AIL
American Income Life
Insurance Company

Agent New Business Transmittal Report

SGA Name: Philip Prata
Transmittal Date:
State:

Rider Add-On/Conversion Apps?

(Print - Agent's Name) | Agent L. Name (5 ltrs) | Agent #

	Name of Applicant Last, First, Middle Initial	Mode Sold	Plan Form	Life Annual Premium	A&H Annual Premium	C. W. A.	Policy Fee	Trial = T Control = C AltDcl = D AltXpl = X
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
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16								
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21								
22								
23								
24								
25								
26								
27								
28								
29								
30								
	Totals							

Application to AMERICAN INCOME LIFE INSURANCE COMPANY _____
P.O. Box 2608 Waco, TX 76797 Affiliation

ID No. _____

*Complete shaded areas for spouse coverage.

☐ UN ☐ CU ☐ Assoc ☐ V-PRIV ☐ SR ☐ Lics Prof
☐ GL ☐ POS ☐ Ref ☐ F-CHSF ☐ DC ☐ _____

1. Names of Proposed Insureds		I Saw	D.O.B.	Age	Birthplace	Ht	Wt	Sex	NTU	2. SS#
A	Adult	☐							☐	— —
B	*Spouse	☐							☐	* — —
C1	Child	☐								3. Driver's License# & State ★
C2	Child	☐								
C3	Child	☐								*

4. Person to be Owner of Policy ☐ Proposed Insured A
☐ Other, name and relationship

5. Occupation/Duties *

6. Employer's Name *

7. Address of Owner of Policy

8. Phone#( ) -
Cell# ( ) -

9. E-mail Address _____ @ _____

10. **Complete B, C1, C2 & C3 ONLY if applying for separate life policies.**

	Primary Beneficiary	Relationship to Insured	Contingent Beneficiary	Relationship to Insured
A				
B				
C1				
C2				
C3				

11. Is any insurance applied for intended to replace or change any insurance or annuities in this or any other company? ☐ Yes ☐ No

12. Amount of insurance on each proposed Insured — Type / Company / Benefit *

13. Is proposed Insured a U.S. citizen? ☐ Yes ☐ No

14. Do you wish the Automatic Premium Loan Provision on your life policy/policies? ☐ Yes ☐ No

Life Insurance - Complete B, C1, C2 & C3 ONLY if applying for separate Life policies.

Proposed Insured A☐ B☐ C☐	B☐	C1 (under 18) ☐	Benefits	Face Amount	Premium
Base ☐ WL ☐ PR ☐ EX ☐ SL	☐ WL ☐ PR ☐ EX ☐ SL	☐ WL ☐ PR ☐ LPU65	☐ ADB	$_____	$_____.___
Plan ☐ LPU65 ☐ _____	☐ LPU65 ☐ _____	☐ _____	☐ B2000		$_____.___
Face Amount Premium	Face Amount Premium	Face Amount Premium	☐ GIO	$_____	$_____.___
$_____ $_____.___	$_____ $_____.___	$_____ $_____.___	☐ TIR	**Premium C1**	**$_____.___**
Riders and Benefits ☐TIR	☐TIR	**C2 (under 18)** ☐	Benefits	Face Amount	Premium
☐10 R&C $_____ $_____.___	☐$_____ $_____.___	☐ WL ☐ PR ☐ LPU65	☐ ADB	$_____	$_____.___
☐ADB $_____ $_____.___	☐$_____ $_____.___	☐ _____	☐ B2000		$_____.___
☐B2000 $_____.___	☐WP $_____.___	Face Amount Premium	☐ GIO	$_____	$_____.___
☐WP (base & riders) $_____.___	Other Riders or Benefits	$_____ $_____.___	☐ TIR	**Premium C2**	**$_____.___**
☐CIR $_____.___	☐ _____	**C3 (under 18)** ☐	Benefits	Face Amount	Premium
☐Spouse $_____ $_____.___	$_____ $_____.___	☐ WL ☐ PR ☐ LPU65	☐ ADB	$_____	$_____.___
☐Child $_____ $_____.___	☐ _____	☐ _____	☐ B2000		$_____.___
☐_____ $_____ $_____.___	$_____ $_____.___	Face Amount Premium	☐ GIO	$_____	$_____.___
☐_____ $_____ $_____.___	☐ _____	$_____ $_____.___	☐ TIR	**Premium C3**	**$_____.___**
☐_____ $_____ $_____.___	$_____ $_____.___				
Life Ins. Premium A $_____.___	**Premium B** $_____.___				

Accident Ins. Policy A☐ B☐ C☐	Cancer Ins. Policy A☐ B☐ C☐		Hospital Indemnity Ins. Policy A☐ B☐ C☐
☐A71 $_____ Benefit	☐ CNM	☐ C20	☐ H34 $_____ Benefit
☐ Individual ☐ Family	☐ Ind. ☐ Fam.	☐ Ind. ☐ Fam.	☐ Optional Recup. Rider
☐ Optional Recup. Rider	$_____	Benefit $_____	Adult $_____.___
☐ Single ☐ Double	$_____.___	Premium $_____.___	Spouse $_____.___
Premium $_____.___	$_____.___	Policy Fee $_____.___	Child X _____ $_____.___
Policy Fee $_____.___			(# of children)
A71 Prem. $_____.___	**$_____.___ CNM/C20 Prem. $_____.___**		Policy Fee $_____.___
			H34 Prem. $_____.___

Proposed Insureds ◀Circle all that apply

Mode Premium ☐A ☐MBD ☐SS ☐_____

Total Paid with application

$_____.___

Critical Illness Ins. Policy A☐ B☐
☐ CI
$ _____ Benefit
Adult $_____.___
Spouse $_____.___
Policy Fee $_____.___
CI Prem. $_____.___

15. I have received an outline of coverage?
☐ A71 ☐ CNM ☐ C20 ☐ H34 ☐ CI

16. Does proposed Insured have a Medicaid Eligibility Card or otherwise eligible for benefits under Medicaid (Title XIX)? ☐ Yes ☐ No

17. Age 65 and Older Only - I have received the Important Notice to Persons on Medicare - This Insurance Duplicates Some Medicare Benefits. ☐ Yes ☐ No

PLACE ORAL SPECIMEN STICKER HERE

PLACE ORAL SPECIMEN STICKER HERE

AUTHORIZATION FOR PREAUTHORIZED PAYMENTS

American Income Life Insurance Company is authorized to initiate debit entries to the account indicated below, and the depository institution named below is authorized to debit the same to such account. This authority can be terminated by the undersigned at any time by written notification to the Company, provided only that the Company and the depository will have a reasonable opportunity to act on such notification.

Depository Name _____ City _____ State _____

Transit/ABA No. _____ Account No. _____ Type of Account: ☐ Checking ☐ Savings

X _____ Date _____ Requested draw date, if any: _____
Signature of Payor

PLEASE ATTACH A VOIDED PERSONAL CHECK

PLACE AN 'X' IN THE BOX WITH THE CORRECT ANSWER
ANSWER ALL QUESTIONS IF APPLYING FOR LIFE, HOSPITAL INDEMNITY OR CRITICAL ILLNESS POLICY
ANSWER **ONLY SECTION "A"** IF APPLYING ONLY FOR **ACCIDENT** POLICY
ANSWER **ONLY SECTION "B"** IF APPLYING ONLY FOR **CANCER** POLICY

SECTION A

18. Has any proposed Insured ever been treated or advised to be treated by a licensed medical professional for alcoholism or alcohol abuse, including membership in A.A. or been advised by a licensed medical professional to reduce alcohol consumption? ☐Yes ☐No
19. Has any proposed Insured ever used cocaine, amphetamines, barbiturates, hallucinogens, tranquilizers, narcotics or illegal or prescription sedatives other than as prescribed by a licensed medical professional? ☐Yes ☐No
20. Has any proposed Insured ever had their driver's license suspended or revoked because of a moving violation or been arrested (including arrests for driving while intoxicated or under the influence)? ☐Yes ☐No
21. Has any proposed Insured flown within the last 2 years as other than a passenger on a scheduled airline? ☐Yes ☐No
22. Has any proposed Insured participated within the last 2 years in any of the following activities: Auto, Motorcycle, or Boat Racing; Parachute Jumping; Skin, Scuba, or Sky Diving? ☐Yes ☐No
23. Has any proposed Insured ever been advised by a licensed medical professional to take tests and not done so or not received the results, been diagnosed or treated by a licensed medical professional for high blood pressure, chest pain, heart attack, stroke or any heart, blood or circulatory disorder? ☐Yes ☐No
24. Has any proposed Insured ever been diagnosed or treated by a licensed medical professional for any of the following conditions:
    a. Diabetes or other endocrine disorder? ☐Yes ☐No
    b. Paralysis, epilepsy, mental disease or disorder or any other nervous system or brain disorder? ☐Yes ☐No
25. Has any proposed Insured ever been diagnosed or treated by a licensed medical professional for arthritis or any injury to or trouble with your back, knees or any of your joints? ☐Yes ☐No
26. To the best of your knowledge and belief, do you have any physical impairment or departure from good health? (give details) ☐Yes ☐No

SECTION B

27. Has any proposed Insured ever been advised by a licensed medical professional to take tests and not done so or not received the results, been diagnosed or treated by a licensed medical professional for cancer, tumor or unexplained masses? ☐Yes ☐No
28. Has any proposed Insured ever been rejected for life or medical-hospital insurance, rated, or failed to receive a policy as applied for? ☐Yes ☐No
29. Has any proposed Insured in the last 5 years:
    a. Had a physical examination? ☐Yes ☐No
    b. Had any medical treatment by a licensed medical professional? (includes prescription medications) ☐Yes ☐No
    c. Been hospitalized? ☐Yes ☐No
30. Is any proposed Insured currently a resident in a nursing home or ever been diagnosed by a licensed medical professional as having a terminal illness, including Alzheimer's disease? ☐Yes ☐No
31. Has any proposed Insured ever been diagnosed or treated by a licensed medical professional for any of the following conditions:
    a. Asthma, emphysema, sleep apnea or other respiratory disorder? ☐Yes ☐No
    b. Ulcer, colitis or other digestive tract disorder? ☐Yes ☐No
    c. Cirrhosis, hepatitis or other liver disorder or any blood disorder or received a bone marrow transplant? ☐Yes ☐No
    d. Kidney, prostate, urinary bladder or other genitourinary disorder? ☐Yes ☐No
    e. Disease of the breasts, uterus or ovaries? ☐Yes ☐No
    f. Rheumatoid arthritis or any other musculoskeletal disorder? ☐Yes ☐No
    g. Loss of hearing or loss of sight? ☐Yes ☐No
32. Has any proposed Insured ever tested positive for exposure to the HIV infection or been diagnosed by a licensed medical professional as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection? ☐Yes ☐No
33. Does any proposed Insured smoke cigarettes or use tobacco in any other form? ☐Yes ☐No
34. If a former user of tobacco, when did proposed Insured quit?
    Name/Date _____
    Name/Date _____
35. Has any proposed Insured used marijuana in the past year? ☐Yes ☐No

If questions are answered "yes", give explanations, dates, names & addresses of physicians & hospital (if any) below.

Proposed Insured	Explanation or Medication	Date	Hospital	How Long	Physician	Address
			☐Yes ☐No			
			☐Yes ☐No			

Name, Address, and Phone Number of Personal Physician	Date Last Seen	Medical Records ID#
( ) -		
* ( ) -	*	*

Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

I agree that no insurance shall be in effect until: (a) a policy has been issued; and (b) the first premium is paid while my insurability remains unchanged and then only if I am actually in the state of health represented in this application. I state that the answers set forth above, are full, complete and true to the best of my knowledge and belief. The answers are to be the basis of any insurance issued. No agent may bind, alter, change or waive any underwriting requirements or other provisions of the application or policy. Final application acceptance is made by the Underwriting Department of the Company. I also acknowledge that I have received the Investigative Consumer Reports notification and MIB Notice and authorize obtaining medical or other information, including MIB, in order to evaluate my application for insurance. American Income Life may also request or obtain additional information to establish or verify my identity. I further acknowledge that American Income Life may report information to MIB or to other insurers which I have or may apply.

X _____ Date _____ at _____
Proposed Insured (if 18 or over) City State

X _____ * _____
Signature of Owner (if other than proposed Insured) | Signature of Spouse (if a proposed Insured) | Signature of Agent

AGENT'S STATEMENT

I certify that I have asked all questions and truly and accurately recorded the information supplied by the Applicant. To the best of my knowledge and belief, the insurance applied for ☐is ☐is not intended to replace any insurance now in effect.

Agent L. Name (5 ltrs) | Agent# | Florida License # | Signature of Agent

Type or Print Agent's Name

Name and Address of Secondary Addressee for notice of past due premiums. (Age 64 +)

REMARKS OR INSTRUCTIONS

Best time to call _____

★ Driver's License # for children age 16 + — For separate life policies ONLY:

Mail Policy To: ☐ Agency ☐ Policyholder

American Income Life Insurance Company
P.O. Box 2608
Waco, TX 76797

Authorization for Release of Health-Related Information

This authorization complies with the HIPAA Privacy Rule

(Print name of proposed insured/patient and birth date)

Name	DOB	Name	DOB
Name	DOB	Name	DOB
Name	DOB	Name	DOB

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical facility, other insurance company, consumer reporting agency, Medical Information Bureau (MIB) or other health care provider that has provided payment, treatment or services to me or on my behalf ("My Providers") to disclose my entire medical record and any other protected health information concerning me to the American Income Life Insurance Company (AIL) and its agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco; but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that AIL may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with AIL.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to AIL, Attention: Underwriting Department, at the above address. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that AIL has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, AIL may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I have received a copy of this authorization.

Signature of Proposed Insured/Patient or Personal Representative _____ Date _____

Signature of Proposed Insured/Patient or Personal Representative _____ Date _____

Personal Representative's Authority or Relationship to Patient, (if patient is under 18 years old) _____

(Submit original with application - white paper) (Proposed Insured's copy - canary paper)

INVESTIGATIVE CONSUMER REPORTS NOTIFICATION

As part of our routine underwriting procedure, an investigative consumer report may be obtained which will provide applicable information concerning character, general reputation, personal characteristics, and mode of living. This information will be obtained through personal interviews with your friends, neighbors, and associates. You may request to be interviewed in connection with the preparation of the report and upon request may receive a copy of the report.

MIB NOTICE

Information regarding your insurability will be treated as confidential. American Income Life Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

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

NOTICE OF INFORMATION PRACTICES

Personal information may be collected from other parties. Such information, and other personal or privileged information later collected, may be disclosed to third parties without authorization. You have the right of access and correction with respect to all personal information collected, and a full notice of your rights will be furnished upon request.

American Income Life Insurance Company
Executive Offices: P.O. Box 2608 Waco, TX 76797 (254) 761-6400
www.ailife.com

NOTICE TO APPLICANT REGARDING REPLACEMENT OF LIFE INSURANCE

A decision to buy a new policy and discontinue or change an existing policy may be a wise choice or a mistake.

Get all the facts. Make sure you fully understand both the proposed policy and your existing policy or policies. New policies may contain clauses which limit or exclude coverage of certain events in the initial period of the contract, such as the suicide and incontestable clauses which may have already been satisfied in your existing policy or policies.

Your best source for facts on the proposed policy is the proposed company and its agent. The best source on your existing policy is the existing company and its agent.

Hear from both before you make your decision. This way you can be sure your decision is in your best interest.

If you indicate that you intend to replace or change an existing policy, Florida regulations require notification of the company that issued the policy.

Florida regulations give you the right to receive a written Comparative Information Form which summarizes your policy values. Indicate whether or not you wish a Comparative Information Form from the proposed company and your existing insurer or insurers by placing your initials in the appropriate box below.

Yes	No

DO NOT TAKE ACTION TO TERMINATE YOUR EXISTING POLICY UNTIL YOUR NEW POLICY HAS BEEN ISSUED AND YOU HAVE EXAMINED IT AND FOUND IT ACCEPTABLE.

I have read this notice and received a copy of it.

Applicant's Signature _____ Date _____

Agent's Signature _____ Date _____

Agent's Name (Printed or Typed) _____

Agent's Address (Printed or Typed) _____

Agent's Company (Printed or Typed) _____

Information on Policies which may be replaced:

Company Name	Policy Number	Name of Insured