



American Mutual Life Association
(A Fraternal Benefit Society)
 19424 S. Waterloo Road, Cleveland, OH 44119
 216-531-1900

Home Office Use Only

App. Status: _____	Lodge # _____
Plan Code: _____	Contract # _____
Issue Age: _____	Issue Date: _____
<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Smoker <input type="checkbox"/> Non-Smoker

A. Proposed Insured

1. Full Name (print): _____
2. Full Address: _____
 (Address) (City) (State) (Zip)
3. Birth date (MM/DD/YY): _____ Phone #: _____
 Birthplace: _____ Email: _____
4. Sex: M F Height: _____ft _____in. Weight: _____
5. Social Security #: _____
6. Occupation: _____
 a. Name of employer: _____
 b. Employer's address and phone #: _____
 c. Length of employment: Years: _____ Months: _____
 d. Describe duties: _____
7. If Proposed Insured is not the Applicant, describe relationship of Applicant to Proposed Insured: _____
8. Name, address and Social Security # of Owner of insurance applied for, if not Proposed Insured: _____

Plan	Code	Ins. Amt.	Prem/\$1000	Tot. Prem
W.L.				
20 PL				
3 PL				
SPWL				
Term				
Rider(s)				
Totals				
Paid with Application:				

9. Face Amount of Insurance applied for: _____ Plan of Insurance: _____
 Rider(s): _____ Premium: _____
- Method of Payment: Single Premium Annual Semi-Annual Quarterly Monthly
- Dividend Option: Purchase Paid Up Adds. Pay In Cash Accum. at Interest Reduce Premiums

B. Beneficiary

	Name and address of Beneficiary:	Social Security #	Relationship:	Share %:
Primary:				
Contingent:				

C. General Information

1. Foreign Travel, Aviation, and Military
 - a. Does the Proposed Insured intend to travel outside the U.S. or Canada within the next two years? Yes No
 - b. Except as a passenger on a regularly scheduled flight, does the Proposed Insured intend to fly or has he/she flown within the past two years? Yes No
 - c. Is the Proposed Insured a member, or does he/she intend to become a member of the Armed Forces (including Reserves and National Guard)? Yes No
2. In the past three years, has the Proposed Insured participated in any form of racing, skin or scuba diving, parachuting, hang gliding, rock climbing or any similar sport or avocation? Yes No
3. Driving Information
 - a. Proposed Insured's driver's license #: _____ State: _____
 - b. Has the Proposed Insured been charged with any moving violation or accident, had driving license suspended or been convicted of driving under the influence of drugs or alcohol within the last five years? Yes No
4. Has any company declined to issue, renew or reinstate, rated, modified or postponed or cancelled any life or health insurance on the life of the Proposed Insured? Yes No
 If YES, explain: When? _____ What Company? _____
5. a. Does the Proposed Insured currently have life insurance on his/her life? Yes No. If YES, in what amount: _____
 b. If YES to part 5a. or if this contract is issued, will the discontinuing of premium payments, surrendering, forfeiting, assigning to the insurer or otherwise terminating an existing policy or contract being considered? Yes No
 c. Is using funds from the existing policy or contract to pay premiums due on the insurance applied for herein being considered? Yes No
6. Does any person named as Beneficiary or Contingent Beneficiary lack an insurable interest* in the person to be insured?
 Yes No If yes, please explain _____
7. Is there an arrangement or an intent to sell or transfer ownership to a third-party on the policy applied for, in whole or in part?
 Yes No If yes, please explain _____

D. Medical Information

Part 1- Please Answer the Following Questions. If Questions 1 or 2-C are Answered "Yes", Skip Part 2 and Complete Part 3.

1. Is Proposed Insured a member of the American Mutual Life Association? If no, apply for membership. Yes No
2. Has the Proposed Insured used any nicotine products (cigarettes, cigars, chewing tobacco, pipe, nicotine gum patch or other)
 - a. In the past 12 months? Yes No
 - b. In the past 36 months? Yes No
 - c. In the past 60 months? Yes No

Part 2- If Any Question Below is Answered "Yes", Please Complete Part 3.

3. Within the past 5 years, has Proposed Insured been hospitalized; or received medical treatment or been diagnosed with any illness, disease, injury or physical condition? Yes No
4. Does Proposed Insured have any physical or mental handicaps? Yes No

Part 3- Please Complete the Following Questions

5. During the past seven years has the Proposed Insured been examined or prescribed medication by a physician or medical practitioner? Yes No
6. Has the Proposed Insured **ever** been treated for, or been diagnosed by a physician as having:
 - a. Cancer, diabetes or high blood pressure? Yes No
 - b. Disease or disorder of the heart or blood? Yes No
 - c. Nervous or mental condition, or any abnormality of the brain or nervous system? Yes No
 - d. Any disease or abnormality of the lungs or respiratory system? Yes No
 - e. Disease or abnormality of the kidneys, liver, prostate or genitourinary system? Yes No
 - f. Disease or abnormality of the gastrointestinal system? Yes No
 - g. Disorder of the muscles, bones or joints? Yes No
7. Has the Proposed Insured ever been advised to seek treatment or counseling, been treated for or received counseling, or joined a support group for the use of alcohol? Yes No
8. During the last 5 years has the Proposed Insured been hospitalized or had surgery of any kind? Yes No
9. Has the Proposed Insured:
 - a. Used barbiturates, heroin, cocaine, marijuana or any illegal, restricted or controlled substance except as prescribed by a physician? Yes No
 - b. Been advised to seek or received treatment for drug use, or been arrested for drug use or distribution? Yes No
10. If female, is Proposed Insured pregnant? Yes No
11. Is any medication currently prescribed for the Proposed Insured? Yes No

Give Details for all YES answers to Questions 2 through 11 above.

Question #	Dates	Medical Condition	Name & Address of Doctor(s)

E. Family History

Family Record	Living		Dead	
	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers/ Sisters				
Have any of your parents, brothers, or sisters ever had heart disease, diabetes or mental illness? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES explain:				

I AGREE THAT NO INSURANCE SHALL TAKE EFFECT UNLESS AND UNTIL: (1) the first premium shall have been paid; (2) a contract is delivered to the Applicant during the Proposed Insured's lifetime; (3) the health of the Proposed Insured is as described in the Application; and (4) all requirements of the Constitution and Bylaws of AMLA have been complied with.

Signed at: _____ this: _____ day of: _____ 20____.

Based upon the information provided, it is my understanding that the insurance applied for herewith will not change or replace any existing insurance or annuities.

Applicant

Signature of Agent/Home Office Representative

Proposed Insured's Signature Required if not Applicant
(Parent or Guardian if Proposed Insured is under age 16)

Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application containing a false or deceptive statement is guilty of insurance fraud.

AMERICAN MUTUAL LIFE ASSOCIATION IS LICENSED TO DO BUSINESS IN THE STATE OF OHIO. AS A TAX-EXEMPT ORGANIZATION, FRATERNAL BENEFIT SOCIETIES ARE NOT INCLUDED IN THE OHIO GUARANTY ASSOCIATION. THIS MEANS THAT FRATERNAL BENEFIT SOCIETIES CANNOT BE ASSESSED FOR THE INSOLVENCY OF OTHER LIFE INSURERS OR OTHER FRATERNAL BENEFIT SOCIETIES. BY LAW, A FRATERNAL BENEFIT SOCIETY IS RESPONSIBLE FOR ITS OWN SOLVENCY. IF THERE IS AN IMPAIRMENT OF RESERVES, A CERTIFICATE HOLDER MAY BE ASSESSED A PROPORTIONAL SHARE OF THE IMPAIRMENT. THIS PROCESS IS DESCRIBED IN THE CERTIFICATE ISSUED BY THE SOCIETY.

AUTHORIZATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, medical or medically related facility, or other health care provider, insurance or reinsuring company, consumer reporting agency, the MIB LLC (MIB), or other organization, institution, or person, that has any records or knowledge of me or my health, to give the AMLA or its representatives or its reinsurer, any such information it may require to determine eligibility for insurance. I authorize MIB, AMLA, or it's reinsurer to make a brief report of my personal health to MIB. The applicant or duly authorized representative of the applicant is entitled to a copy of this authorization.

Duration and revocation: This authorization is valid for 30 months after the date shown below, but I understand that I may revoke it at any time by giving written notice to AMLA at the above address. I understand that there are limitations on my right to revoke this authorization. Any action taken in reliance on this authorization will be valid if such action has been taken prior to receipt of notice of revocation. If this authorization is used to collect information in connection with a claim for benefits, it will be valid for the duration of the claim. If the law of my state so provides, my authorization may not be revoked during a contestable investigation. I also understand that my revocation of this authorization will not result in the deletion of codes in the MIB database if such codes are reported by AMLA (or AMLA becomes obligated to report such codes to MIB) while this authorization is in force.

A photographic copy of this authorization shall be as valid as the original.

**Insurable interest - A connection by blood of the beneficiary to the insured or an economic connection under which the beneficiary stands to suffer financial loss by reason the death of the insured.*

For Home Office Use

Approved Remarks: _____
 Disapproved _____

Dated: _____ Signed _____



PRE-NOTICE REGARDING MIB, LLC (MIB)

Information regarding your insurability will be treated as confidential. American Mutual Life Association, or our reinsurers, may make a brief report to MIB. MIB is a membership organization of insurance companies that 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 of benefits is submitted to such a company, MIB, upon request, will supply the company with the information in its file. At your request, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in MIB's file, you may contact MIB and seek 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]. The telephone number is [866-692-6901]. Information for consumers about MIB may be obtained on its website at [www.MIB.com].

(This page stays with the Applicant at the time the application is completed)