Golden Solution

Whole Life Insurance

Final Expenses

If *you* don't plan for them, *who will?*

American-Amicable Life Insurance Company of Texas

Golden Solution

Whole Life Insurance Policy

An economical way to free your loved ones from financial worry over meeting your final expenses.

- Affordable rates that will not increase
- Benefits that remain level *
  (See plan details.)

  Immediate Death Benefit Plan
  — Maximum $25,000 to age 75
  Maximum $15,000 ages 76 through 85

  Graded Death Benefit Plan
  — Maximum $15,000 all ages

  Return of Premium Death Benefit Plan
  — Maximum $15,000 all ages
- Cash value you can use for emergencies or other financial needs
- Optional accidental death benefit **
  (with additional premium)
- Optional Grandchild Rider

  (with additional premium)
- Benefits paid to the beneficiary and not subject to federal income tax
- Cannot be canceled as long as premiums are paid

* Benefits for death from suicide during the first 2 policy years are limited to the total amount of premiums paid.
** Not Available on Return of Premium Death Benefit Plan.

Your agent will help you identify the plan that you qualify for.

☐ **Immediate Death Benefit** (Form No. 9464)
100% of face amount paid immediately ***

☐ **Graded Death Benefit** (Form No. 9465)
30% of selected face amount paid the 1st year, 70% paid the 2nd year and 100% paid the 3rd and subsequent years. 100% paid for accidental death, all years ***

☐ **Return of Premium Death Benefit** (Form No. 9471)
Return of premium plus 10% annual interest for 3 years if under age 65, 2 years if 65 or older. 100% paid after graded period. 100% paid for accidental death, all years ***

Terminal Illness Accelerated Benefit Rider (Form No. 9473)

— Available At No Premium Cost
(Administrative Charge and Actuarial Adjustment Upon Acceleration)

— See Disclosure Form for Tax Treatment

*** Less Any Outstanding Loans
Not All Plans Are Available In All States

AMERICAN-AMICABLE LIFE INSURANCE COMPANY OF TEXAS
P.O. BOX 2549, WACO, TX 76702-2549 • (254) 297-2777

LIFE INSURANCE APPLICATION (Please print in black ink)

Proposed Insured ____________________ (First) (Middle) (Last)

Address (No. & Street)____________________

City State Zip Code

Telephone interview completed ☐ Yes ☐ No

__________ Phone __________ Best time to call ☐ am ☐ pm

E-mail Address @

☐ Male ☐ Female	Date of Birth / /	Age	State of Birth	Social Security Number / /	Height ft in	Weight lbs

Owner: Name____________________Relationship__________SS#____/___/____
Address City/State/Zip

Primary Beneficiary	Relationship	Contingent Beneficiary	Relationship

Plan: ☐ Immediate Death Benefit ☐ Graded Death Benefit (Percentage of Face Amount) ☐ Return of Premium Death Benefit
During the past 12 months have you used tobacco in any form? ☐ Yes ☐ No Face Amount of Insurance $

Rider: ☐ Grandchild Coverage (Indicate Number of Grandchildren Applying) __________
☐ ADB (not available on Return of Premium Death Benefit) Amount $

Automatic Premium Loan Elected? ☐ Yes ☐ No

Billing Mode: ☐ Bank Draft ☐ Quarterly ☐ Semi Annual ☐ Annual
Modal Premium $ ☐ CWA $ ☐ None, draft 1st premium

Mail Policy To: ☐ Agent ☐ Insured ☐ Owner
Requested Policy Date: / /

A. Do you have existing life insurance or an annuity contract? ☐ Yes ☐ No Company
B. Will you replace an existing life insurance policy or an annuity? ☐ Yes ☐ No Policy # Amount of Coverage $

Personal Physician Name: **City/State:**

HEALTH INFORMATION

1. Are you currently hospitalized, confined to a bed or nursing facility, or using oxygen equipment to assist in breathing, or receiving Hospice Care? ☐ Yes ☐ No
2. Have you had or been medically advised to have an organ transplant, or have you been medically diagnosed as having a life expectancy of 12 months or less, Alzheimer's, dementia, mental incapacity, or have you been diagnosed, treated (including dialysis) or taken medication for kidney or liver failure, or respiratory failure? ☐ Yes ☐ No
3. Have you been medically treated or diagnosed by a medical professional as having Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC), or any immune deficiency related disorder or tested positive for the Human Immunodeficiency Virus (HIV)? ☐ Yes ☐ No

If any answer to questions 1 through 3 is answered "Yes" the Proposed Insured is not eligible for any coverage.

4. Have you ever been treated for insulin shock, diabetic coma, had an amputation caused by disease, or taken insulin shots prior to age 50 or been medically diagnosed with diabetes combined with a medical history of any of the following: stroke, TIA, heart disease, or circulatory disease? ☐ Yes ☐ No
5. Have you ever been medically diagnosed, treated, or taken medication for congestive heart failure, cardiomyopathy, Lou Gehrig's disease, or Huntington's disease? ☐ Yes ☐ No
6. Have you had more than one occurrence of cancer (excluding basal or squamous cell skin cancer) in your lifetime? ☐ Yes ☐ No
7. Within the past 12 months have you:
   a. been medically diagnosed, treated or taken medication for angina, stroke or TIA, cirrhosis, chronic hepatitis, chronic pancreatitis, chronic obstructive pulmonary disease (COPD), emphysema, or required oxygen equipment to assist in breathing? ☐ Yes ☐ No
   b. had or been medically advised to have surgery for brain or heart disorders (including catheterization or a pacemaker insertion), or any procedure to improve circulation? ☐ Yes ☐ No
   c. had a heart attack, aneurysm, heart valve surgery, coronary artery bypass surgery, angioplasty, or stent implant? ☐ Yes ☐ No
   d. been medically diagnosed, treated, or taken medication for internal cancer, lymphoma, melanoma, leukemia, or systemic lupus (SLE)? ☐ Yes ☐ No
   e. had or been recommended to have treatment or counseling for alcohol or drug use, or abused alcohol or drugs, or any diagnostic testing or surgery recommended by a medical professional which has not been completed or for which the results have not been received? ☐ Yes ☐ No

If any answer to questions 4 through 7 is answered "Yes" the Proposed Insured should apply for the Return of Premium Death Benefit Plan.

8. Within the past 24 months have you been medically diagnosed or treated, or taken medication for:
   a. stroke, angina (chest pain), heart attack, aneurysm, heart or circulatory surgery or any procedure to improve circulation? ☐ Yes ☐ No
   b. internal cancer, leukemia, melanoma, emphysema, chronic obstructive pulmonary disease (COPD), ulcerative colitis, cirrhosis, liver disease? ☐ Yes ☐ No
   c. paralysis of two or more extremeties or any neuro-muscular disease (including cerebral palsy, multiple sclerosis, grand mal seizures, or Parkinson's disease)? ☐ Yes ☐ No

If any answer to question 8 is answered "Yes" the Proposed Insured should apply for the Graded Death Benefit Plan.

If all questions 1 through 8 are answered "No" the Proposed Insured should apply for the Immediate Death Benefit Plan.

FOR GRANDCHILD COVERAGE ONLY Grandchildren Proposed for Insurance (any additional children should be listed on a separate sheet):

Proposed Insured Name	Sex	Birthdate	Amt.	Proposed Insured Name	Sex	Birthdate	Amt.
			$5,000				$5,000
			$5,000				$5,000
			$5,000				$5,000
			$5,000				$5,000

GRANDCHILD HEALTH STATEMENT—To the best of my knowledge and belief, none of the grandchildren listed above for coverage have been treated for or told by a physician that they have or had any of the following medical conditions: Hypertension, heart or circulatory disorder, malignancy in any form, diabetes, sickle cell anemia, seizures, Down's Syndrome, cystic fibrosis, cerebral palsy, hydrocephalus, paralysis, or hospitalized for asthma or any respiratory disorder in past 12 months.

List below the names of the grandchildren that are exceptions to the GRANDCHILD HEALTH STATEMENT.

Grandchildren listed as an exception are excluded from the Grandchild Rider Coverage.

Exceptions are:____

AGREEMENT—I agree with American-Amicable Life Insurance Company of Texas (the Company) as follows: (1) To the best of my knowledge and belief, all answers contained in this application are true, complete and correctly recorded; and (2) This application and any policy issued on the basis of such application shall form the entire contract; and (3) No change in this contract shall be effected without my written consent with regard to: (a) the amount of insurance; (b) age at issue; (c) classification of risk; (d) plan of insurance; or (e) benefits. If this application is declined by the Company, I will accept the return of any premium paid. Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application containing a false or deceptive statement may be guilty of insurance fraud.

AUTHORIZATION—In order to properly classify my application for life insurance, I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person that has knowledge or records of me and my health to give such information to: (a) American-Amicable Life Insurance Company of Texas; and (b) its reinsurers.

All said sources, except the Medical Information Bureau, are authorized to give such knowledge or records to any agency employed by the Company to collect and transmit data. I authorize American-Amicable Life Insurance Company of Texas to disclose any personal data gathered while processing this application. This data may be released to the following: (a) reinsuring companies; (b) the Medical Information Bureau; (c) other persons or groups performing services in connection with this application; or (d) any others to whom it may be lawfully required or authorized. This authorization shall remain valid for two years from this date. A copy of this authorization shall be as valid as the original.

I acknowledge receiving the Fair Credit Reporting Act Notice and the MIB Pre-Notice.

I acknowledge receiving the Terminal Illness Accelerated Benefit Rider Disclosure Form.

Signed at ________________________ Date of Application ________________________
CITY STATE MONTH DAY YEAR

Agent ________________ No: ______ % ____ ________________________
SIGNATURE SIGNATURE OF PROPOSED INSURED

Agent ________________ No: ______ % ____ ________________________
SIGNATURE SIGNATURE OF OWNER (IF OTHER THAN PROPOSED INSURED)

Agent ________________ No: ______ % ____
SIGNATURE

AGENT'S REPORT

Is the proposed insurance intended to replace or change any existing insurance or annuities? ☐ Yes ☐ No

I certify that the answers I have given are true and complete to the best of my knowledge. I also certify that each question in all parts of the application was asked and that I have accurately recorded the answers in full as they were given.

I certify that the Terminal Illness Accelerated Benefit Rider Disclosure Form has been presented to the applicant.

Agent's Remarks:________________________ ____________________ __________
WRITING AGENT'S SIGNATURE DATE

PREAUTHORIZATION CHECK PLAN - AUTHORIZATION TO HONOR CHARGE DRAWN

Insured________________________Account Holder________________________

Financial Institution________________________Address________________________

Transit/ABA Number__________Account Number__________☐Checking ☐Savings Requested Draft Day (1st-28th)______

ATTACH VOIDED CHECK OR DEPOSIT SLIP

As a convenience to me, I hereby request and authorize you to pay and charge to my account amounts drawn on my account, whether by electronic or paper means, by and payable to the order of American-Amicable Life Insurance Company of Texas, for the purpose of paying premiums on life insurance policy, provided there are sufficient funds in said account to pay the same upon presentation. I agree that your rights with respect to each such charge shall be the same as if it were signed personally by me. This authorization is to remain in effect until revoked by me in writing and until you actually receive such notice. I agree that you shall be fully protected in honoring any such check. I further agree that if any such check be dishonored, whether with or without cause, and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

________________________ ____________________
SIGNATURE (AS ON FINANCIAL INSTITUTION RECORDS) DATE

AMERICAN-AMICABLE LIFE INSURANCE COMPANY OF TEXAS
P.O. BOX 2549, WACO, TX 76702-2549

CONDITIONAL RECEIPT

NO COVERAGE WILL BECOME EFFECTIVE PRIOR TO POLICY DELIVERY UNLESS AND UNTIL ALL CONDITIONS OF THIS RECEIPT ARE MET. NO AGENT HAS THE AUTHORITY TO ALTER THE TERMS OR CONDITIONS OF THIS RECEIPT.

Received of____the sum of $_______________________________as first payment on this application.

Date____Agent____

If (1) an amount equal to the first full premium is submitted; and if (2) all underwriting requirements, including any medical examinations required by the Company's rules, are completed; and (3) the proposed insured is, on the date of application, a risk acceptable for insurance exactly as applied for without modification of plan, premium rate, or amount under the Company's rules and practices, then insurance under the policy applied for shall become effective on the latest of (a) the date of application, or (b) the date of the latest medical exam required by the Company. THE AMOUNT OF LIFE INSURANCE, INCLUDING ANY AMOUNT IN FORCE OR BEING APPLIED FOR, WHICH MAY BECOME EFFECTIVE PRIOR TO THE DELIVERY OF THE POLICY SHALL IN NO EVENT EXCEED $30,000.00 (INCLUDING LIFE INSURANCE AND ACCIDENTAL DEATH BENEFITS).

If any of the above conditions are not met, the liability of the Company shall be limited to the return of any amount paid.

NOTICE

Printed in compliance with Public Law 91-508

Thank you for considering American-Amicable Life Insurance Company of Texas for your insurance needs. This is to inform you that as part of our procedure for processing your insurance application, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation and personal characteristics. You have the right to make a written request within a reasonable period of time to receive additional detailed information about the nature and scope of this investigation.

MIB PRE-NOTICE

Information regarding your insurability will be treated as confidential. American-Amicable Life Insurance Company of Texas, or its reinsurers, may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112.

American-Amicable Life Insurance Company of Texas, or its reinsurers, may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.