Ultra Protector Series

Application Packet

Use ADD5099 (06/11) with Ultra Protector I and II only - Use AEE5099 (06/11) for Ultra Protector III

Ultra Protector Series Whole Life insurance offers you and your family these valuable benefits:

- ✓ Rates never increase
- ✓ Lifetime benefit[1]
- ✓ No medical exams - just a few simple questions to answer[2]
- ✓ Guaranteed qualification[3]
- ✓ Income tax-free death benefit[4]
- ✓ Terminal Illness Accelerated Benefit Rider on Ultra Protector I
- ✓ Coverage available for eligible children and grandchildren on Ultra Protector I
- ✓ Coverage cannot be cancelled because of age or health

1) As long as premiums are paid and there are no loans or accelerations. 2) Issuance of policy may depend upon answers to medical questions. 3) Subject to age limits. 4) 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.

Ultra Protector Series offers three products to fit every need:	How do I qualify?
❒ **Ultra Protector I** (use application ADD5099 06/11) **Full Death Benefit Day One** ▸ Children's Term Rider (Rider Series 2147) ▸ Accelerated Benefit Payment Rider (Rider Series 2146), included at no additional cost	All health questions on the application are answered "no" (both parts 1 and 2).*
❒ **Ultra Protector II** (use application ADD5099 06/11) **Full Death Benefit Day One**	All health questions in Part 1 are answered "no", one or more questions in Part 2 are answered "yes."*
❒ **Ultra Protector III 2- or 3-year graded death benefit** (depending on state); **Guaranteed Issue** (use application AEE5099 06/11) inside Ultra Protector Client Brochure 10-170-2-EE (08/11) ▸ Accidental Death Benefit Provision, included at no additional cost	No health questions are answered on the application OR any "yes" answers are reported in Part 1 of the application.

*MIB and height and weight must be within guidelines to issue Ultra Protector I and II.

Americo Financial Life and Annuity Insurance Company is authorized to do business in the District of Columbia and all states except NY and VT. Some riders are optional and available for an additional cost. Ultra Protector Series (Policy Series 281/283/284), Children's Term Rider (Rider Series 2147), and the Accelerated Benefit Payment Rider (Rider Series 2146) are underwritten by Americo Financial Life and Annuity Insurance Company, Kansas City, MO. Certain restrictions and variations apply. Consult policy and riders for all limitations and exclusions. For exact terms and conditions, please refer to the contract.

Policy Series 281/283/284

10-170-2-DD (08/11) © Americo

AMERICO

Application for
Life Insurance
ADD5099 (06/11)

1. PROPOSED INSURED INFORMATION

Name *(Last, First, Middle Initial)* | Address *(If address is a PO BOX, a street address is also required.)*

Years at current address: _______ If less than five (5) years, prior address required. ☐ Male ☐ Female

Phone Number	SSN or Taxpayer ID	Date of Birth	Age	Place of Birth *(City, State, Country)*

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

Name *(Last, First, Middle Initial)*	Relationship to Proposed Insured	SSN or Taxpayer ID

Address *(If address is a PO BOX, a street address is also required.)*

Years at current address: ______ If less than five (5) years, prior address required.

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

If not specified, all beneficiaries will be Primary.	Name	SSN or Taxpayer ID	Relationship	% of Share *(Must total 100%)*
Primary				
☐ Primary ☐ Contingent				
☐ Primary ☐ Contingent				

4. PRODUCT INFORMATION

☐ Ultra Protector I ☐ Ultra Protector II

☐ Check here if you are willing to accept any Ultra Protector product for which you qualify based on this application. The insurance for which you qualify may have a face amount less than any indicated on this application, and riders may not be available. All premiums will be applied toward the insurance for which you qualify.

Face Amount
☐ Solve for Face Amount
☐ Face Amount
$ _______________

Premium Mode
☐ Monthly Bank Draft
☐ Annually

Modal Premium
$ _________

☐ Check here to select Automatic Premium Loan.

Children's Term Rider: *This rider is only available on Ultra Protector I.*

1. Are you applying for the Children's Term Rider? ☐ Yes ☐ No *If* ***Yes,*** *complete this section.*
2. Amount of Children's Term coverage desired: $ ______________________
3. **Please list below any Eligible Child proposed for coverage. NOTE:** An Eligible Child means any child, stepchild, legally adopted child, or dependent grandchild of the Proposed Insured. A dependent grandchild means a grandchild who is eligible to be claimed on the federal tax return of, and resides with, the Proposed Insured.

Full Name of Eligible Child Proposed for Coverage	Date of Birth	Sex	Height	Weight
		☐ M ☐ F		
		☐ M ☐ F		
		☐ M ☐ F		

4. In the past seven (7) years, has any Eligible Child proposed for coverage ever been diagnosed or treated by a member of the medical profession for: birth defects or blood disorders, cancer, convulsions or seizures, diabetes, Down's syndrome, digestive disorder, emotional or psychiatric disorder, heart disorder, kidney or liver disorder, lung or respiratory disorder, nervous system disorder, alcohol or drug abuse, Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC), or any immune deficiency related disorder; or tested positive for antibodies to the Human Immunodeficiency Virus (HIV)? *If* ***Yes****, circle the condition(s) and provide details below.* .... ☐ Yes ☐ No
5. Has any Eligible Child proposed for coverage been diagnosed or treated by a member of the medical profession for any disease or disorder not mentioned above? *If* ***Yes****, provide details below.* .... ☐ Yes ☐ No

Name of Eligible Child	Reason Treated	Date(s) of Treatment	Name/Address/Phone Number of Doctor/Hospital Where Treated

5. REPLACEMENT INFORMATION

1. Is there any existing life insurance or annuity coverage on the life of any Proposed Insured? ***If Yes**, provide information below and complete the applicable replacement form(s) and submit with application. Application and replacement forms(s) must be dated on the same date.* .... ☐ Yes ☐ No
2. Will the life insurance applied for replace, or otherwise reduce in value, any existing life insurance or annuity now in force?................................ ☐ Yes ☐ No

Insured's Name	Company	Owner	Life Amount	Accidental Death Benefit	Policy Date

6. HEALTH INFORMATION *(Provide details of all Yes answers in the Health Question Details/Remarks section.)*

Has the Proposed Insured smoked cigarettes within the last twelve (12) months?.... ☐ Yes ☐ No	**Proposed Insured's Height**	**Proposed Insured's Weight**

PART 1 — **Yes No**

1. Is the Proposed Insured currently: hospitalized, bedridden, confined to a nursing facility, receiving hospice or home health care; using oxygen to assist in breathing now or within the last six (6) months; confined to a wheelchair or using a walker for a chronic illness now or within the last six (6) months; waiting for or have received an organ transplant; advised to have tests or surgery which have not been completed within the last twelve (12) months; diagnosed with a terminal illness; or paralyzed? .... ☐ ☐
2. Has the Proposed Insured ever:
   a. Had, been told they have, been treated for, or been prescribed medication for: Alzheimer's disease, dementia, memory loss, muscular dystrophy, or ALS (Lou Gehrig's Disease)? .... ☐ ☐
   b. Been diagnosed as having, been treated by a medical professional for, or tested positive for: Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or the Human Immunodeficiency Virus (HIV)? .... ☐ ☐
3. In the past three (3) years, has the Proposed Insured been told they have, or been treated by surgery, chemotherapy, radiation, been prescribed medication for any internal cancer or malignant melanoma (not basal cell skin cancer)? .... ☐ ☐
4. In the past twelve (12) months, has the Proposed Insured had, been told they have, been treated for, been prescribed medication or had surgery for: heart bypass, angioplasty (balloon procedure), stent placement, heart valve disorder; cardiac arrhythmia (including atrial fibrillation or flutter and ventricular fibrillation or flutter), heart attack, or angina (chest pain)?........ ☐ ☐
5. In the past two (2) years, has the Proposed Insured had, been told they have, been treated for, or been prescribed medication or had surgery for congestive heart failure, cardiomyopathy, stroke, circulation or blood clot problems in the legs or to the heart or brain, systemic lupus, chronic kidney disease, or kidney failure? .... ☐ ☐
6. In the past two (2) years has the Proposed Insured:
   a. Had, been told they have, been treated for, or been prescribed medication for drug or alcohol abuse/dependency or addiction? .... ☐ ☐
   b. Been asked to discontinue use or reduce intake of drugs or alcohol? .... ☐ ☐
7. In the past two (2) years, has the Proposed Insured taken medication for diabetes in combination with a medical history of stroke or TIA, heart disease or disorders, kidney disease, eye problems or any other circulatory disease (any disease that affects the heart and the blood vessels)?........ ☐ ☐

PART 2 — **Yes No**

1. In the past two (2) years, has the Proposed Insured ever been told they have, been treated for, or been prescribed medication for: Parkinson's disease, cirrhosis of the liver, chronic hepatitis, or other liver diseases or disorders? .... ☐ ☐
2. In the past three (3) years, has the Proposed Insured experienced complications of diabetes including: amputation, eye or kidney problems, insulin shock, or diabetic coma?........ ☐ ☐
3. In the past two (2) years, has the Proposed Insured had, or been told they have, been treated for, or been prescribed medication for heart bypass, angioplasty (balloon procedure), stent placement, heart valve disorder, heart attack, angina (chest pain), or coronary disease? .... ☐ ☐
4. In the past two (2) years, has the Proposed Insured had, been told they have, been treated for, or been prescribed medication for: emphysema, chronic bronchitis that is not seasonal, or any other chronic respiratory or lung problem excluding allergies or asthma?........ ☐ ☐

Eligibility for a level death benefit policy, is based on answers to the Health Questions and additional underwriting criteria.

7. HEALTH QUESTION DETAILS/REMARKS *(Attach a separate sheet if more space is needed; additional sheet must be signed and dated by Proposed Insured/Owner to avoid amendments.)*

8. AUTHORIZATION AND ACKNOWLEDGMENT

I/We authorize any insurance or reinsurance company, employer, 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 the Medical Information Bureau (MIB, Inc.) that has any record of information about me/us or my/our minor children who are to be insured, to give to Americo Financial Life and Annuity Insurance Company (Americo), its reinsurers or its authorized representatives, information about other insurance coverage, employment, age, general character, motor vehicle records, habits, court records, foreign travel, finances, participation in hazardous activities, medical care or advice about any physical or mental condition including information about drugs and alcoholism required by Americo to determine insurability and/or claims eligibility, for the duration of the claim.

Americo may release information obtained by this Authorization to its reinsurers, MIB, Inc., to other insurers with whom I/we have policies or to whom I/we may apply or submit a claim, to other persons or organizations performing business or legal services in connection with an insurance transaction for me/us, or as may otherwise be lawfully required. Although federal regulations require that Americo inform You of the potential that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by such regulation, all information received by Americo pursuant to this authorization will be protected by federal and state privacy laws and regulations.

I/We have received a copy of the Notice of Insurance Information Practices. I/We, or my/our authorized representative, may obtain a copy of this Authorization on request. This Authorization will be valid for two (2) years from the date signed. It is Americo's practice to prohibit third parties who lawfully receive nonpublic health information from redisclosing or reusing the disclosed information. A photographic copy shall be as valid as the original. I/We understand that a copy of this authorization will be provided, upon request, to me/us or a person authorized on my/our behalf.

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 may be sent, in writing, to Americo at its Administrative Office address.

IN ACCORDANCE WITH STATE LAW, WE MUST PROVIDE YOU WITH THE FOLLOWING FRAUD NOTICE: 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.

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 us to verify your identity. Our verification process may include the use of third-party sources to verify the information provided.

REQUEST FOR OWNER'S TAXPAYER IDENTIFICATION NUMBER AND CERTIFICATION: Under penalties of perjury, I as the Owner, certify that the number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me).

Any policy issued on this application will be deemed to be delivered in and governed by the laws of the jurisdiction in which this application was signed. Notwithstanding the foregoing, if this application is not solicited face to face and is effected through any electronic means, any policy issued on this application will be deemed to be delivered in and governed by the laws of the jurisdiction of the Owner, and said jurisdiction will also be the "Signed at (City and State)" inserted below.

No agent or medical examiner can waive the answer to any question in this application nor decide on insurability nor waive any of the company's underwriting requirements nor make or change any contract. The company shall have no knowledge of statements made by or to the Agent or medical examiner unless such statements are shown on the application.

I/We have read this application and represent to Americo that the statements made on this application are true, complete and correctly recorded to the best of my/our knowledge and belief. I/We agree that Americo can rely on these statements. I/We agree that this application and/or any medical exam form and any supplemental application or amendment to the application will be the basis for any policy issued on this application or any amendment to the application. **I/WE AGREE THAT ALL ANSWERS TO THE HEALTH QUESTIONS ON PAGE 2 OF THIS APPLICATION, SIGNED AND DATED BELOW, ARE COMPLETE AND ACCURATE.**

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

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

AGENT'S REPORT

Proposed Insured's Name:______________________________

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

Provide details of all No answers in the Agent Comments/Remarks section.

		Yes	No
2.	How long has the Agent known the Proposed Insured(s)? __________		
3.	At the time this application was taken, were all of the Proposed Insured(s) present and did you witness their signatures?	☐	☐
4.	Did the Proposed Insured(s) directly respond to each application question?	☐	☐
5.	Was a government-issued picture I.D. 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)*?	☐	☐

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

		Yes	No
6.	Did the applicant approach you to purchase insurance? *(If **Yes**, list their stated need for the insurance in the Agent Comments/Remarks section.)*	☐	☐
7.	Does the applicant have any existing life insurance or annuity coverage on the life of any Proposed Insured? ***If Yes**, complete the applicable replacement form(s) and submit with application. Application and replacement forms(s) must be dated on the same date.*	☐	☐
8.	Will the life insurance applied for replace, or otherwise reduce in value, any existing life insurance or annuity now in force? ***If Yes**, leave copies of sales materials with Owner. If you used an electronic sales presentation, you must mail a copy to the Owner.*	☐	☐

Agent Comments/Remarks:

I hereby certify that I have personally asked each question on this application to the Proposed Insured(s), 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	Agent #	%

AAA5099-AS (06/11) Agent's Report

BANK DRAFT AUTHORIZATION

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 authority is to remain in effect until revoked by me. 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 understand that Americo requires a five business day advance notice to set up, change, or discontinue my bank draft information. I understand also 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.

Requested Draft Date: _________ *(Note: bank drafts cannot occur on the 29th, 30th, or 31st of the month)*

Unless otherwise requested, premium will be drafted from your account IMMEDIATELY upon policy issuance.

ACCOUNT INFORMATION

Check One:

☐ Checking Account *(include voided check)*
☐ Savings Account *(include deposit slip)*
☐ Check with Application *(Use the deposit & routing number from the enclosed check in lieu of a voided check.)*

☐ Check here if the account selected above is a business account.

X__________________________________ ____________
Payor's Signature *(as it appears on bank records)* Date

PAYOR INFORMATION *(Complete only when Payor is different than Proposed Insured & Owner.)*

Name	Relationship to Proposed Insured
SSN or Taxpayer ID	Proposed Insured's Name

Address (*If address is a PO BOX, a street address is also required.)*

Years at current address: ______ If less than 5 years, prior address required.

Attach voided check or deposit slip here.

IMPORTANT NOTE: sign and submit this Disclosure ONLY when applying for Ultra Protector I.

DISCLOSURE STATEMENT FOR ACCELERATED BENEFIT PAYMENT RIDER - RIDER SERIES 2146

Americo Financial Life and Annuity Insurance Company

AAA8386

GENERAL DESCRIPTION OF THE ACCELERATED BENEFIT

The Accelerated Benefit Payment Rider allows the Owner of the Policy to which the Rider is attached to receive an accelerated benefit following a Qualifying Event. A Qualifying Event is defined as a non-correctable medical condition of the Insured that, with reasonable medical certainty, will result in the death of the Insured in 12 months or less. The Company must receive a physician's written statement certifying the medical condition and the Insured's life expectancy.

The Owner may make only one request for an accelerated benefit payment. The Owner may request an accelerated payment of up to 50% of the death benefit amount after deducting all outstanding Policy loans. The minimum accelerated benefit the Company will pay is $1,000 and the maximum benefit is $15,000. The accelerated benefit will be paid only as a lump sum.

Request for an accelerated benefit payment must be in writing and the Company must receive the request while the Policy is in force (other than as extended term or paid-up insurance, if available). The Company must receive written approval by any irrevocable beneficiary under the Policy and a full release of any assignment of the Policy as collateral.

TAX CONSEQUENCES OF RECEIVING AN ACCELERATED BENEFIT PAYMENT

Depending on a number of factors, an accelerated benefit payment may be considered taxable income. The Owner should seek assistance from a qualified tax advisor before requesting an accelerated benefit.

COSTS OF THE ACCELERATED BENEFIT PAYMENT

There is no premium for the Rider. However, the Company will add an administrative fee not exceeding $250 to the accelerated benefit amount at the time of payment. The Company will charge interest on the accelerated benefit payment. Interest will accrue at the policy loan interest rate stated in the Policy on the portion of the benefit amount equal to the cash value. For the portion of the benefit amount that exceeds this amount, interest will accrue at a rate no more than the greater of: (a) the current yield on a 90-day treasury bill; or (b) the current maximum adjustable policy loan interest rate allowed by law.

EFFECT OF ACCELERATED BENEFIT PAYMENT

The accelerated benefit payment, the administrative fee and any accrued interest will be a lien against the Policy. The total amount of the lien and all Policy loans outstanding will reduce the amount otherwise available under the Policy's: (1) death benefit and (2) cash value.

The Rider provides that the Company will waive all premiums under the Policy and riders, if any, for up to 12 months immediately following the payment of an accelerated benefit. If the Insured is living following the twelfth month, the waiver provided by the Rider will no longer apply and premiums will be due.

Except as stated in the waiver provision of the Rider, Policy and rider premiums will remain payable and will not be reduced or eliminated as a result of an accelerated benefit payment. Any accidental death benefit provision of the Policy or any other rider attached to it will not be affected by the payment of an accelerated benefit payment.

ACKNOWLEDGMENT

I, the undersigned Insured (and Policy Owner, if other than the Insured), acknowledge that I have read and received this Disclosure Statement for Accelerated Benefit Payment Rider at the time of application for the Rider.

________________________________ ______________
Proposed Insured's Signature Date

________________________________ ______________
Owner's Signature (if other than Insured) Date

________________________________ ______________
Agent or Broker's Signature Date

Americo Financial Life and Annuity Insurance Company
Home Office: Dallas, Texas • Administrative Office: PO BOX 410288, Kansas City, MO 64141-0288

THIS IS A CONDITIONAL RECEIPT - PLEASE READ CAREFULLY!

NO INSURANCE WILL BE PROVIDED BY YOUR FIRST PAYMENT UNLESS ALL TERMS IN PARAGRAPH "A" 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.

A: 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 "B": (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 class of risks not less favorable than standard; and (4) the amount shown above must be equal to at least the first full modal premium for insurance.

IF ALL OF THE TERMS IN PARAGRAPH "A" 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, if any, requested in the application.

B: 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 ______________, _________.

____________________________ Agent's Signature

____________________________ Applicant's Signature

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.

AAA8404 (01/11)

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. 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 nonprofit 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 (TTY 866-346-3642). 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, Massachusetts 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

We may make or obtain an investigative consumer report, which may contain information secured through personal interviews with your friends, neighbors and others with whom you are acquainted. This report may contain information as to your character, general reputation, personal characteristics and mode of living (no information collected concerning the sexual orientation of the proposed insured will be used to determine his or her eligibility for insurance). The consumer reporting agency may keep a copy of the report and may disclose its contents to others for whom it performs such services. On receipt of a request from you, we will tell you if a report has been requested and we will provide you with the name, address, and telephone number of the consumer reporting agency. 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. Please send your request to: Americo Financial Life and Annuity Insurance Company, PO BOX 410288, Kansas City, MO 64141-0288, Attention: Underwriting Department.

AAA8394

Bank Draft
Authorization Form
AF55019 (09/10)

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 authority is to remain in effect until revoked by me. 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 5-10 days**.

I understand that Americo requires a ***five*** 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 NEW BUSINESS APPLICATIONS: **Premium will be drafted from your account immediately upon issuance, except in the event of additional delivery requirements needed, or if an alternate draft date is chosen.**

FOR EXISTING POLICIES: **Unless otherwise requested, premium draft date will be the existing premium due date. Drafts occurring more than 10 days after the payment due date may generate a grace notice.**

ALTERNATE DRAFT DATE: **I request an alternate draft date of: _____________, in lieu of my regular premium due date.**
(If the 29th, 30th or 31st is requested, the draft date will default to the 1st of the following month.)

CHECK ONE:
- ☐ 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
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

Name of Financial Institution: ____

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**

Important Notice:
Replacement of Life Insurance or Annuities
AAA8327 (2008)

AMERICO®

Important Note - This document must be signed by the applicant and the agent, if there is one, and a copy left with the applicant. Application and Replacement Notice must be signed on the same date.

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A *replacement* occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on an existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A *financed* purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interest. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy or contract and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? .... ☐ Yes ☐ No
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? .... ☐ Yes ☐ No

If you answered "Yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (including the name of the insurer, the insured or annuitant, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

Insurer Name	Contract or Policy #	Insured or Annuitant	Replaced (R) or Financing (F)
1.			
2.			
3.			

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because:

____

____

____

I certify that the responses herein are, to the best of my knowledge, accurate:

Applicant's Signature	Applicant's Printed Name	Date
Agent's Signature	Agent's Printed Name	Date

I do not want this notice read aloud to me________ (Applicants must initial only if they do not want the notice read aloud.)

SALES MATERIAL CERTIFICATION

☐ I certify that I used the following company-approved and/or individualized marketing materials, including any electronically presented materials, in my presentation (list form numbers below).

______________ ______________ ______________

☐ I certify that I did not use any marketing materials in my presentation.

By signing below, I certify that the information above is correct and that I left copies of all sales materials used in my presentation with the applicant.

Agent's Signature	Agent's Printed Name	Date

Important Note: Application and replacement notice must be signed on the same date.

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

PREMIUMS:

- Are they affordable?
- Could they change?
- You're older - are the premiums higher for the proposed new policy?
- How long will you have to pay premiums on the new policy? On the old policy?

POLICY VALUES:

- New policies usually take longer to build cash values and to pay dividends.
- Acquisition costs for the old policy may have been paid; you will incur costs for the new one.
- What surrender charges do the policies have?
- What expense and sales charges will you pay on the new policy?
- Does the new policy provide more insurance coverage?

INSURABILITY:

- If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.
- You may need a medical exam for a new policy.
- Claims on most new policies for up to the first two years can be denied based on inaccurate statements.
- Suicide limitations may begin anew on the new coverage.

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:

- How are premiums for both policies being paid?
- How will the premiums on your existing policy be affected?
- Will a loan be deducted from death benefits?
- What values from the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:

- Will you pay surrender charges on your old contract?
- What are the interest rate guarantees for the new contract?
- Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:

- What are the tax consequences of buying the new policy?
- Is this a tax free exchange? (See your tax advisor.)
- Is there a benefit from favorable "grand-fathered" treatment of the old policy under the federal tax code?
- Will the existing insurer be willing to modify the old policy?
- How does the quality and financial stability of the new company compare with your existing company?