



101 Continental Place
Brentwood, Tennessee 37027
800 264.4000
cont-life.com

APPLICATION

WHOLE LIFE INSURANCE

Underwritten by
An Aetna Company American Continental Insurance Company

Ohio



American Continental Insurance Company
 An Aetna Company
 101 Continental Place
 Brentwood, TN 37027

Application for Whole Life Insurance from American Continental Insurance Company

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- Please print clearly and use blue or black ink.
- Use Section 4 for additional remarks, requests, or explanations.

1. Proposed insured information

Full name of proposed insured *First, M.I., Last*

Address _____ Phone _____

City _____ State _____ Zip _____

E-mail _____ Social Security Number _____

Write the date of birth that is on the birth certificate. Birth date *mm/dd/yyyy* _____ Age _____

Height *Feet and inches* _____ Weight *Pounds* _____ Male Female

Are you a legal resident of the United States? Yes No

Have you used any form of tobacco in the past 12 months? Yes No

2. Benefits, beneficiary and owner information

To determine which Plan the applicant qualifies for, complete the health questions in Section 3.

Initial amount of insurance applied for: \$ _____

Plan requested: Modified benefit plan Graded benefit plan Level benefit plan

Riders requested (if available): _____

If a nonforfeiture option is not selected, extended term insurance is the default.

Nonforfeiture options: Automatic premium loan Paid-up insurance Extended term insurance

Amount paid with this application: \$ _____

You have a choice of four payment modes for paying your premium. The Company does not charge you more based on the premium mode you select. There may be reasons, such as the time value of money, you would want to consider in making a decision on which premium mode to choose. Your agent can explain the differences in modes and help you decide which is best for you.

Payment mode: Annually Quarterly Semi-Annually Monthly EFT (Electronic Funds Transfer)

Full name of primary beneficiary *First, M.I., Last* _____ Relationship to insured _____

Contingent beneficiary *First, M.I., Last* _____ Relationship to insured _____

Does the proposed insured currently have any life insurance or annuity in force? Yes No

Will insurance applied for in this application replace, reduce or modify premiums paid for any existing life insurance or an annuity in force? Yes No

If the answer to either question is "yes", please provide the information below:

Company name _____ Face amount _____ Policy number _____

Application for Whole Life Insurance

3. Health questions

A. Modified benefit plan

If you answered "yes" to any questions in Section A, you are not eligible for insurance coverage.

- | | | |
|---|-------------------------|-------------------------|
| 1. Do any of the following apply to you? | | |
| A. currently hospitalized, in a nursing facility, confined to a bed, receiving hospice care | <input type="radio"/> Y | <input type="radio"/> N |
| B. require use of oxygen for any lung or respiratory disorder | <input type="radio"/> Y | <input type="radio"/> N |
| C. have been diagnosed by a medical professional to have an aneurysm that has not been surgically repaired | <input type="radio"/> Y | <input type="radio"/> N |
| 2. At any time have you been diagnosed or treated by a medical professional or had surgery for any of the following? | | |
| A. any condition requiring bone marrow, stem cell, or organ transplant | <input type="radio"/> Y | <input type="radio"/> N |
| B. kidney disease requiring dialysis | <input type="radio"/> Y | <input type="radio"/> N |
| C. Alzheimer's Disease, dementia, mental incapacity | <input type="radio"/> Y | <input type="radio"/> N |
| D. Lou Gehrig's Disease (ALS) | <input type="radio"/> Y | <input type="radio"/> N |
| E. a life expectancy of 12 months or less | <input type="radio"/> Y | <input type="radio"/> N |
| F. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), tested positive for the Human Immunodeficiency Virus (HIV) | <input type="radio"/> Y | <input type="radio"/> N |

B. Graded benefit plan

If you answered "yes" to any questions in Section B, you qualify for the Modified benefit plan.

- | | | |
|---|-------------------------|-------------------------|
| 3. Do you have diabetes? | | |
| A. diagnosed by a medical professional before age 40 | <input type="radio"/> Y | <input type="radio"/> N |
| B. in combination with any heart or circulatory disorder diagnosed by a medical professional (excluding high blood pressure) | <input type="radio"/> Y | <input type="radio"/> N |
| C. requiring 40 or more units of insulin daily | <input type="radio"/> Y | <input type="radio"/> N |
| 4. Within the past 12 months, have you been diagnosed or treated by a medical professional or had surgery for any of the following? | | |
| A. heart attack, heart valve disorder, heart blockage, stroke or transient ischemic attack (TIA) | <input type="radio"/> Y | <input type="radio"/> N |
| B. any lung or respiratory disorder requiring the use of a nebulizer | <input type="radio"/> Y | <input type="radio"/> N |
| C. any lung or respiratory disorder and currently use tobacco | <input type="radio"/> Y | <input type="radio"/> N |
| D. internal cancer, melanoma, lymphoma, multiple myeloma, leukemia, systemic lupus (SLE) | <input type="radio"/> Y | <input type="radio"/> N |
| E. chronic pancreatitis, chronic hepatitis, cirrhosis | <input type="radio"/> Y | <input type="radio"/> N |
| 5. Within the past 12 months, have you been recommended by a medical professional to have any of the following? | | |
| A. treatment or counseling for alcohol or drug abuse | <input type="radio"/> Y | <input type="radio"/> N |
| B. test, surgery, treatment or further evaluation that has not been performed or are there any test results pending other than a test or further evaluation for HIV | <input type="radio"/> Y | <input type="radio"/> N |

C. Level benefit plan

If you answered "yes" to any questions in Section C, you qualify for the Graded benefit plan.

If you answered "no" to ALL questions in Section C, you qualify for the Level benefit plan.

- | | | |
|---|-------------------------|-------------------------|
| 6. Within the past 24 months, have you been diagnosed or treated by a medical professional or had surgery for any of the following? | | |
| A. aneurysm, heart attack, any circulatory disorder, stroke or transient ischemic attack (TIA) | <input type="radio"/> Y | <input type="radio"/> N |
| B. emphysema, chronic obstructive pulmonary disease (COPD) | <input type="radio"/> Y | <input type="radio"/> N |
| C. internal cancer, melanoma, leukemia | <input type="radio"/> Y | <input type="radio"/> N |
| D. neuromuscular disorder including, but not limited to, cerebral palsy, multiple sclerosis, muscular dystrophy | <input type="radio"/> Y | <input type="radio"/> N |
| E. any connective tissue disorder, ulcerative colitis, Crohn's disease | <input type="radio"/> Y | <input type="radio"/> N |
| 7. At any time, have you been diagnosed or treated by a medical professional or had surgery for any of the following? | | |
| A. congestive heart failure, cardiomyopathy, Parkinson's disease | <input type="radio"/> Y | <input type="radio"/> N |
| B. any permanent paralysis, amputation caused by disease | <input type="radio"/> Y | <input type="radio"/> N |
| 8. Are you dependent on a wheelchair or motorized mobility device? | | |
| | <input type="radio"/> Y | <input type="radio"/> N |

Application for Whole Life Insurance

4. Remarks

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5. Privacy notice

Your application and telephone interview are American Continental Insurance Company's primary sources of information in determining whether to provide coverage to you. The Company, its affiliates, or its reinsurer(s) may also in certain circumstances release information collected by us to third parties without authorization from you. Upon written request, we will provide you with the information contained in your file. Should you wish to request correction, amendment or deletion of any information in your file, which you believe inaccurate, please contact us and we will advise you of the necessary procedures.

6. Producer compensation

When you purchase insurance from us, we pay compensation to the licensed agent, who represents us for such limited purposes as taking your insurance application, collecting your initial premiums and delivering your policy, and to any intermediaries through which the licensed agent works. This compensation may include commissions when a policy is purchased or renewed, and fees for marketing and administrative services and educational opportunities. The compensation may vary by the type of insurance purchased, or the particular features included with your policy. Additionally, some licensed agents and/or their intermediaries may also receive discounts on their own policy premiums and bonuses, and incentive trips or prizes associated with sales contests based on sales criteria, such as the overall sales volume of an agent or intermediary with our companies, or for the percentage of completed sales. (Generally, this will not be the case for registered variable insurance products or for fixed products sold through banks or broker-dealers.) Intermediaries may also pay compensation directly to the licensed agent. If the licensed insurance agent can sell insurance policies from other insurance carriers, those carriers may pay compensation that differs from ours.

7. Applicant agreement

I hereby apply to American Continental Insurance Company for a policy to be issued in reliance on my answers to the questions in this application. The applicant and agent represent that the applicant has read, or had read to applicant, the completed application, and the applicant understands that any false statements or misrepresentations made in the application may result in loss of coverage under the policy to which this application is a part.

I, the applicant, represent that the statements and answers given in the application are true, complete and correctly recorded to the best of my knowledge and belief. I agree that no insurance shall be in effect until the application has been accepted and approved by the Company and the first full modal premium has been paid. I understand that no insurance agent is authorized to waive any part of any answer on the application, to approve insurability, make or modify any contract or waive any of the Company's rights or requirements.

I understand and agree that, if I choose to pay my premium by electronic funds transfer (EFT) from my checking or savings account, I am accepting the terms and conditions of the EFT authorization attached to this application.

Any person who, knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Applicant signature

Date signed

X

.

Owner signature (if not proposed insured)

X

Signed in *City and State*

.

Application for Whole Life Insurance

8. Account information

Complete this section if you are requesting electronic funds transfer (EFT) for premium payment.

Include a voided check with the application.

Proposed insured's name

•

Account owner name, if different than proposed insured's

•

Account owner relationship to proposed insured:

Business owned

Living trust

Employer

by proposed insured

Power of Attorney

Conservator/guardian

Family member; specify

Financial institution name

•

Checking

Savings

Routing number

•

Account number

•

This is an example of a personal check. A business check may be different.

For all other checks, use the nine-character bank **routing number**, which appears between the **||** symbols, usually at the bottom left corner of the check.

John Henry Doe
PH. 000-000-0000
1234 Any Street
Mycity, TN 00000

Date _____

Pay to the Order of _____ \$ _____ Dollars

Local Bank
Mycity, TN

ACH RT 012345678

For _____

987654321 123456789 001234

For checks with an **ACH RT (Automated Clearing House Routing) number**, please use this number.

The **account number** is up to 17 characters long and appears next to the **||** symbol at the bottom of the check and usually to the right of the bank routing number.

9. Electronic funds transfer (EFT) authorization

I understand and accept these terms and conditions:

- We are authorized to withdraw funds periodically from your account to pay insurance premiums for the insured.
- If your financial institution does not honor an EFT request, we will NOT consider your premium paid.
- If your financial institution does not honor an EFT request, we may make a second attempt within five business days.
- We have the right to end EFT payments at any time and bill you directly either quarterly or less frequently for premiums due.
- Information as to each EFT charge will be provided by entry on your account statement or by any other means provided by your financial institution. You will not receive premium notices from us.
- If you want to cancel or change this authorization, you must contact us at least three business days before a scheduled withdrawal.
- Any refund of unearned premium will be made to the policy owner or the policy owner's estate.

Signature only required if the account owner is different than the proposed insured.

Signature of account owner

Date

X

•

Application for Whole Life Insurance

10. Agent Statement

Number 4 is applicable only if agent has personally recorded the information on the application.

I represent the following:

1. That the insurance being applied for is suitable for the owner's insurance needs.
2. I have explained to the applicant the premium mode options.
3. I have provided all required forms on or before the date the application was taken.
4. I have accurately recorded the information supplied by the applicant.

Does the proposed insured have any existing life insurance or annuity contracts? Yes No

Will the policy applied for be a replacement or change existing life insurance or an annuity? Yes No

If the answer to either question is "yes", have you complied with the requirements of the Company and your state regarding this replacement? Yes No

The writing number reflects where commissions will be paid.

Agent name <i>Printed</i>	Writing number (agent or company)
.....

Agent signature

X

Phone	E-mail
.....

11. Agent request to split commissions

This section must be completed with this application in order to split commissions.

If this application results in an issued policy through American Continental Insurance Company (ACI), the agents listed below have agreed to split the commissions earned on the policy.

- Both agents must be properly licensed and appointed with ACI in the policy's state of issue.
- Split commissions are calculated as a percentage of commissionable premium and will apply while the policy remains inforce.
- The percentage of the premium split can be for any amount but must be stated in whole numbers and total 100%. (For example, the percentage for the premium split can be from 1% to 99% but cannot be 0% or 100%.)
- Calculation of each agent's commissions are based on their respective ACI commission schedule.

Writing agent <i>Printed</i>	Percentage
..... %

Secondary agent <i>Printed</i>	Writing number	Percentage
..... %

By signing this form, the writing agent agrees to split his/her commission with the secondary agent as indicated above.

Writing agent signature

X



American Continental Insurance Company
 An Aetna Company
 101 Continental Place
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800 264.4000
 cont-life.com
 office hours 7:30 a.m. - 4:30 p.m. CST

Receipt

from American Continental Insurance Company

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- Print clearly and use blue or black ink.
- Applicant keeps this receipt for their records.

Proposed insured's name *Printed* _____ Date of application _____
 . _____ . _____

Initial payment collected (if applicable)
 \$ _____ Check Money order

EFT draft amount
 \$ _____

This acknowledges receipt of your application for an American Continental Insurance Company Whole Life insurance policy.

Agent name *Printed* _____ Phone _____
 . _____ . _____

Agent signature
X _____

- Payment will be refunded for any coverage not issued.
- All premium payments must be made payable to American Continental Insurance Company.
- DO NOT make any check payable to the agent and do not leave the payee blank on the check.
- A recorded interview may be required as part of the underwriting on your application for insurance.

Thank you for choosing American Continental Insurance Company!