Eagle Premier Series Worksheet

For use in California with Eagle Premier Series eApp. TeleApp not available in California.

This worksheet contains sensitive information and should be kept in a secure location for your records or destroyed.

Agent Information

Name:_____ Agent ID #:_____

Proposed Insured Information

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

Name *(First, MI, Last)*: _____

Mailing Address: _____

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

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

Phone Number: _____-_____- _____ SSN or Taypayer ID: _____

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

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

Name *(First, MI, Last)*: _____

Relationship to Proposed Insured:_____ SSN or Taypayer ID: _____

Mailing Address: _____

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

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

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

Date of Birth: _____/ _____/ _____ Phone Number: _____-_____- _____

Relationship to Proposed Insured:_____

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

Date of Birth: _____/ _____/ _____ Phone Number: _____-_____- _____

Relationship to Proposed Insured:_____

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

☐ Level ☐ Guaranteed Face Amount $_____ Effective Date *(If Not Current Date)*: _____/ _____/ _____

Monthly Premium $_____ ☐ Automatic Premium Loan

If applying for Eagle Premier Level, complete the following information:

1. ☐ Cigarette Smoker ☐ Non-Smoker 2. Height _____' _____" 3. Weight _____ (in pounds)

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

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

Mailing Address: _____

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

Bank Information

Name of Financial Institution: _____

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

Notes:

Policy Number *(Will be provided at the end of the call.)* ☐☐☐☐☐☐☐☐☐☐

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REPLACEMENT INFORMATION

1. Is there any existing life insurance or annuity coverage on the life of any Proposed Insured? ☐ Yes ☐ No
   If **Yes**, provide information in the table below and answer question 2. If **No**, skip question 2, and proceed to the next applicable section.

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

2. Will the life insurance applied for replace, or otherwise reduce in value, any existing life insurance or annuity now in force? ☐ Yes ☐ No

Complete the replacement form(s) in accordance with applicable state replacement regulations. Replacement forms must be submitted with the application.
APPLICATION AND REPLACEMENT FORMS(S) MUST BE COMPLETED AND DATED ON THE SAME DAY.

PROPOSED INSURED HEALTH INFORMATION

☐ **N/A – Guaranteed Issue Product Elected.**

1. Have You smoked cigarettes within the last twelve (12) months? ☐ Yes ☐ No
2. Height:
3. Weight:

	Yes	**No**
4. Have You ever been diagnosed, treated, tested positive, or been given medical advice, or prescribed medication by a member of the medical profession for:		
a. Alzheimer's disease, dementia, memory loss, muscular dystrophy, or ALS (Lou Gehrig's disease)?	☐	☐
b. Congestive heart failure or cardiomyopathy, chronic kidney disease or kidney failure, or received kidney dialysis?	☐	☐
c. Cirrhosis of the liver, liver failure or other liver diseases (excluding Hepatitis A, B, or C)?	☐	☐
d. Emphysema, chronic obstructive pulmonary disease (COPD), or any other chronic respiratory or lung problem, excluding allergies or asthma?	☐	☐
e. Metastatic cancer (cancer that has spread to other parts of the body)?	☐	☐
f. Two (2) or more occurrences of cancer of any kind or a reoccurrence of a previous cancer?	☐	☐
5. In the past twenty-four (24) months, have You been diagnosed, treated, tested positive, or been given medical advice by a member of the medical profession for:		
a. Internal cancer or malignant melanoma (not basal cell skin cancer)?	☐	☐
b. Complications of diabetes, including amputation, retinopathy (eye disease), nephropathy (kidney disease), neuropathy, insulin shock, or diabetic coma?	☐	☐
c. Chronic hepatitis or alcoholic hepatitis?	☐	☐
6. Have you ever been diagnosed, treated, or been given medical advice, or prescribed medication by a member of the medical profession for AIDS or ARC or had a positive test of HIV antibodies in connection with an application for insurance?	☐	☐
7. In the past twenty-four (24) months, have You received a diagnosis, been treated, received medical treatment or counseling, or been prescribed medication by a member of the medical profession for drug or alcohol abuse/dependency or addiction?	☐	☐
8. Within the last twelve (12) months, have You been advised to have tests, surgery or hospitalization (except for those related to HIV or AIDS), which have not been completed, or waiting for a medical diagnosis or results of medical tests or procedures which have not been received?	☐	☐
9. In the past twelve (12) months, have You been diagnosed, treated, tested positive, prescribed medication, or been given medical advice by a member of the medical profession for:		
a. Angioplasty (balloon procedure), stent placement, or heart bypass surgery?	☐	☐
b. Stroke; Heart attack, heart valve disorder, coronary disease, angina (chest pain), or heart disorder (excluding heart murmurs, rhythm disorders, and hypertension)?	☐	☐
10. Have You received advice from a member of the medical profession to have, are You waiting for, or have You ever received, an organ or tissue transplant?	☐	☐
11. Are You now, or within the past six (6) months have you been:		
a. Hospitalized for 48 hours or more, bedridden or confined to or living in a nursing facility or correctional facility?	☐	☐
b. Receiving or been advised by a member of the medical profession to receive hospice care?	☐	☐
c. Receiving home health care for a chronic or debilitating condition?	☐	☐
d. Receiving assistance with activities of daily living, including eating, bathing, toileting, or dressing due to a chronic or debilitating condition?	☐	☐
e. Confined to a wheelchair or using a walker for a chronic illness (except in the case of a temporary condition that is expected to last three (3) months or less)?	☐	☐
f. Using oxygen to assist in breathing?	☐	☐
12. Have You been diagnosed with a terminal illness that is expected to result in death within twenty-four (24) months?	☐	☐

Sales of Life Insurance and Annuities to Seniors in California 03-185-1 CA (10/12)

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Important Notice: *Any person who meets with a senior (age 65 and older) in the senior's home is required to deliver a notice in writing to the senior no less than 24 hours prior to and no more than 14 days before that individual's initial meeting. If the senior has an existing insurance relationship with an agent and requests a meeting with the agent in the senior's home the same day, a notice shall be delivered to the senior prior to the meeting.*

Appointment Date: ____/____/____ **Appointment Time: _____ ☐ AM ☐ PM**

1. **I am a licensed insurance agent. My purpose for coming to your home is to sell, discuss, and/or deliver one of the following (indicate all that apply):**
   - ☐ **Life insurance, including annuities**
   - ☐ **Other insurance products (please specify):**

   _____

   _____
2. **You have the right to have other persons present at the meeting, including family members, financial advisors, or attorneys.**
3. **You have the right to end the meeting at any time.**
4. **You have the right to contact the Department of Insurance for information or to file a complaint. The consumer assistance telephone number at the California Insurance Department is (800) 927-4357 or (213) 897-8921.**
5. **The following individuals will be coming to your home (list all attendees, and insurance license information, if applicable):**

   _____ _____

   _____ _____

   _____ _____

_____ _____ _____

Agent's Printed Name **Agent's Signature** **Date**

_____ _____

Agent's Phone Number **Agent's Address**

By signing this form, I certify that this notice was delivered to me no less than 24 hours prior to and no more than 14 days before the meeting time shown at the top of this form or was provided to me prior to the meeting if the agent has an existing relationship with me.

_____ _____

Signature of Applicant/Proposed Insured **Date**

Notice Regarding
Replacement ACA8328 (2008)

AMERICO

Replacing your life insurance or annuity?

Are you thinking about buying a new life insurance policy or annuity and discontinuing or changing an existing one? If you are, your decision could be a good one – or a mistake. You will not know for sure unless you make a careful comparison of your existing benefits and the proposed benefits.

Make sure you understand the facts. You should ask the company or agent that sold you your existing policy to give you information about it.

Hear both sides before you decide. This way you can be sure you are making a decision that is in your best interest.

We are required by law to notify your existing company that you may be replacing their policy.

_____ _____ _____

(Applicant) (Agent) (Date)

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

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 _____ on (Month/Day/Year) _____ $_____ 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.

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

X _____ Signature of Licensed Agent

X _____ 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.

AAA8404

Important
Consumer Notices

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 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, 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

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. 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.