
- **AUTHORIZE** Americo to act on electronic and/or telephonic information from all parties specified in this application. This authorization may be revoked by sending written notice to Americo at its administrative office address. The absence of this authorization constitutes a rejection of this authorization.

You furthermore Agree to the following:

- The answers and statements in the application for insurance are the basis for any policy issued by Americo and no information will be considered to have been given to Americo unless it is stated in the application.
- Your sales representative does not have Americo's authorization to waive the answer to any question in this application, nor decide on the insurability, nor waive any of the company's underwriting requirements, nor change any contract.
- All answers and statements in this application for insurance, as they pertain to You, are true and complete to the best of Your knowledge and belief.

Signed at (City and State)_____ on (Month/Day/Year) _____

_____ _____

Signature of Proposed Insured *(required)* Signature of Owner (*if different than the Proposed Insured)*

_____ _____

Printed Name of Witnessing Agent *(required)* Signature of Witnessing Agent *(required)*

Disclosure for

HMS Plus ADB with Return of Premium

18-010-1 (01/18)

AMERICO

This signed Disclosure must be completed and returned when applying for:

HMS Plus ADB w/ROP

HMS Plus ADB w/ROP provides the following benefits:

- Subject to policy provisions, the Term Life policy pays $1,000 if the Insured dies for any reason*.
- The Accidental Death Benefit Rider will pay, in addition to the Term Life Insurance Policy death benefit, if the Insured dies from a bodily injury which is a direct result of an accident within 90 days (180 days in Oregon and Utah) of the injury.
- The amount of the Accidental Death Benefit Rider is selected at time of application and will be included on the Policy Data Page of your issued policy.

ACKNOWLEDGMENT

I, the undersigned Insured (and Policy Owner, if other than the Insured) acknowledge that I have read this Disclosure and I understand the above-stated benefits and will consult the policy and riders form for all other terms, limitations and exclusions.

Signed at (State) _____ on (Month/Day/Year) _____

_____ Signature of Proposed Insured *(required)*

_____ Signature of Owner *(if different than the Proposed Insured)*

*This Policy is designed to be life insurance for federal income tax purposes under Section 7702. In some circumstances, the cash value may cause the Policy's Death Benefit to be increased so that the policy will continue to qualify as life insurance. Neither Americo Financial Life and Annuity Insurance Company nor any agent representing Americo Financial Life and Annuity Insurance Company is authorized to give legal or tax advice. Please consult a qualified professional regarding the information and concepts contained in this material.

HMS Plus ADB w/ROP (Policy Series 310) and Accidental Death Benefit Rider (Rider Series 2200) are underwritten by Americo Financial Life and Annuity Insurance Company (Americo), Kansas City, MO, and may vary in accordance with state laws. Products and benefits may not be available in all states. Certain restrictions apply. Consult policy and rider for all terms, exclusions, and limitations, as well as to determine what constitutes accidental death.

Disclosure for
HMS Plus
with Accidental Death Benefit

AMERICO

This signed Disclosure must be completed and returned when applying for:

HMS Plus w/ADB

The features and benefits of term and/or universal life insurance have been presented to me by my agent. I understand that I had the opportunity to apply for a policy that offers a higher death benefit payable upon the death of the insured for any reason.

HMS Plus w/ADB offers term life insurance with an Accidental Death Benefit Rider. It provides the following benefits:

- Subject to policy provisions, the Term Life policy will pay **$1,000** if the insured dies for any reason.
- The Accidental Death Benefit Rider will pay, in addition to the Term Life policy, if the insured dies from a bodily injury which is a direct result of an accident within 180 days of the injury.
- The Common Carrier Accidental Death Benefit will pay, in addition to the Term Life policy and the Accidental Death Benefit, only if the insured dies from a bodily injury which is a direct result of an accident while riding as a fare-paying passenger in a Common Carrier. The Common Carrier benefit equals the Accidental Death Benefit Rider amount.
- The amount of the Accidental Death Benefit Rider is selected upon application and will be included on the Policy Data Page of your issued policy.

ACKNOWLEDGMENT

I, the undersigned Insured (and Policy Owner, if other than the Insured), acknowledge that I have read this Disclosure. I understand the above-stated benefits and will consult the policy and rider forms for all other terms, limitations, and exclusions.

Signed at (City and State) _____ on (Month/Day/Year) _____

_____ _____

Signature of Proposed Insured *(required)* Signature of Owner *(if different than Proposed Insured)*

HMS Plus w/ADB (Policy Series 301) and Accidental Death Benefit Rider (Rider Series 2165) are offered on a group or individual basis depending on the state and are underwritten by Americo Financial Life and Annuity Insurance Company (Americo), Kansas City, MO, and may vary in accordance with state laws. Products and benefits may not be available in all states. Certain restrictions apply. Consult policy and rider for all terms, exclusions, and limitations as well as to determine what constitutes accidental death.

Accelerated Death Benefit

Rider Disclosure

AAA8604

Americo Financial Life and Annuity Insurance Company

ACCELERATED DEATH BENEFITS DO NOT AND ARE NOT INTENDED TO QUALIFY AS LONG-TERM CARE INSURANCE.

This disclosure is a brief description of the HMS Plus Living Benefit Accelerated Death Benefit Riders. This disclosure is not an insurance contract, but only a summary of the coverage provided by these riders. **There is no premium charged for these riders.**

Accelerated Death Benefit payments, as described below are intended to qualify for favorable tax treatment under the Internal Revenue Code. However, the benefits received under any accelerated death benefit rider may be taxable and may adversely affect your eligibility for Medicaid or other government benefits or entitlements. You should consult your personal tax advisor regarding the tax treatment of accelerated death benefits. You should contact a qualified tax advisor or the applicable government agency such as the local State Medicaid Office for advice regarding eligibility for Medicaid or other government benefits or entitlements before requesting this benefit.

The accelerated death benefit is reduced by an actuarial discount rate and an administrative fee of $250.

A Full Acceleration of the death benefit will result in termination of the policy.

A Partial Acceleration of the death benefit will reduce the policy face amount with a pro rata reduction of your policy's cash value, if any and the policy premium will be based on the new face amount. Any request for Partial Acceleration must be at least $5,000 and the remaining policy face amount cannot be less than $20,000.

Living Benefit Riders available with HMS Plus*

Critical Illness Accelerated Death Benefit Rider *(Rider Series 2190)*
You may request an acceleration of your policy's death benefit if the insured is diagnosed with a **Critical Illness**. A **Critical Illness** is one or more of the following conditions: Amyotrophic Lateral Sclerosis (ALS/Lou Gehrig's Disease); End Stage Renal disease (Kidney Failure); invasive cancer; major organ failure; myocardial infarction (heart attack); stroke.

A full or partial accelerated death benefit is available under this rider. A partial acceleration for a **Critical Illness** may only be requested once every 12 months.

Chronic Illness Accelerated Death Benefit Rider *(Rider Series 2191)*
You may request an acceleration of your policy's death benefit if the insured is diagnosed with a **Chronic Illness**. A **Chronic Illness** means that within the last 12 months, a physician has certified that for a continuous period of at least 90 days, the insured is unable to perform at least 2 activities of daily living or requires substantial supervision to protect themselves due to severe cognitive impairment.

Each requested acceleration may not exceed the per diem allowance permitted by section 101(g)(3) of the Internal Revenue Code. The per diem allowance is annualized to determine the maximum lump sum amount payable every 12 months. The Internal Revenue announces the per diem limit for each calendar year.

A full or partial accelerated death benefit is available under this rider. A partial acceleration for a **Chronic Illness** may only be requested once every 12 months.

Terminal Illness Accelerated Death Benefit Rider *(Rider Series 2192)*
You may request an acceleration of your policy's death benefit if the insured is diagnosed with a **Terminal Illness.** A Terminal Illness is a medical condition that is reasonably expected to result in the insured's death within 12 months or less.

A full or partial accelerated death benefit is available under this rider. A partial acceleration for Terminal Illness may only be elected one time. If you elect a partial acceleration for Terminal Illness Accelerated Death Benefit, the accelerated death benefits for Critical Illness or Chronic Illness are no longer available.

Living Benefit Riders available with HMS Plus CBO†

Critical Illness Accelerated Death Benefit Rider *(Rider Series 2195)*
You may request an acceleration of your policy's death benefit if the insured is diagnosed with a **Critical Illness**. A **Critical Illness** is one or more of the following conditions: Amyotrophic Lateral Sclerosis (ALS/Lou Gehrig's Disease); End Stage Renal disease (Kidney Failure); Life-threatening (invasive) cancer; major organ failure; myocardial infarction (heart attack); stroke.

Only a full acceleration of the policy's death benefit is available under this rider.

Chronic Illness Accelerated Death Benefit Rider *(Rider Series 2196)*
You may an acceleration of your policy's death benefit if the insured is diagnosed with a **Chronic Illness**. A **Chronic Illness** means that within the last 12 months, a physician has certified that for a continuous period of at least 90 days, the insured is unable to perform at least 2 activities of daily living or requires substantial supervision to protect themselves due to severe cognitive impairment.

Each requested acceleration may not exceed the per diem allowance permitted by section 101(g)(3) of the Internal Revenue Code. The per diem allowance is annualized to determine the maximum lump sum amount payable every 12 months. The Internal Revenue announces the per diem limit for each calendar year.

Only a full acceleration of the policy's death benefit is available under this rider.

Terminal Illness Accelerated Death Benefit Rider *(Rider Series 2197)*
You may request a full or partial acceleration of your policy's death benefit if the insured is diagnosed with a **Terminal Illness.** A **Terminal Illness** is a medical condition that is reasonably expected to result in the insured's death within 12 months or less.

Only a full acceleration of the Policy's death benefit is available under this rider.

**Rider Series 2190, 2191, and 2192 are issued automatically with term life insurance policy Series 300, 301, 302. †Rider Series 2195, 2196, and 2197 are issued automatically with universal life policy Series 295, 296, 297, 395, 396, and 397. Products may not be available in all states. Not available with HMS Plus ADB w/ROP or HMS Plus w/ADB.*

Accelerated Death Benefit Rider

Applicant's Acknowledgment

AAA8604

Americo Financial Life and Annuity Insurance Company

I acknowledge that I have read the Accelerated Death Benefit Rider Disclosure, have been given a copy of this Disclosure, and that the features of this product have been explained to me.

_____ _____

Owner's Signature Date

I acknowledge that I have reviewed this Rider Disclosure with the Owner.

_____ _____

Agent's Signature Date

Consumer Disclosure and
Health Information Authorization

AAA8480 (05/17)

Americo Financial Life and Annuity Insurance Company

MIB, INC. PRE-NOTICE

Information regarding your insurability will be treated as confidential. However, Americo Financial Life and Annuity Insurance Company or its reinsurers may make a brief report to the MIB, Inc. formerly known as Medical Information Bureau, a not-for-profit membership organization of life insurance companies operating as an information exchange for its members. If you apply to another MIB member company for life or health insurance or a claim is submitted to such a company, upon request the MIB will supply the company with the information it has in its file.

Upon receipt of a request from you, the MIB, Inc., will arrange disclosure of any information it has in your file. Please contact MIB at 866.692.6901. If you question the accuracy of information in the file, you may contact the MIB and seek a correction in accordance with the procedures in the Fair Credit Reporting Act. The MIB's information office address is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734. The Company and its reinsurers may release information in its file to its reinsurers and to other life and health insurance companies to whom you apply for insurance or to whom a claim is submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

MEDICAL INFORMATION AUTHORIZATION

Information regarding your insurability will be treated as confidential. Americo Financial Life and Annuity Insurance Company (Americo) is a member of MIB, Inc. (MIB). Americo, or its reinsurers, may make a brief report to MIB, which operates an information exchange on behalf of its members. If you apply to another member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB may supply such company with the information in its file. Americo or its reinsurers may also release information to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. It is Americo's practice to prohibit third parties who lawfully receive nonpublic health information from redisclosing or reusing the disclosed information. You may request to see the information kept in Your MIB file. You may also contact MIB and seek a correction for any errors in your file.

Your authorization permits any insurance or reinsurance company, licensed medical physician, medical professional, hospital, pharmacy or pharmacy benefit manager, records custodians, other medical or medically related facility, clearing house, consumer reporting agency, and/or MIB, Inc. that has any information about you, or anyone listed in this application who are proposed to be insured, to give Americo, its reinsurers or any MIB-authorized third-party administrator performing underwriting services on Americo's behalf, information about other insurance coverage, age, general character, habits, finances, motor vehicle records, medical care or advice about any physical or mental condition, including medications prescribed, chart notes, labs, x-rays and special tests, information on the diagnosis and treatment of Human Immunodeficiency Virus (HIV) infection, sexually transmitted diseases, and the use of drugs, alcohol, tobacco and psychotherapy notes and alcoholism, required by Americo to determine insurability and/or claims eligibility, for the duration of the claim. Health information obtained will not be re-disclosed without your authorization unless permitted by law, in which case it may not be protected under federal privacy rules.

You, may obtain a copy of this Medical Information Authorization on request. This authorization will be valid for 2 years from the date signed. This authorization may be revoked; however, it may not be revoked during the contestability period of the policy or to the extent Americo has taken action in reliance on this authorization. Notice of revocation must be sent, in writing, to Americo at its Administrative Office address.

I understand that the aforementioned parties requesting access to my (electronic or paper) medical records are acting as a patient authorized representative and will attempt to access my medical records in the most efficient manner possible, including electronic interchange through a Health Information Exchange or directly through My Providers' electronic health record system.

Name of Proposed Insured (please print)	Signature of Proposed Insured	Date
Name of Additional Proposed Insured (please print) (if applicable)	Signature of Additional Proposed Insured	Date

Signature of Child	Signature of Child	Signature of Child
Signature of Child	Signature of Child	Signature of Child

Signature of Parent/Legal Guardian

AGENT'S REPORT

Important Note: Agent's Report must be completed and submitted with all applications

Proposed Insured's Name: _____

1. Is the Agent related to the Proposed Insured(s)? ☐ Yes ☐ No If **Yes**, provide relationship: _____

2. How long has the Agent known the Proposed Insured(s)? ..... _____

Provide details of all Yes answers in the Agent Comments/Remarks section.

	Yes	No
3. Did the applicant approach you to purchase insurance? *If **Yes**, list their stated need for the insurance in the Agent Comments/Remarks section.*	☐	☐
4. Is there any existing life insurance or annuity coverage on the life of any Proposed Insured? *If **Yes**, answer question 5. If **No**, skip question 5.*	☐	☐
5. Will the life insurance applied for replace, or otherwise reduce in value, any existing life insurance or annuity now in force? *Complete replacement form(s) in accordance with applicable state replacement regulations. Provide copies of replacement form(s) to the Owner and the Company. Leave copies of sales materials with Owner. If you used an electronic sales presentation, you must mail a copy to the Owner.*	☐	☐
6. At the time the application was taken, were all of the Proposed Insured's present and did you witness their signatures?	☐	☐
7. Did the Proposed Insured(s) directly respond to you regarding each application question?	☐	☐
8. Was a government-issued picture ID requested, reviewed, and confirmed (by reviewing a second document, such as a utility bill, tax return, etc.) for the Proposed Insured, Owner, and Payor *(if different than the Proposed Insured)*?	☐	☐

ANY PAYMENT BY CHECK MUST BE MADE PAYABLE TO AMERICO FINANCIAL LIFE AND ANNUITY INSURANCE COMPANY. THE CHECK MUST NOT BE MADE PAYABLE TO THE AGENT/INSURANCE PRODUCER OR THE PAYEE MUST BE LEFT BLANK.

State Specific Questions.

9 Is this application being taken in the state of **CALIFORNIA**? *If **Yes,** and the Proposed Insured is 65 or older: Did you meet with the senior in his/her own residence? If **Yes**, form 03-185-1 CA must be completed 24 hours prior to the appointment. This form must be submitted with the application.*	☐	☐
10. Is this application being taken in the state of **FLORIDA**?	☐	☐
If **Yes**, do you authorize Americo to act on electronic and/or telephonic information specified in this application? *This authorization may be revoked by sending written notice to Americo at its administrative office address. The absence of this authorization constitutes rejection of this authorization.*	☐	☐

Agent Comments/Remarks:

I hereby certify that I have personally asked each question on this application to the Proposed Insured(s), the Proposed Insured(s) directly responded to each application question, all Proposed Insured(s) were present and I witnessed their signatures, a government-issued picture I.D. was requested, reviewed, and confirmed (by reviewing a second document such as a utility bill, tax return, etc.) for the Proposed Insured, Owner, and Payor (if different than the Proposed Insured) and that I have truly and accurately recorded on the application the information supplied by him/her, and that I have no reason to believe that any of the information provided is inaccurate or incomplete. If not, I have set forth my reservations in the Agent Comments/Remarks section above.

Agent Signature	Print Agent Name	Agent Phone Number	Agent Email Address	Americo Producer #	State License # (if required)	%

Does Americo have your current contact information? If not, email: submit@americo.com.

No Premium

Conditional Receipt

IMPORTANT NOTICE — PLEASE READ CAREFULLY!

NO INSURANCE WILL BE PROVIDED UNLESS ALL TERMS STATED BELOW ARE MET EXACTLY AND IN FULL! NO AGENT OR BROKER HAS THE AUTHORITY TO CHANGE OR WAIVE ANY OF THESE TERMS. NO INSURANCE PREMIUMS HAVE BEEN RECEIVED WITH THIS APPLICATION.

1. ALL OF THE FOLLOWING TERMS MUST BE MET EXACTLY AND IN FULL BEFORE COVERAGE WILL BEGIN:
   (A) Payment of the first full modal premium is received by the Company;
   (B) All medical examinations, X-rays, tests, physicians' statements and any other underwriting requirements of the Company must be received; and
   (C) The Proposed Insured in the application must be acceptable to the Company without change on the Effective Date under its rules for insurance (1) on the Plan applied for (2) in the amount and (3) in a premium class not less favorable than the premium class applied for and with no ratings.
2. **IF PREMIUM PAYMENT IS RECEIVED BY THE COMPANY AND ALL OF THE REQUIREMENTS IN (B) ABOVE ARE NOT RECEIVED BY THE COMPANY WITHIN THE FOLLOWING 60 DAYS, THE APPLICATION WILL BE VOID AND THE PREMIUM WILL BE RETURNED.**
3. **IF ANY PROPOSED INSURED DIES DURING THE PROCESSING OF THIS APPLICATION AND BEFORE ALL OF THE FOREGOING TERMS HAVE BEEN MET, NO INSURANCE COVERAGE WILL EXIST, AND THE COMPANY'S ONLY LIABILITY WILL BE TO REFUND PREMIUMS RECEIVED, IF ANY.**
4. If all requirements are met, the "Effective Date" will be the later of: (1) the date all of the above required information is received by the Company or (2) the date of issue.

Dated at _____ this _____ day of _____, _____.

_____ _____

Signature of Licensed Agent Signature of Applicant

THIS IMPORTANT NOTICE IS APPLICABLE IF NO PREMIUM IS RECEIVED WITH THE APPLICATION.

Premium

Conditional Receipt

THIS IS A CONDITIONAL RECEIPT — PLEASE READ CAREFULLY!

NO INSURANCE WILL BE PROVIDED BY YOUR FIRST PAYMENT UNLESS ALL TERMS IN PARAGRAPH "FIRST" ARE MET EXACTLY AND IN FULL! NO AGENT OR BROKER HAS THE AUTHORITY TO CHANGE OR WAIVE ANY OF THESE TERMS.

Received from _____ this _____ day of_____, _____ $ _____ by check, preauthorized order for withdrawal, or salary deduction plan. This payment is the amount of the first full modal premium for the policy applied for in the application for life insurance to Americo Financial Life and Annuity Insurance Company having the same number and date as this Conditional Receipt. This payment is made and accepted under the terms of this Conditional Receipt. This Conditional Receipt cannot be transferred. ANY PAYMENT BY CHECK MUST BE MADE PAYABLE TO AMERICO FINANCIAL LIFE AND ANNUITY INSURANCE COMPANY. DO NOT MAKE ANY CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK. If your check or draft is not honored when first presented for payment, this Conditional Receipt will not be valid.

FIRST: TERMS ALLOWING INSURANCE TO BECOME EFFECTIVE BEFORE POLICY DELIVERY: If ALL of the following terms are met exactly and in full, insurance under the terms of the policy applied for, if then being sold by the Company, will become effective on the Effective Date subject to the limitations in Paragraph "SECOND": (1) All representations made in the application must be true and complete in all material respects; (2) all medical examinations, X-rays, tests, physician's statements and any other underwriting requirements of the Company must be completed and received not later than 60 days from the date the application is signed; (3) all persons proposed for insurance in the application must be acceptable to the Company without change on the Effective Date under its rules for insurance (A) on the Plan applied for (B) in the amount and (C) in a premium class not less favorable than the premium class applied for and with no ratings; and (4) the amount shown above must be equal to at least the first full modal premium for insurance.

IF ANY PROPOSED INSURED DIES DURING THE PROCESSING OF THIS APPLICATION AND BEFORE ALL OF THE FOREGOING TERMS HAVE BEEN MET, NO INSURANCE COVERAGE WILL EXIST, AND THE COMPANY'S ONLY LIABILITY WILL BE TO REFUND PREMIUMS RECEIVED, IF ANY.

IF ALL OF THE TERMS ABOVE ARE NOT MET EXACTLY AND IN FULL, THE COMPANY'S ONLY LIABILITY WILL BE TO REFUND THE AMOUNT FOR WHICH THIS CONDITIONAL RECEIPT WAS GIVEN. "Effective Date" means the latest of: (1) the date the application is signed; (2) the date all required information is completed and received by the Company; and (3) the date of issue.

SECOND: LIMITS OF LIABILITY — MAXIMUM AMOUNT OF INSURANCE AND PERIOD OF TIME WHICH INSURANCE CAN BECOME EFFECTIVE BEFORE POLICY DELIVERY. The Company's liability for insurance under this Conditional Receipt plus all insurance which is in force or is pending in the Company on any Proposed Insured can never exceed $250,000 of life insurance including (a) Accidental Death Benefits, and (b) any coverage in force. The time for which the Company can be liable under this Conditional Receipt can never exceed a period of 60 days from the date this Receipt was signed.

Dated at _____ this _____ day of _____, _____.

_____ _____

Signature of Licensed Agent Signature of Applicant

If the application is not approved and accepted within 60 days from the date it was signed, the Company shall have no liability except for the return of this payment on surrender of this Receipt.

INFORMATION PRACTICES NOTICE
THIS NOTIFICATION MUST BE DELIVERED TO THE PROPOSED INSURED WHEN THE APPLICATION IS COMPLETED.

Thank you for your application. This notice is given to you at the time you apply for life insurance to tell you about the kinds of information we may obtain in connection with your application. We rely primarily on information provided by you. We may also collect information from others, such as medical professionals who have treated you, hospitals, other insurance companies, and consumer reporting agencies. In certain limited situations, we are allowed by law to disclose necessary items of personal information to third parties without your specific authorization. You have a right of access and correction with respect to this information. You have the right to receive, in writing, the specific reason for an adverse underwriting decision. If you wish a more detailed explanation of our information practices, please write us at: Americo Financial Life and Annuity Insurance Company, PO BOX 410288, Kansas City, MO 64141-0288, Attention: Underwriting/New Business Department. Any requests to correct, amend or alter will be responded to within 30 days. Information that is corrected will be provided to any person who is designated by the requesting party and who may have received the information in the prior two years (within a seven year timeframe). Any statement of disagreement made by a requesting party will be filed and made available to those reviewing it in the future.

MIB, INC. PRE-NOTICE

Information regarding your insurability will be treated as confidential. However, Americo Financial Life and Annuity Insurance Company or its reinsurers may make a brief report to the MIB, Inc. formerly known as Medical Information Bureau, a not-for-profit membership organization of life insurance companies operating as an information exchange for its members. If you apply to another MIB member company for life or health insurance or a claim is submitted to such a company, upon request the MIB will supply the company with the information it has in its file.

Upon receipt of a request from you, the MIB, Inc., will arrange disclosure of any information it has in your file. Please contact MIB at 866.692.6901. If you question the accuracy of information in the file, you may contact the MIB and seek a correction in accordance with the procedures in the Fair Credit Reporting Act. The MIB's information office address is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734. The Company or its reinsurers may release information in its file to its reinsurers and to other life and health insurance companies to whom you apply for insurance or to whom a claim is submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

INVESTIGATIVE CONSUMER REPORTS

Americo Financial Life and Annuity Insurance Company (Americo) and/or its/their duly authorized representative(s), may request and obtain an investigative consumer report for the purpose of serving as a factor in the underwriting of your insurance application. An investigative consumer report means any written, oral or other communication of information from a consumer reporting agency bearing on your character, general reputation, personal characteristics or mode of living obtained through personal interviews with your neighbors, friends, acquaintances, associates, or those who may have knowledge concerning such information. You may request to be personally interviewed and, when the report is completed, you have a right to inspect and receive a copy of it from the consumer reporting agency.

Upon written request, we will provide you with additional disclosures relating to the nature and scope of the investigative consumer report. Following this Notice is a written summary of Your Rights Under Section 505 (a) of the Fair Credit Reporting Act, as amended. If you request additional disclosures from the Company, please send your request to: Americo Financial Life and Annuity Insurance Company, PO BOX 410288, Kansas City, MO 64141-0288, Attention: Underwriting Department.

Para información en español, visite www.consumerfinance.gov/learnmore o escribe a la Consumer Financial Protection Bureau, 1700 G Street N.W., Washington, DC 20552.

A Summary of Your Rights Under the Fair Credit Reporting Act

The federal Fair Credit Reporting Act (FCRA) promotes the accuracy, fairness, and privacy of information in the files of consumer reporting agencies. There are many types of consumer reporting agencies, including credit bureaus and specialty agencies (such as agencies that sell information about check writing histories, medical records, and rental history records).

Here is a summary of your major rights under the FCRA. **For more information, including information about additional rights, go to www.consumerfinance.gov/learnmore or write to: Consumer Financial Protection Bureau, 1700 G Street N.W., Washington, DC 20552.**

- **You must be told if information in your file has been used against you.** Anyone who uses a credit report or another type of consumer report to deny your application for credit, insurance, or employment – or to take another adverse action against you – must tell you, and must give you the name, address, and phone number of the agency that provided the information.
- **You have the right to know what is in your file.** You may request and obtain all the information about you in the files of a consumer reporting agency (your "file disclosure"). You will be required to provide proper identification, which may include your Social Security number. In many cases, the disclosure will be free. You are entitled to a free file disclosure if:
  - a person has taken adverse action against you because of information in your credit report;
  - you are the victim of identity theft and place a fraud alert in your file;
  - your file contains inaccurate information as a result of fraud;
  - you are on public assistance;
  - you are unemployed but expect to apply for employment within 60 days.

  In addition, all consumers are entitled to one free disclosure every 12 months upon request from each nationwide credit bureau and from nationwide specialty consumer reporting agencies. See www.consumerfinance.gov/learnmore for additional information.
- **You have the right to ask for a credit score.** Credit scores are numerical summaries of your credit-worthiness based on information from credit bureaus. You may request a credit score from consumer reporting agencies that create scores or distribute scores used in residential real property loans, but you will have to pay for it. In some mortgage transactions, you will receive credit score information for free from the mortgage lender.
- **You have the right to dispute incomplete or inaccurate information.** If you identify information in your file that is incomplete or inaccurate, and report it to the consumer reporting agency, the agency must investigate unless your dispute is frivolous. See www.consumerfinance.gov/learnmore for an explanation of dispute procedures.
- **Consumer reporting agencies must correct or delete inaccurate, incomplete, or unverifiable information.** Inaccurate, incomplete, or unverifiable information must be removed or corrected, usually within 30 days. However, a consumer reporting agency may continue to report information it has verified as accurate.
- **Consumer reporting agencies may not report outdated negative information.** In most cases, a consumer reporting agency may not report negative information that is more than seven years old, or bankruptcies that are more than 10 years old.
- **Access to your file is limited.** A consumer reporting agency may provide information about you only to people with a valid need – usually to consider an application with a creditor, insurer, employer, landlord, or other business. The FCRA specifies those with a valid need for access.
- **You must give your consent for reports to be provided to employers.** A consumer reporting agency may not give out information about you to your employer, or a potential employer, without your written consent given to the employer. Written consent generally is not required in the trucking industry. For more information, go to www.consumerfinance.gov/learnmore.
- **You many limit "prescreened" offers of credit and insurance you get based on information in your credit report.** Unsolicited "prescreened" offers for credit and insurance must include a toll-free phone number you can call if you choose to remove your name and address from the lists these offers are based on. You may opt out with the nationwide credit bureaus at 1-888-5-OPTOUT (1- 888-567-8688).
- **You may seek damages from violators.** If a consumer reporting agency, or, in some cases, a user of consumer reports or a furnisher of information to a consumer reporting agency violates the FCRA, you may be able to sue in state or federal court.
- **Identity theft victims and active duty military personnel have additional rights.** For more information, visit www.consumerfinance.gov/learnmore.

States may enforce the FCRA, and many states have their own consumer reporting laws. In some cases, you may have more rights under state law. For more information, contact your state or local consumer protection agency or your state Attorney General. For information about your federal rights, contact:

TYPE OF BUSINES	CONTACT
1. a. Banks, savings associations, and credit unions with total assets of over $10 billion and their affiliates.	a. Consumer Financial Protection Bureau 1700 G Street, N.W. Washington, DC 20552
b. Such affiliates that are not banks, savings associations, or credit unions also should list, in addition to CFPB:	b. Federal Trade Commission: Consumer Response Center – FCRA Washington, DC 20580 (877) 382-4357
2. To the extent not included in item 1 above: a. National banks, federal savings association, and federal branches and federal agencies of foreign banks.	a. Office of the Comptroller of the Currency Customer Assistance Group 1300 McKinney Street, Suite 3450 Houston, TX 77010-9050
b. State member banks, branches and agencies of foreign banks (other than federal branches, federal agencies, and Insured State Branches of Foreign Banks), commercial lending companies owned or controlled by foreign banks, and organizations operating under section 25 or 25A of the Federal Reserve Act.	b. Federal Reserve consumer Help Center P.O. Box 1200 Minneapolis, MN 55480
c. Nonmember Insured Banks, Insured State Branches of Foreign Banks, and insured state savings associations	c. FDIC Consumer Response Center 1100 Walnut Street, Box 11 Kansas City, MO 64106
d. Federal Credit Unions	d. National Credit Union Administration Office of Consumer protection (OCP) Division of Consumer Compliance and Outreach (DCCO) 1775 Duke Street Alexandria, VA 22314
3. Air Carriers	Asst. General Counsel for Aviation Enforcement & Proceedings Aviation Consumer Protection Division Department of Transportation 1200 New Jersey Avenue, S.E. Washington, DC 20590
4. Creditors Subject to the Surface Transportation Board	Office of Proceedings, Surface Transportation Board Department of Transportation 395 E Street, S.W. Washington, DC 20423
5. Creditors Subject to the Packers and Stockyard Acts, 1921	Office of Proceedings, Surface Transportation Board Department of Transportation 395 E Street, S.W. Washington, DC 20423
6. Small Business Investment Companies	Associate Deputy Administrator for Capital Access United States Small Business Administration 409 Third Street, S.W., 8th Floor Washington, DC 20416
7. Brokers and Dealers	Securities and Exchanges Commission 100 F Street, N.E. Washington, DC 20549
8. Federal Land Banks, Federal Land Bank Associations, Federal Intermediate Credit Banks, and Production Credit Associations	Farm Credit Administration 1501 Farm Credit Drive McLean, VA 22102-5090
9. Retailers, Finance Companies, and All Other Creditors Not Listed Above	FTC Regional Office for region in which the creditor operates or Federal Trade Commission: Consumer Response Center – FCRA Washington, DC 20580 (877) 382-4357

Bank Draft
Authorization Form
AF55019 (11/16)

AMERICO

DRAFT INFORMATION

As a convenience to me, I hereby request and authorize the banking institution below (the "Bank") to pay and charge to my account drafts on my account by and payable to the order of the company who issued or assumed the policy listed below (the "Company") administering my insurance policy provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that the Bank's rights in respect to such draft shall be the same as if it were a check drawn on the bank and signed personally by me. **This authorization will remain in effect until revoked by me or the Company. Notifications should be sent to PO BOX 410288, Kansas City, MO 64141-0288, Attention Customer Service. Our toll-free number is 800.231.0801.** I agree that the Bank shall be fully protected in honoring any such draft. I further agree that if any such draft be dishonored, whether with or without cause and whether intentionally or inadvertently, the Bank shall be under no liability whatsoever. Should any draft not be honored by the Bank upon presentation, I understand that this method of payment may be terminated. **I further understand that should any draft not be honored for the reason of "insufficient funds", a second attempt to draft may occur within 5 business days from the returned draft date.**

I understand that Americo requires a 5 business day advance notice to set up, change, or discontinue my bank draft information. I also understand that my insurance policy may lapse if said draft is returned unpaid by my Bank, or if I discontinue payments, prior to receiving confirmation of draft processing from the Company. ***Please keep a copy of this authorization with your banking records.***

FOR EXISTING POLICIES: Unless otherwise requested, premium draft date will be the existing premium due date.

DRAFT DATE: ***(If no option is selected, Draft Date will default to the first option listed below)***

☐ Upon issue and on the policy's regular due date thereafter

☐ Specific start date: _____ (Month) / _____ (Day) *(must be within 10 days of the Due Date and cannot be on the 29th, 30th, or 31st of the month. It may take up to 4 business days from the day we initiate the draft for your bank to process this transaction.)*

Additional option for Final Expense applications *(Also available for in-force policy numbers starting with "AM" issued after December 2011.)*

☐ Day of week: _____ (Week of Month) / _____ (Day of Week) *(Draft day must be specified using Monday through Friday for a specific week of the month (First-Fourth). The actual date of draft could vary each month.)* *Example:* Second (Week of Month) / Monday (Day of Week)

ACCOUNT TYPE: ***(If no option is selected, Account Type will default to the checking account option)***

☐ Checking Account *(attach voided check)*

☐ Savings Account *(attach deposit slip)*

☐ Check with Application *(use the deposit and routing numbers from the enclosed check in lieu of a voided check)*

☐ Please use Bank Draft information from Americo policy number: _____

INSURED INFORMATION

Insured Name(s)	Policy Number(s)

PAYOR INFORMATION

Name	Relationship to Proposed Insured	Phone Number
Address *(If mailing address is a PO Box, a street address is also required)*		
How long at current address? _____ If less than 5 years at current address, prior address required.		

SIGNATURE

_____ **Payor's Signature (REQUIRED, as it appears on bank records)**

_____ **Date**

Attach Voided Check/Deposit Slip Here

Complete below only when voided check or deposit slip is not available

ALTERNATE ACCOUNT VERIFICATION

Routing Number | | | | | | | | | | |

Account Number | | | | | | | | | | | | | | | |

☐ Check here if this is a business account

Agent's Certification (For New Business only)

I do hereby attest that I personally verified this information. I understand that any misrepresentation or falsification on my part will rescind my privilege to use this form and may lead to immediate termination of my appointment with the Company.

_____ **Agent's Signature (REQUIRED)**

_____ **Agent's Number**