APPLICATION FOR LIFE INSURANCE

GEORGIA

NEW BUSINESS COVER SHEET

GEORGIA – ICC18A2896

PLEASE SUBMIT COMPLETED SHEET WITH EVERY APPLICATION.

AGENT INFORMATION		
Agent Name		Agent ID
Agent Phone		

INSURED NAME

TO SUBMIT AN APPLICATION		
EMAIL: oaicnewbusiness@OAIC.com	**DOCUMENT TRANSFER ON KCLIC**	**POINT OF SALE (POS):** 1-800-239-7620
FAX: 1-877-523-2265 (IF FAXING, DO NOT MAIL ORIGINAL.)	**OVERNIGHT ADDRESS:** 3520 Broadway Kansas City, Missouri 64111	**NEW BUSINESS ADDRESS:** P.O. Box 219844 Kansas City, Missouri 64121

FORMS INCLUDED IN THIS PACKET

- Bank Draft Authorization (page 7 of the application) **If applicable.**
- Conditional Receipt (page 8 of the application) **Required if money is collected or P.A.P premium mode box marked on application.**
- ID:SF487 How the Accelerated Benefit Prepayment Option Works **Required if the Accelerated Death Benefit Rider is elected.**
- ID:SF571 Authorization for Release of Information to Insurance Agent or Agency
- BL:IN691 Life Insurance Buyer's Guide **Leave with the Proposed Insured.**

OTHER FORMS / SUPPLEMENTS NOT INCLUDED IN THIS PACKET

If this application requires any of the following forms, please access the form(s) via kclic.net (Sales & Marketing Resources) or Supply and include with the submission.

Replacement Forms

- ID:SF339 (Internal & External)
- ID:SF548 (Internal & External)

P.O. Box 218573, Kansas City, MO 64121-8573

Application for Individual Life Insurance

POINT OF SALE INTERVIEW HAS BEEN COMPLETED ☐ YES ☐ NO Interviewer/Case Number ______________________________	Agent ID

PROPOSED INSURED

Name			Date of Birth - -
Address			☐ Male ☐ Female
City	State	Zip	State of Birth
SSN	Email		
Phone Number	Height Ft. In.	Weight Lbs.	

OWNER INFORMATION *(if different from proposed Insured)*

Name		Date of Birth - -
Address		
City	State	Zip
SSN	Relationship	

BENEFICIARIES

Primary	Name	SSN
	Relationship	Date of Birth - -
☐ Primary ☐ Contingent	Name	SSN
	Relationship	Date of Birth - -
☐ Primary ☐ Contingent	Name	SSN
	Relationship	Date of Birth - -

PRODUCT INFORMATION

PLANS	RIDERS	PREMIUM MODE
☐ BMP ☐ BMS ☐ BMQ ☐ BMQL ☐ POM – GUARANTEED ☐ POM – TOMORROW *(Complete page 1 & 3)* ☐ ______________________	☐ ABR ☐ WPNH ☐ ADB ☐ CTR *(See page 3)* ☐ ______________________	☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ P.A.P. ☐ Combine Monthly Billing *(With policy #______________________)*

Face Amount $______________ Premium Amount $______________	MPD – Policy #	Automatic Premium Loan ☐ Yes ☐ No
	☐ Mail policy to Agency	☐ Split application with Agent %

Have you used any form of nicotine/tobacco (cigar, pipe, smokeless tobacco, cigarettes, nicotine patch, nicotine gum, or other products containing nicotine or tobacco) or marijuana in the last 12 months?	☐ Yes ☐ No
Does the proposed Insured have any existing annuity contracts or life insurance policies?	☐ Yes ☐ No
If issued, will this policy replace or change any other life insurance or annuity you now own? If your answer is yes, give details below. Name of current company ______________________________ City ______________________ State __________ Policy No. ______________________	☐ Yes ☐ No

HEALTH QUESTIONS (QUESTIONS 1-8 MUST BE ANSWERED FOR ALL PRODUCTS.)

1. Is the proposed Insured currently hospitalized, confined to a nursing home, hospice, bed, assisted living facility, convalescent home, institutionalized, permanently confined to a wheelchair due to disease or illness, or receiving assistance with performing the following Activities of Daily Living (ADLs): eating, bathing, toileting, continence, dressing, or transferring?	☐ Yes ☐ No
2. Has the proposed Insured **ever** been diagnosed with or received treatment by a member of the medical profession for acquired immune deficiency syndrome (AIDS), AIDS related complex (ARC), tested HIV positive, or been diagnosed by a member of the medical profession as having a terminal medical condition that is expected to result in death within the next 12 months?	☐ Yes ☐ No
3. Has the proposed Insured **ever** been diagnosed with or received treatment (including medication) by a member of the medical profession for Alzheimer's disease, dementia, memory loss, or Lou Gehrig's disease (ALS)?	☐ Yes ☐ No
4. **In the last 12 months**, has the proposed Insured had or been advised by any member of the medical profession to have a diagnostic test (excluding testing related to the Human Immunodeficiency Virus (HIV)), other than for routine screening purposes, for which results have not yet been received?	☐ Yes ☐ No

Has the proposed Insured been diagnosed, treated (including medication), or been given advice by any member of the medical profession:

5. **ever**, for mental retardation, Down syndrome, cystic fibrosis, Huntington's disease, or sickle cell anemia?	☐ Yes ☐ No
6. **in the last 24 months**, for leukemia, lymphoma, melanoma, or any other form of cancer (other than basal cell or squamous cell skin cancer)?	☐ Yes ☐ No
7. **in the last**:	
a. **12 months**, for stroke, TIA (transient ischemic attack), heart attack, or undergone surgery for heart or vascular disease?	☐ Yes ☐ No
b. **24 months**, for congestive heart failure or does the proposed Insured have a cardiac defibrillator?	☐ Yes ☐ No
8. **ever**, for an organ (excluding corneal and kidney) or bone marrow transplant, or had an amputation due to disease (not injury)?	☐ Yes ☐ No

COMPLETE QUESTIONS 9-12 FOR THE FOLLOWING PRODUCTS: BMP, BMS, BMQ, POM-G

9. **In the last 3 years**, has the proposed Insured been convicted of a felony requiring incarceration?	☐ Yes ☐ No
10. **In the last 24 months**, has the proposed Insured had a pacemaker implant, bypass surgery, angioplasty, stent placement, or any other procedure to improve circulation to the heart or brain?	☐ Yes ☐ No

Has the proposed Insured been diagnosed, treated (including medication), or been given advice by any member of the medical profession:

11. **ever**:	
a. for hepatitis B, hepatitis C, systemic lupus, cirrhosis, liver disease, schizophrenia, hospitalized for mental or nervous disorder, emphysema, chronic obstructive pulmonary disease (COPD), chronic bronchitis, sarcoidosis, or used oxygen equipment to assist in breathing (excluding use for sleep apnea)?	☐ Yes ☐ No
b. for a kidney transplant, kidney disease, dialysis, or required insulin before the age of 40?	☐ Yes ☐ No
12. **in the last 24 months**:	
a. for stroke, TIA (transient ischemic attack), heart attack, or undergone surgery for heart or vascular disease?	☐ Yes ☐ No
b. for heart disease, peripheral vascular disease, atrial or ventricular fibrillation, aneurysm, cardiomyopathy, or angina?	☐ Yes ☐ No
c. for alcohol or drug overuse, abuse, or dependency, or been advised to discontinue the use of alcohol or drugs?	☐ Yes ☐ No
d. for complications of diabetes, including nephropathy (kidney), retinopathy (eyes), peripheral vascular disease, diabetic coma, insulin shock?	☐ Yes ☐ No

COMPLETE QUESTIONS 13-16 FOR THE FOLLOWING PRODUCTS: BMP, POM-G

13. **In the last 5 years**, has the proposed Insured had a pacemaker implant, bypass surgery, angioplasty, stent placement, or any other procedure to improve circulation to the heart or brain?	☐ Yes ☐ No

Has the proposed Insured been diagnosed, treated (including medication), or been given advice by any member of the medical profession:

14. **in the last 24 months**, for seizures, multiple sclerosis, Parkinson's disease, cerebral palsy, or muscular dystrophy?	☐ Yes ☐ No
15. **in the last 5 years**:	
a. for alcohol or drug overuse, abuse, or dependency, or been advised to discontinue the use of alcohol or drugs?	☐ Yes ☐ No
b. for stroke, TIA, heart attack, heart disease, peripheral vascular disease, atrial or ventricular fibrillation, aneurysm, cardiomyopathy, angina, or any form of cancer (other than basal cell or squamous cell skin cancer)?	☐ Yes ☐ No
c. for bipolar disorder, requiring more than one prescription medication to control?	☐ Yes ☐ No
16. **ever**, for diabetes requiring insulin treatment or was their most recent hemoglobin A1c above 7.5 or fasting blood sugar above 170?	☐ Yes ☐ No

OLD AMERICAN INSURANCE COMPANY
P.O. Box 218573, Kansas City, MO 64121-8573

Application for Individual Life Insurance
Peace of Mind for Tomorrow
Children's Term Insurance Rider
Must complete pages 1 and 3 of the application.

JUVENILE PRODUCT

☐ **PEACE OF MIND FOR TOMORROW** (One Insured per application.) ☐ **$5,000** ☐ **$10,000**

Name		☐ Male ☐ Female	Date of Birth - -	
Address	City	State	Zip	
State of Birth	SSN	Height Ft. In.	Weight Lbs.	
Beneficiary	Name		SSN	
	Relationship		Date of Birth - -	

COMPLETE THIS SECTION ONLY FOR CHILDREN'S TERM RIDER

☐ CHILDREN'S TERM RIDER (CTR) FACE AMOUNT $ ____________

NAME OF ELIGIBLE CHILD PROPOSED FOR COVERAGE*	DATE OF BIRTH	SEX	HEIGHT (FT. / IN.)	WEIGHT (LBS.)
		☐ Male ☐ Female		
		☐ Male ☐ Female		
		☐ Male ☐ Female		
		☐ Male ☐ Female		
		☐ Male ☐ Female		

*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 as a dependent on the federal tax return of, and resides with, the proposed Insured.

HEALTH QUESTIONS – Complete section if applying for either Peace of Mind for Tomorrow or the Children's Term Rider.

1.	Has the proposed Insured child **ever** been diagnosed with or treated by a member of the medical profession for any of the following conditions: anemia, leukemia, diabetes, nervous disorder, ulcers, tumors, cancer, high blood pressure, or diseases of the heart, liver, kidney, stomach, lungs, or any physical or mental impairment?	☐ Yes ☐ No
2.	Within **the last 2 years**, has the proposed Insured child sought treatment or advice from a member of the medical profession for any illness? If yes, please explain: ____________	☐ Yes ☐ No
3.	Has the proposed Insured child **ever** been diagnosed with or treated by a member of the medical profession for acquired immune deficiency syndrome (AIDS), AIDS related complex (ARC), or tested HIV positive?	☐ Yes ☐ No

AGENT'S SECTION

(If you believe special consideration should be given to the proposed Insured child, please give details of all questions answered "yes".)

____

____

____

AGENT'S CERTIFICATION

I certify that:

1. I have personally seen the proposed Insured. ☐ Yes ☐ No
2. All responses given by the proposed Insured have been recorded accurately on this application and that any premium payment shown in item 7. under Agreements on page 5 has been collected by me and that a Conditional Receipt has been given to the Owner. ☐ Yes ☐ No

Is the proposed Insured related to you? If yes, relationship: ______________________ ☐ Yes ☐ No

Does the proposed Insured have any existing annuity contracts or life insurance policies? ☐ Yes ☐ No

Is the policy applied for in this application intended to replace any life insurance policy or annuity now in force? ☐ Yes ☐ No

I further certify that:

- The above answers are full, complete, and true to the best of my knowledge.
- I know of no factors affecting the insurability of the proposed Insured, except as stated.
- The signatures on page 6 are those they are represented to be and were signed in my presence. If 1. above is No, this statement will not apply.

______________________ ______________________

Licensed Agent Signature Code Number

______________________ ______________________

General Agent Manager Code Number

______________________ ______________________

Signed at City State

ADDITIONAL SPECIAL INFORMATION OR REQUESTS

____

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AGREEMENTS

It is understood and agreed as follows:

1. The statements and answers recorded in all parts of this application are true and complete, to the best of my knowledge and belief.
2. No information regarding any proposed Insured will be considered known by the Company unless explicitly set out in writing on this application.
3. This application and the answers to any required medical exam will become a part of any policy issued on it.
4. No agent has the authority to waive any of the Company's rights or rules or to make or change any contract.
5. The insurance applied for will take effect only after the following occur while the proposed Insured(s) is(are) living and his/her(their) health is as stated in this application: (1) the policy is delivered to, and accepted by, the Owner; and (2) the first full premium is paid in cash. The only exception to this is provided in the Conditional Receipt if it has been issued and the advance payment required by the Conditional Receipt has been made.
6. I(We) have received the Notice of Information Practices which explains my(our) rights under the Fair Credit Reporting Act.
7. I(We) have paid $____________________* to the agent in exchange for the Conditional Receipt and I(we) acknowledge that I(we) fully understand and accept its terms.

By signing on page 6 of this application, you certify that you have completely read and fully understand the above statements. Before signing, read and review your answers for accuracy.

AUTOMATED TECHNOLOGY CONSENT

Old American Insurance Company and its service partners, including ExamOne World Wide, use technology that includes automated telephone dialing systems and prerecorded messages ("Automated Technology") to improve the application process. I understand that I am not required to provide consent to use this Automated Technology as a condition of completing the application process or purchasing insurance or other products from Old American Insurance Company. Unless specified below, I consent to the parties indicated above contacting me at any of the phone numbers I have provided, including cell phones, using Automated Technology.

☐ I do not consent to the parties indicated above contacting me using Automated Technology.

TAXPAYER IDENTIFICATION NUMBER CERTIFICATION

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2. above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2. does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN.

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

______________________________	______________________________
Primary Insured's Signature (if age 18 or over)	**Owner's Signature (if other than Primary Insured)**

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien;
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States;
- An estate (other than a foreign estate); or
- A domestic trust (as defined in Regulations section 301.7701-7).

AUTHORIZATION FOR THE RELEASE OF PERSONAL AND MEDICAL INFORMATION

To obtain a copy of or to revoke this authorization, contact:
New Business Department
Old American Insurance Company
P.O. Box 219844
Kansas City, MO 64121

This authorization applies to all persons whose signatures appear below. The proposed Primary Insured and all other proposed Insureds must sign.

I authorize any health plan; physician; health care professional; hospital; clinic; laboratory; pharmacy or pharmacy benefit manager; medical facility; or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers"); MIB, Inc.; insurers; reinsurers; government agencies; consumer reporting agencies and/or employers to disclose my entire medical record, prescription history, medications prescribed and any other personal, financial, or protected health information concerning me to Old American Insurance Company or any person acting on behalf of Old American Insurance Company. I authorize Old American Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB. "Information" means facts regarding my physical or mental condition (including the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection; sexually transmitted diseases; mental illness; the use of alcohol, drugs, and tobacco; but excluding psychotherapy notes); employment; other insurance coverage; financial status; or any other relevant information about me or my minor children. Information obtained will be released only to reinsurers; MIB, Inc.; persons and entities performing business duties as delegated or contracted for by Old American Insurance Company related to my application and subsequent insurance-related functions as permitted or required by law or as I further authorize. Some of the health information obtained may be disclosed to persons or organizations that are not subject to federal health information privacy laws, resulting in the information no longer being protected under such laws.

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 health plan; physician; health care professional; hospital; clinic; laboratory; pharmacy or pharmacy benefit manager; medical facility; or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers"); MIB, Inc.; insurers; reinsurers; government agencies; consumer reporting agencies and/or employers to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this authorization so that Old American Insurance Company 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 Old American Insurance Company.

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. This time limit complies with the time limit, if any, permitted by applicable law in the state where the policy is delivered or issued for delivery. I understand that I have the right to revoke this authorization in writing at any time by providing written notification to the entity identified above, and I understand that a revocation is not effective to the extent that any of My Providers has already relied on this authorization to disclose information about me or to the extent that Old American Insurance Company 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 is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be redisclosed by the recipient except as authorized by me or as required by law.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization or otherwise condition my enrollment or eligibility for health benefits on my signing this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, Old American Insurance Company may not be able to process my application or, if coverage has been issued, may not be able to make any benefit payments. I understand that any authorized representative or I will receive a copy of this authorization upon request.

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Dated at ______________________________ this ________ day of ______________________, 20 ________
City/State Month Year

____
Signature of Owner (if other than Primary Insured)

____
Proposed Insured's Signature (if age 18 or over)

____
Additional Signature (if age 18 or over)

____
Additional Signature (if age 18 or over)

Bank Draft Authorization

Please select only one option. Include a copy of a voided check for bank draft.

Available draft days are the 1st through the 28th. Withdrawals will be made on or about the premium draft date shown.
The Conditional Receipt is required in all cases.

- ☐ Draft my account for the first premium. Please draft subsequent premiums on the ____________ of each month.
- ☐ Delay my first draft until: ________________________________. All subsequent drafts will occur on this same day each month.
- ☐ The initial premium is attached, please draft subsequent premiums on the ______________ of each month.

Please make check or money order payable to Old American Insurance Company.

Account Information

Bank Name			
Address	City	State	Zip
Routing Number (Must fill in all boxes and start with a 0, 1, 2, or 3.) ☐☐☐☐☐☐☐☐☐	Account Number		☐ Checking ☐ Savings

Agreement for Automatic Premium Payments and Authorization to Honor Checks Drawn by the Company

It is agreed that:

1) This bank draft authorization does not change any policy provisions. The payor's authorization is not in lieu of payment in cash of the first premium and does not constitute advance payment required by the Conditional Receipt.
2) Upon 30 days written notice, this bank draft authorization may be stopped or changed at any time by: the owner of any policy under this bank draft authorization, the Company, or the payor.
3) No premium notices or receipts will be sent. Debit entries or checks, when paid, will constitute receipts for premiums.
4) The privilege of paying premiums under this bank draft authorization may be revoked by the Company if any check or debit entry is not paid upon presentation.
5) The Company's rights in respect to each check and/or debit entry will be the same as if I signed it personally.
6) If any debit or check entry is dishonored, the Company will be under no liability whatsoever, even if such dishonor results in forfeiture of insurance.
7) I authorize the Company to pay and charge to my(our) account, debit entries or checks drawn by and payable to the order of the Company, provided there are sufficient collected funds present to pay same upon presentation. This authorization will remain in effect until revoked by me in writing, a copy of which will be sent to the Company. Until the Company receives such notice, I agree that the Company will be fully protected in honoring any such debit.

Print Premium Payor's Name: ____

Signature of Premium Payor: ____ Date: ______________________

PLEASE TAPE A VOIDED CHECK IN THIS BOX.

OLD AMERICAN INSURANCE COMPANY
P.O. Box 218573, Kansas City, MO 64121-8573

Conditional Receipt

If the proposed Insured in this application dies before coverage under this Receipt terminates, we will pay the Receipt benefit described below to the beneficiary named in the application, subject to the Conditions.

Please read this Receipt carefully. No coverage is in force other than as stated in this Receipt. No agent may change the terms of this Receipt. No coverage will be effective under this Conditional Receipt if advance payment is not made by check or bank draft.

Conditions

If the amount received by check or bank draft with the application is at least one month's premium for the policy applied for, the coverage will be in effect as of the date of this Receipt, BUT ONLY IF the proposed Insured is hereafter determined by the Company, according to the underwriting standards of the Company then in effect, to be insurable for the policy exactly as applied for.

Fraud or material misrepresentations invalidate this Receipt and the Company's only liability is for refund of any payment made. All parts of the application must be completed and received by the Company.

Benefit

The benefit under this Receipt is an amount equal to the lesser of the Face Amount applied for on the proposed Insured in the application or $50,000. The benefit provided by this Receipt is further limited as follows:

(1) the maximum total coverage provided under all Conditional Receipts of the Company in effect on the proposed Insured is limited to $50,000;

(2) for death due to suicide, the Company's liability is limited to return of any amount paid with the application;

(3) this Receipt is not effective as to any rider or supplemental benefits to the policy;

(4) if payment is made by check or bank draft, coverage is effective only if the check or bank draft is honored on first presentation for payment;

(5) in no event may this Receipt and the policy applied for provide coverage at the same time.

Date Coverage Terminates

The coverage provided by this Receipt will end on the earliest of:

(1) the date coverage becomes effective under the policy applied for;

(2) the date the Company mails notice of termination of coverage to the Owner;

(3) 60 days from the date of this Receipt; or

(4) the date the Owner withdraws the application for insurance.

If the application is declined or withdrawn, the Company will immediately refund any amount paid with this application.

All premium checks must be payable to Old American Insurance Company. Do not make check payable to the agent or leave the payee blank.

Name of Proposed Insured: ____

Payment Amount: ______________________

Dated at: _________________________________ this ______ day of ____________________, 20_______.
City/ State Month Year

Agent's Signature: ____

To obtain further information contact:
New Business Department
Old American Insurance Company
P.O. Box 219844
Kansas City, MO 64121

NOTICE OF INFORMATION PRACTICES

Including Fair Credit Reporting Act Notice and MIB, Inc. Notice

Thank you for your application. It is the major source of information about you which we use in evaluating your application and issuing your contract. However, we wish to inform you that an investigative consumer report may be ordered as to your insurability. If an investigative consumer report is prepared in connection with this application, you may request to be interviewed in connection with the preparation of this report. This report may include, if applicable, information as to your character, general reputation, personal characteristics and mode of living (except as may be related directly or indirectly to your sexual orientation) as may be obtained through interviews with family members, friends, neighbors and associates. We may also order a credit report.

If you would like to know whether such a report was ordered and, if so, receive additional information as to its nature and scope, including the name, address and phone number of the reporting agency, we will be pleased to furnish this information upon your written request to our Home Office at the address above. You may receive a copy of such report by contacting the reporting agency. Our experience shows that information from investigative reports usually does not have any adverse effect on our underwriting decision. However, if it should, we will notify you in writing of this fact as well as provide you the identity by name and address of the reporting agency. You may then wish to discuss the matter with that agency.

We are committed to protecting the privacy of our customer's nonpublic personal information. We will only disclose our customer's nonpublic personal information: among the affiliated companies of Old American Insurance Company; to provide services to our customers and administer our business; to market products; and as otherwise permitted by law. We may disclose our customer's nonpublic personal information to our agents and representatives to provide services to our customers and for marketing purposes. When we contract with other entities to provide support or marketing services, we will require them to adhere to our privacy standards.

Sometimes we acquire medical information about our customers, for instance, to underwrite an insurance contract or to process an insurance claim. We will keep our customer's medical information confidential. We will not share our customer's medical information even among the affiliated companies of Old American Insurance Company without the customer's consent. We will only use or disclose our customer's medical information to underwrite insurance, process claims, administer our business, to comply with laws and regulations or as otherwise authorized by our customers.

You have the right to obtain access to certain items of information we have collected about you, and you have the further right to request correction of information if you feel it is inaccurate.

If you wish to have a more detailed description of our information practices, we will be pleased to furnish this information upon your written request to our New Business Department, Old American Insurance Company, P.O. Box 219844, Kansas City, MO 64121.

MIB, Inc. Notice

Information regarding your insurability will be treated as confidential. Old American 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 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. 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.

Old American Insurance Company, or its reinsurers, may also release information from its file 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.

This page remains with the applicant.

How the Accelerated Benefit Prepayment Option Works:

If in a physician's best medical judgment an Insured will die within one year, the policy owner may request prepayment of up to 50% of the policy face amount. This amount, less the same percentage of any outstanding policy loan amount, will then be paid to the policy owner.

For example, if an Insured requests a 50% benefit prepayment on a $10,000 policy with an outstanding policy loan of $1,000, the accelerated benefit would be $4,500 ($5,000 less $500). This same percentage will apply to other policy values as noted below:

- After payment of the accelerated benefit, the policy premium payment will be reduced by the accelerated benefit payment percentage. (An $800 annual premium* payment would be reduced to $400.)
- If the policy has built up cash value, the cash value at the time of the benefit prepayment will also be reduced by the accelerated benefit payment percentage requested. (A $1,000 cash value would be reduced to $500.)
- If there is a policy loan outstanding, the loan amount is also reduced by the accelerated benefit payment percentage. (A $1,000 outstanding policy loan would be reduced to $500.)

EXAMPLE: Male, Age 60

Policy Status Before Benefit

Item		Amount
Original Face Amount	$	10,000.00
Policy Annual Premium*	$	804.80
Outstanding Policy Loan	$	1,000.00
Policy Cash Value	$	1,000.00
Terminal Benefit Requested (50% of Face Amount)	$	5,000.00
Less 50% of Policy Loan Amount		500.00
Benefit Prepayment Made to Insured	$	4,500.00

Policy Status After Benefit Prepayment

Item		Amount
Face Amount of Policy	$	5,000.00
Policy Annual Premium*	$	402.40
Policy Cash Value	$	500.00
Outstanding Policy Loan	$	500.00

*Does not include $42.00 policy fee.

ANY ACCELERATED BENEFITS PAID UNDER THIS POLICY MAY BE TAXABLE. IF SO, YOU OR YOUR BENEFICIARY MAY INCUR A TAX OBLIGATION. AS WITH ALL TAX MATTERS YOU SHOULD CONSULT YOUR PERSONAL TAX ADVISOR TO ASSESS THE IMPACT OF THIS BENEFIT.

OLD AMERICAN

INSURANCE COMPANY

3520 Broadway, Kansas City, MO 64111

Authorization for Release of Information to Insurance Agent or Agency

I authorize Old American Insurance Company, or its authorized third-party vendor, to disclose personal and medical information about me to the insurance agent and/or agency stated in my application for life insurance.

Information that Old American Insurance Company or its authorized third-party vendor may disclose includes medical information and other personal information as it relates to actions Old American Insurance Company may have taken based on this information, such as charging me a higher premium for my insurance, changing benefits to something other than I applied for, or declining my application for insurance.

The information will be used to help me with the insurance application process or to find other insurance coverage options.

I understand that if the person or entity that receives the above information is not covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

I understand that I may refuse to sign this authorization. If I refuse to sign, it will not affect the issuance of the insurance for which I am applying.

Unless revoked earlier, this authorization will remain in effect for 24 months from the date I sign it. I understand that I may revoke this authorization at any time, by written notice to: Old American Insurance Company, New Business Department, P.O. Box 219844, Kansas City, Missouri 64121-9844.

I realize that my right to revoke this authorization is limited to the extent that Old American Insurance Company, or its authorized third-party vendor, has taken action in reliance on the authorization.

I understand that I will receive a copy of the authorization.

Proposed Insured's signature: ____

Date: ___________________________

ID:SF571 Company Copy

Instructions to Agent

Client Copy must be given to the proposed Insured.
Forward the Company Copy to the Home Office.

LEAVE WITH CLIENT

COMPLETE THE FOLLOWING FORMS AND LEAVE THESE COPIES WITH THE OWNER.

P.O. Box 218573, Kansas City, MO 64121-8573

Conditional Receipt

If the proposed Insured in this application dies before coverage under this Receipt terminates, we will pay the Receipt benefit described below to the beneficiary named in the application, subject to the Conditions.

Please read this Receipt carefully. No coverage is in force other than as stated in this Receipt. No agent may change the terms of this Receipt. No coverage will be effective under this Conditional Receipt if advance payment is not made by check or bank draft.

Conditions

If the amount received by check or bank draft with the application is at least one month's premium for the policy applied for, the coverage will be in effect as of the date of this Receipt, BUT ONLY IF the proposed Insured is hereafter determined by the Company, according to the underwriting standards of the Company then in effect, to be insurable for the policy exactly as applied for.

Fraud or material misrepresentations invalidate this Receipt and the Company's only liability is for refund of any payment made. All parts of the application must be completed and received by the Company.

Benefit

The benefit under this Receipt is an amount equal to the lesser of the Face Amount applied for on the proposed Insured in the application or $50,000. The benefit provided by this Receipt is further limited as follows:

(1) the maximum total coverage provided under all Conditional Receipts of the Company in effect on the proposed Insured is limited to $50,000;

(2) for death due to suicide, the Company's liability is limited to return of any amount paid with the application;

(3) this Receipt is not effective as to any rider or supplemental benefits to the policy;

(4) if payment is made by check or bank draft, coverage is effective only if the check or bank draft is honored on first presentation for payment;

(5) in no event may this Receipt and the policy applied for provide coverage at the same time.

Date Coverage Terminates

The coverage provided by this Receipt will end on the earliest of:

(1) the date coverage becomes effective under the policy applied for;

(2) the date the Company mails notice of termination of coverage to the Owner;

(3) 60 days from the date of this Receipt; or

(4) the date the Owner withdraws the application for insurance.

If the application is declined or withdrawn, the Company will immediately refund any amount paid with this application.

All premium checks must be payable to Old American Insurance Company. Do not make check payable to the agent or leave the payee blank.

Name of Proposed Insured: ____

Payment Amount: ______________________

Dated at: ________________________________ this ______ day of ____________________, 20______.
City/ State Month Year

Agent's Signature: ____

How the Accelerated Benefit Prepayment Option Works:

If in a physician's best medical judgment an Insured will die within one year, the policy owner may request prepayment of up to 50% of the policy face amount. This amount, less the same percentage of any outstanding policy loan amount, will then be paid to the policy owner.

For example, if an Insured requests a 50% benefit prepayment on a $10,000 policy with an outstanding policy loan of $1,000, the accelerated benefit would be $4,500 ($5,000 less $500). This same percentage will apply to other policy values as noted below:

- After payment of the accelerated benefit, the policy premium payment will be reduced by the accelerated benefit payment percentage. (An $800 annual premium* payment would be reduced to $400.)
- If the policy has built up cash value, the cash value at the time of the benefit prepayment will also be reduced by the accelerated benefit payment percentage requested. (A $1,000 cash value would be reduced to $500.)
- If there is a policy loan outstanding, the loan amount is also reduced by the accelerated benefit payment percentage. (A $1,000 outstanding policy loan would be reduced to $500.)

EXAMPLE: Male, Age 60

Policy Status Before Benefit

Original Face Amount	$	10,000.00
Policy Annual Premium*	$	804.80
Outstanding Policy Loan	$	1,000.00
Policy Cash Value	$	1,000.00
Terminal Benefit Requested (50% of Face Amount)	$	5,000.00
Less 50% of Policy Loan Amount		500.00
Benefit Prepayment Made to Insured	$	4,500.00

Policy Status After Benefit Prepayment

Face Amount of Policy	$	5,000.00
Policy Annual Premium*	$	402.40
Policy Cash Value	$	500.00
Outstanding Policy Loan	$	500.00

*Does not include $42.00 policy fee.

ANY ACCELERATED BENEFITS PAID UNDER THIS POLICY MAY BE TAXABLE. IF SO, YOU OR YOUR BENEFICIARY MAY INCUR A TAX OBLIGATION. AS WITH ALL TAX MATTERS YOU SHOULD CONSULT YOUR PERSONAL TAX ADVISOR TO ASSESS THE IMPACT OF THIS BENEFIT.

3520 Broadway, Kansas City, MO 64111

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Date: ___________________________

ID:SF571 Client Copy

Instructions to Agent
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Life Insurance Buyer's Guide

This guide can show you how to save money when you shop for life insurance. It helps you to:

- decide how much life insurance you should buy,
- decide what kind of life insurance policy you need, and
- compare the cost of similar life insurance policies.

Prepared by the National Association of Insurance Commissioners

Reprinted by Old American Insurance Company (January 2019)

The National Association of Insurance Commissioners is an association of state insurance regulatory officials. This association helps the various Insurance Departments to coordinate insurance laws for the benefit of all consumers. You are urged to use this Guide in making a life insurance purchase.

This Guide Does Not Endorse Any Company or Policy.

Buying Life Insurance

When you buy life insurance, you want a policy which fits your need without costing too much. Your first step is to decide how much you need, how much you can afford to pay and the kind of policy you want. Then, find out what various companies charge for that kind of policy. You can find important differences in the cost of life insurance by using the life insurance cost indexes which are described in this guide. A good life insurance agent or company will be able and willing to help you with each of these shopping steps.

If you are going to make a good choice when you buy life insurance, you need to understand which kinds are available. If one kind does not seem to fit your needs, ask about the other kinds which are described in this Guide. If you need more information than is given here, you may want to check with a life insurance agent or company or books on life insurance in your public library.

Choosing the Amount

One way to decide how much life insurance you need is to figure how much cash and income your dependents would need if you were to die. You should think of life insurance as a source of cash needed for expenses of final illnesses, paying taxes, mortgages or other debts. It can also provide income for your family's living expenses, educational costs and other future expenses. Your new policy should come as close as you can afford to making up the difference between (1) what your dependents would have if you were to die now, and (2) what they would actually need.

Choosing the Right Kind

All life insurance policies agree to pay an amount of money if you die. But all policies are not the same. There are three basic kinds of life insurance.

1. Term Insurance
2. Whole Life Insurance
3. Endowment Insurance

Remember, no matter how fancy the policy title or sales presentation might appear all life insurance policies contain one or more of the three basic kinds. If you are confused about a policy that sounds complicated, ask the agent or company if it combines more than one kind of life insurance.

The following is a brief description of the three basic kinds:

Term Insurance:

Term Insurance is death protection for a “term” of one or more years. Death benefits will be paid only if you die within that term of years. Term insurance generally provides the largest immediate death protection for your premium dollar.

Some term insurance policies are “renewable” for one or more additional terms even if your health has changed. Each time you renew the policy for a new term, premiums will be higher. You should check the premiums at older ages and the length of time the policy can be continued. Some term insurance policies are also “convertible.” This means that before the end of the conversion period, you may trade the term policy for a whole life or endowment insurance policy even if you are not in good health. Premiums for the new policy will be higher than you have been paying for term insurance.

Whole Life Insurance:

Whole life insurance gives death protection for as long as you live. The most common type is called “straight life” or “ordinary life” insurance, for which you pay the same premiums for as long as you live. These premiums can be several times higher than you would pay initially for the same amount of term insurance. But they are smaller than the premiums you would eventually pay if you were to keep renewing a term insurance policy until your later years.

Some whole life policies let you pay premiums for a shorter period such as 20 years, or until age 65. Premiums for these policies are higher than for ordinary life insurance since the premium payments are squeezed into a shorter period.

Although you pay higher premiums, to begin with, for whole life insurance than for term insurance, whole life insurance policies develop “cash values” which you may have if you stop paying premiums. You can generally either take the cash, or use it to buy some continuing insurance protection. Technically speaking, these values are called “nonforfeiture benefits.” This refers to benefits you do not lose (or “forfeit”) when you stop paying premiums. The amount of these benefits depends on the kind of policy you have, its size, and how long you have owned it.

A policy with cash values may also be used as collateral for a loan. If you borrow from the life insurance company, the rate of interest is shown in your policy. Any money which you owe on a policy loan would be deducted from the benefits if you were to die or from the cash value if you were to stop paying premiums.

Endowment Insurance:

An endowment insurance policy pays a sum or income to you -- the policyholder -- if you live to a certain age. If you were to die before then, the death benefit would be paid to your beneficiary. Premiums and cash values for endowment insurance are higher than the same amount of whole life insurance. Thus, endowment insurance gives you the least amount of death protection for your premium dollar.

Finding a Low Cost Policy

After you have decided which kind of life insurance fits your needs, look for a good buy. Your chances of finding a good buy are better if you use two types of index numbers that have been developed to aid in shopping for life insurance. One is called the “Surrender Cost Index” and the other is the “Net Payment Cost Index.” It will be worth your time to try to understand how these indexes are used, but in any event, use them only for comparing the relative costs of similar policies. LOOK FOR POLICIES WITH LOW COST INDEX NUMBERS.

What is Cost?

“Cost” is the difference between what you pay and what you get back. If you pay a premium for life insurance and get nothing back, your cost for the death protection is the premium. If you pay a premium and get something back later on, such as a cash value, your cost is smaller than the premium.

The cost of some policies can also be reduced by dividends; these are called “participating” policies. Companies may tell you what their current dividends are, but the size of future dividends is unknown today and cannot be guaranteed. Dividends actually paid are set each year by the company.

Some policies do not pay dividends. These are called “guaranteed cost” or “nonparticipating” policies. Every feature of a guaranteed cost policy is fixed so that you know in advance what your future cost will be. The premiums and cash values of a participating policy are guaranteed, but the dividends are not. Premiums for participating policies are typically higher than for guaranteed cost policies, but the cost to you may be higher or lower, depending on the dividends actually paid.

What Are Cost Indexes?

In order to compare the cost of policies, you need to look at:

1. Premiums
2. Cash Values
3. Dividends

Cost indexes use one or more of these factors to give you a convenient way to compare relative costs of similar policies. When you compare costs, an adjustment must be made to take into account that money is paid and received at different times. It is not enough to just add up the premiums you will pay and to subtract the cash values and dividends you expect to get back. These indexes take care of the arithmetic for you. Instead of having to add, subtract, multiply, and divide many numbers yourself, you just compare the index numbers which you can get from life insurance agents and companies.

1. ***Life Insurance Surrender Cost Index –*** This index is useful if you consider the level of the cash values to be of primary importance to you. It helps you compare costs if, at some future point in time, such as 10 or 20 years, you were to surrender the policy and take its cash value.
2. ***Life Insurance Net Payment Cost Index –*** This index is useful if your main concern is the benefits that are to be paid at your death and if the level of cash values is of secondary importance to you. It helps you compare costs at some future point in time, such as 10 or 20 years, if you continue paying premiums on your policy and do not take its cash value.

There is another number called the Equivalent Level Annual Dividend. It shows the part dividends play in determining the cost index of a participating policy. Adding a policy's Equivalent Level Annual Dividend to its cost index allows you to compare total costs of similar policies before deducting dividends. However, if you make any cost comparisons of a participating policy with a non-participating policy, remember that the total cost of the participating policy will be reduced by dividends, but the cost of the nonparticipating policy will not change.

How Do I Use Cost Indexes?

The most important thing to remember when using cost indexes is that a policy with a small index number is generally a better buy than a comparable policy with a larger index number. The following rules are also important:

1. Cost comparisons should only be made between similar plans of life insurance. Similar plans are those which provide essentially the same basic benefits and require premium payments for approximately the same period of time. The closer policies are to being identical, the more reliable the cost comparison will be.
2. Compare index numbers only for the kind of policy, for your age and for the amount you intend to buy. Since no one company offers the lowest cost for *all* types of insurance at *all* ages and for *all* amounts of insurance, it is important that you get the indexes for the actual policy, age, and amount which you intend to buy. Just because a “Shopper's Guide” tells you that one company's policy is a good buy for a particular age and amount, you should not assume that all of that company's policies are equally good buys.
3. Small differences in index numbers could be offset by other policy features, or differences in the quality of service you may expect from the company or its agent. Therefore, when you find small differences in cost indexes, your choice should be based on something other than cost.
4. In any event, you will need other information on which to base your purchase decision. Be sure you can afford the premiums, and that you understand its cash values, dividends and death benefits. You should also make a judgment on how well the life insurance company or agent will provide service in the future, to you as a policyholder.
5. These life insurance cost indexes apply to new policies and should not be used to determine whether you should drop a policy you have already owned for a while, in favor of a new one. If such a replacement is suggested, you should ask for information from the company which issued the old policy before you take action.

IMPORTANT THINGS TO REMEMBER -- A SUMMARY

The first decision you must make when buying a life insurance policy is choosing a policy whose benefits and premiums most closely meet your needs and ability to pay. Next, find a policy which is also a relatively good buy.

If you compare Surrender Cost Indexes and Net Payment Cost Indexes of similar competing policies, your chances of finding a relatively good buy will be better than if you do not shop. REMEMBER, LOOK FOR POLICIES WITH LOWER COST INDEX NUMBERS. A good life insurance agent can help you to choose the amount of life insurance and kind of policy you want and will give you cost indexes so that you can make cost comparisons of similar policies.

Don't buy life insurance unless you intend to stick with it. A policy which is a good buy when held for 20 years can be very costly if you quit during the early years of the policy. If you surrender such a policy during the first few years, you may get little or nothing back and much of your premium may have been used for company expenses.

Read your new policy carefully, and ask the agent or company for an explanation of anything you do not understand. Whatever you decide now, it is important to review your life insurance program every few years to keep up with changes in your income and responsibilities.

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OA-GA 10/19
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