American Home Life Pre-Interview Final Expense Worksheet

1 – Client Name (First, M.I., Last):_____. **2** – Insured ST Residence:_____.

3 - Read Declarations & Authorizations? Y ☐ OR ☐ N See Pg. 3 **4** –Auto Premium Loan Option? Y ☐ OR ☐ N

5 – Level ☐ OR ☐ Graded?: **6** – Face Amount? $_____. **3** – Accidental Death Benefit? Y ☐ OR ☐ N

4 -Premium Quoted (monthly) -_____.; **5** - DOB: (Mo/Day/Year):_____.

6 - Age _____. ; **7** – Insured Birthplace (City, ST):_____.

8 - Client Telephone #:_____. **9**- Height & Weight:_____.

10 – Address (House / Apt #, Street, City, State, Zip) **11**– SSN :_____.

(Address Line)_____.

12 – Primary Bene (Name + Relationship) –_____.

13 – Contingent Bene (Name + Relationship) –_____.

14 – Any Health Questions Answers Yes? Which, Why? Question #s:

15 – **Dr. Info** – ***Required*** on ALL Applicants 66 or Older – We WILL ask for ALL applicants though!

Dr. or Clinic Name:_____. ; City, St:_____.

Dr or Clinic Telephone Number:_____.

16 – **Banking Info**:
Bank Name:_____; Bank City, St: _____
Routing #:_____; Acct #: _____
Name as it appears on acct: _____

17 – Secondary Addressee (FL, ID, MY Only) (Name, Address)_____

_____

19-Preferred Withdrawal Date: (1-28th **OR** 1st or 3rd of month **OR** 2nd, 3rd, 4th Weds of month?_____

20 – Policy Mailed to: Owner ☐ / Agency ☐ / Other (Who, Address) : _____

Other Notes:

If any part of questions 1-5 is answered "YES" do not submit the application.

1-Y ☐ or N ☐	2-Y ☐ or N ☐	2A-Y ☐ or N ☐	2B-Y ☐ or N ☐	2C-Y ☐ or N ☐	2D-Y ☐ or N ☐
2E-Y ☐ or N ☐	2F-Y ☐ or N ☐	2G-Y ☐ or N ☐	3-Y ☐ or N ☐	4-Y ☐ or N ☐	5-Y ☐ or N ☐

1. Are you hospitalized, bedridden or confined to a nursing home, hospice or long-term care facility?
2. To the best of your knowledge and belief, has a medical professional diagnosed you, provided treatment or advised you to receive treatment for any of the following:
   - A. A medical condition that, with reasonable medical certainty, will result in death within 12 months, ALS, Alzheimer's, memory loss, mental incapacity or dementia?
   - B. Medication (pills or Insulin) for diabetes accompanied by history of a heart attack, artery bypass or stent, angina, kidney disease, peripheral arterial disease (PAD, poor circulation) or amputation, Transient Ischemic Attack (TIA) or stroke?
   - C. Cirrhosis, liver failure, kidney failure requiring dialysis, Leukemia or organ transplant?
   - D. Current cancer or history of pancreatic, ovarian, or metastatic cancer, or two or more instances of internal cancer?
   - E. Implantation of a defibrillator, or used or been advised to use oxygen to assist breathing?
   - F. Congestive heart failure?
3. Have you ever been diagnosed or treated by a medical professional, for an immune deficiency disorder, Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), or AIDS related complex (ARC)?
4. Have you, within the past 12 months, been advised by a medical professional to have a diagnostic test (excludes HIV or AIDS related test), surgery, dialysis, home health care, nursing home, hospice or long-term care facility confinement or hospitalization which has not yet been started, completed or for which results are not known?
5. In the last 36 months, have you been convicted of a felony or are you currently on probation or parole?

If two or less of the following questions (6-9) are answered "yes", Proposed Insured will only be eligible for Graded Benefit. If more than two questions (6-9) are answered yes, do not submit the application.

6-Y ☐ or N ☐	7-Y ☐ or N ☐	8A-Y ☐ or N ☐	8B-Y ☐ or N ☐	8C-Y ☐ or N ☐	8D-Y ☐ or N ☐
8E-Y ☐ or N ☐	8F-Y ☐ or N ☐	8G-Y ☐ or N ☐	9-Y ☐ or N ☐	10-Y ☐ or N ☐	Nicotine-Y ☐ or N ☐

6. Do you have diabetes diagnosed by a medical professional that is not controlled (includes A1c over 10.0, blood sugar over 200, insulin shock or diabetic coma in past 6 months)?
7. Are you wheelchair bound or do you need ongoing assistance with activities of daily living (eating, bathing, dressing, transferring, use of the toilet or the taking of medications) either provided by a family member or third party?
8. In the last 24 months has a medical professional diagnosed you, provided treatment or advised you to receive treatment for any of the following:
   - A. Heart disease (excluding hypertension) or any procedure to improve circulation to the heart including coronary artery bypass or stents?
   - B. Stroke or Transient Ischemic Attack (TIA) or a procedure to improve circulation to the brain?
   - C. Peripheral arterial disease (PAD, poor circulation) or any procedure to improve circulation to the extremities?
   - D. Counseling, treatment or ongoing abuse of alcohol or substances including taking prescribed medications other than as prescribed?
   - E. Opioid dependence or convicted of operating a vehicle while intoxicated?
   - F. Kidney or liver disease, hepatitis C, Lupus, Parkinson's Disease or Multiple Sclerosis (MS)?
   - G. Any chronic lung disorder excluding intermittent asthma attacks?
9. Have you had a seizure in the last 30 days or more than one seizure in the last 12 months?
10. In the last 36 months has a medical professional diagnosed you, provided treatment or advised you to receive treatment for internal cancer, melanoma or disorder of the blood (this excludes squamous cell and basal cell skin cancers)?

FYI QUESTION #10 IS A SEPARATE SECTION! IT DOES NOT COUNT AS A YES ANSWER TOWARDS GRADED!

11. In the past 12 months, has the Proposed Insured used any form of tobacco or nicotine products?

DECLARATIONS AND AUTHORIZATION DECLARATIONS

I have read and received the Pre-Notices attached to this application. I agree that: 1) all statements and answers are true and complete to the best of my knowledge and belief; 2) this application will be a part of the policy; 3) temporary insurance coverage starts and remains in effect only as provided in the "Conditional Receipt". I certify, under penalty of perjury that the social security numbers shown on the application are correct. I understand that the agent is not authorized to accept risks or pass on insurability, to make or modify contracts, or waive the Company's rights including the requirement that the adult Proposed Insured personally sign this application in the agent's presence.

If the Company does not issue a policy from this application, the application will be cancelled, and a refund will be made. By accepting a policy issued from this application, the owner agrees to any changes made by the Company. I understand that I may attend any and all meetings of the policyholders of the Company. If I do not attend, the Executive Committee of the Board of Directors will act as my lawful proxy, until that proxy is revoked by me, in writing. The annual meeting of policyholders shall be held at 10:00 a.m. on the second Tuesday in March, each year.

I permit the Company to give information about me and any Proposed Insured except HIV test results to MIB, LLC, any reinsurer, and other insurer(s) from which benefits have been claimed or insurance purchased. I acknowledge receipt of the Notice Regarding MIB, LLC, Notice Regarding Fair Credit Reporting Act and Notice of Information Practices before signing this form. I understand that I may request in writing to be interviewed. If any investigative consumer report is prepared in connection with this application, upon written request, I am entitled to receive a copy. I understand that there is no benefit paid for suicide for the first two policy years.

I consent for the Company to use my signature for electronic processing of this application. This electronic signature will have the same effect as a physical wet signature associated with paper applications and will appear on all records related to the purchase of this policy. My consent also permits the general use of electronic records and electronic signatures in connection with the policy applied for. By giving my consent, the Company can deliver any required information to me electronically. I may change my mind and withdraw consent for electronic delivery or e-signature at any time; however, if I withdraw my consent prior to electronic delivery of the policy, I understand that the Company cannot continue to process the application. To withdraw my consent, I can send notice by email or US mail to the Company's service center.

AUTHORIZATION TO OBTAIN INFORMATION

By this form, I authorize any licensed physician, medical practitioner, clinic, hospital, other medical or medically-related facility, the Veterans Administration, MIB, LLC, an employer, consumer reporting agency, any person, organization, other institution or other insurance companies that have records or knowledge about me or any children to be insured (if applicable) to release this information to The American Home Life Insurance Company. This information may be about: (a) employment; (b) occupation; (c) avocations; (d) other insurance coverage; (e) driving record; (f) age; (g) prescription drug usage; (h) any medical history, condition, care or advice relative to the Proposed Insured's physical or mental health; and (i) other personal characteristics. This AUTHORIZATION extends to information on the use of alcohol, drugs and tobacco; and the diagnosis or treatment of HIV (the virus that causes AIDS) infection or other sexually transmitted disease. I understand that this information will be used by The American Home Life Insurance Company, its representatives or reinsurers in the evaluation of this application to determine eligibility for insurance and/or to investigate claims. The American Home Life Insurance Company or its representatives may release information covered by this AUTHORIZATION to the American Home Agent(s) listed in my application for insurance, to its subsidiaries, reinsurers, the MIB, LLC, or other insurance companies. The American Home Life Insurance Company may also release this information to others who I authorize in writing or as allowed by law.

This AUTHORIZATION may be used for the period of time allowed by law in the state where the policy is delivered or issued for delivery from the date signed below for collecting information in connection with an application for an insurance policy, policy reinstatement or claim unless sooner revoked. I may revoke this AUTHORIZATION at any time by notifying The American Home Life Insurance Company in writing at Underwriting Department, The American Home Life Insurance Company, P.O. Box 1497, Topeka, KS 66601. My revocation will not be effective to the extent The American Home Life Insurance Company, its reinsurers, or any other person already has disclosed or collected information or taken other action in reliance on the AUTHORIZATION. I understand this authorization will continue to be effective to the extent that The American Home Life Insurance Company has a legal right to contest a claim under an insurance policy or to contest a policy itself and that neither death nor revocation would void this authorization. I understand that my application for insurance will not be considered unless this AUTHORIZATION is signed and dated. The information The American Home Life Insurance Company or its reinsurers obtains through this AUTHORIZATION may become subject to further disclosure, as required by law. 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 except as authorized by me or as required by law. I agree that a photocopy of this AUTHORIZATION is as valid as the original. I understand that I have the right to receive a copy of this AUTHORIZATION upon request.